*****REVISED*****

INFORMAL NOTICE OF RULEMAKING

THE DEPARTMENT INTENDS TO CONDUCT NEGOTIATED RULEMAKING IN NOVEMBER 2021 REGARDING DRAFT RULE CHANGES NECESSARY FOR THE IMPLEMENTATION OF A NEW RESOURCE ALLOCATION MODEL FOR MEDICAID'S ADULT DEVELOPMENTAL DISABILITIES PROGRAM.

PEOPLE WILL HAVE AN OPPORTUNITY TO PROVIDE FORMAL WRITTEN COMMENTS TO THE DEPARTMENT FROM NOVEMBER 3, 2021 THROUGH NOVEMBER 26, 2021. ADDITIONALLY, PEOPLE WILL HAVE AN OPPORTUNITY TO PROVIDE SPOKEN COMMENTS TO THE DEPARTMENT DURING AN ON-LINE PUBLIC MEETING ON TUESDAY, NOVEMBER 16, 2021 AT 2:00 PM (MOUNTAIN TIME).

AFTER COMPLETING THE NEGOTIATED RULEMAKING PROCESS, THE DEPARTMENT WILL REVIEW THE PUBLIC COMMENTS RECEIVED AND REVISE THE DRAFT RULES AS NEEDED.

THE DEPARTMENT INTENDS TO PUBLISH TEMPORARY RULES WHICH WILL BECOME EFFECTIVE MAY 2022 TO ALLOW THE DEPARTMENT TO BEGIN THE IMPLEMENTATION OF THE NEW RESOURCE ALLOCATION MODEL IN JUNE 2022 AS REQUIRED BY THE FEDERAL DISTRICT COURT OF IDAHO.

IN ADDITION TO THE TEMPORARY RULES, THE DEPARTMENT INTENDS TO PUBLISH THE SAME TEXT AS PROPOSED RULES THAT WILL UNDERGO AN ADDITIONAL 90-DAY PUBLIC COMMENT PERIOD, BE REVISED AS NEEDED BY THE DEPARTMENT, AND THEN BE REVIEWED BY THE IDAHO LEGISLATURE DURING THE 2023 LEGISLATIVE SESSION.

The Department is making these draft rule changes available prior to the publication of the negotiated rulemaking notice in the Idaho Administrative Bulletin to ensure people have enough time to review the draft changes prior to the comment period and the on-line public meeting. Additional details about how people can join the on-line public meeting and submit formal comments will be published on this website and in the Idaho Administrative Bulletin on November 3, 2021.

INSTRUCTIONS FOR READING THIS DOCUMENT

This draft reflects proposed changes to the temporary administrative rules published in the July 21, 2021 special edition of the Idaho Administrative Bulletin. Additions are marked in red underlined font and deletions are marked in ~~blue strikethrough font~~. An initial draft of these proposed changes was published on the "What's New" tab of the My Choice Matters website on October 18, 2021. Additional updates have been made since the initial posting. Changes made since the initial posting are highlighted in yellow.

OVERVIEW OF RULEMAKING

BACKGROUND

Since 2012, the Department has been party to a class action lawsuit, (known as *K.W. v. Armstrong*), which relates to the allocation of Medicaid dollars among individuals in the Idaho adult developmental disabilities program. The federal court concluded that the then-existing budget tool (used to allocate resources within the state's adult developmental disabilities program) violated individuals' due process rights under the fourteenth amendment of the U.S. Constitution because of its unreliability. The parties then reached a settlement agreement, which was approved by the federal court in 2017.

Under the settlement agreement, the Department is required to adopt and implement a new resource allocation model that will determine personal supports budgets for participants in the adult developmental disabilities program. The settlement agreement set a deadline for the implementation of the new resource allocation model, but allowed the parties to negotiate a new completion deadline if the original deadline could not be met.

Additionally, if the parties could not agree on a new completion deadline, they could ask the Court to set a "reasonable completion deadline."

In this case, the Department could not meet the original deadline and the parties could not agree on a new completion deadline. The parties returned to court and the Department requested an extension of the completion deadline to July 2024. In December of 2020, the Court set the new "reasonable completion deadline" as June 2022.

To implement the new resource allocation model, the Department intends to make the following primary program changes:

- Replace SIB-R assessment tool with the Vineland-3 and SIS-A Assessment tools;
- Determine annual budgets using proposed five-level framework and stop calculating budgets using the old budget tool; and
- Change the available service array to provide more service options for participants to choose:
    - Modify supported living residential habilitation services;
    - Add Community Habilitation services;
    - Add Prevocational services;
    - Add Career Planning services;
    - Modify Non-Medical Transportation services; and
    - Modify Service Coordination services.

SUMMARY OF DRAFT RULE CHANGES FOR IDAPA 16.03.10

SECTION 09 (Pages 6-7). Updates criminal history and background check requirements to require that providers of new or modified services have and pass a criminal history and background check.

SECTION 079 (Pages 7). Updates section references.

SECTIONS 310, 311 and 317 (Pages 8-10). Updates section references and clarifies that plan developers must sign an individual's Medicaid Plan of Service.

SECTIONS 326 (Pages 10-16). Updates section references and splits out the A&D Waiver Habilitation service into two distinct benefits (Residential Habilitation and Day Habilitation) for programmatic alignment with new program array.

SECTIONS 330 (Page 16). Adds Residential Habilitation to the per diem reimbursement structure for programmatic alignment with new program array.

SECTION 501 (Pages 16-20). Updates the standard deviation used to identify when an adult has a substantial functional limitation in a major life activity required to decide if a person has a developmental disability. The Department is proposing to change the standard deviation for adults from 2 to 1.5, which has the potential to broaden the definition of a developmental disability. Includes technical updates to clarify the standards being utilized for determining a developmental disability.

SECTION 507 (Pages 20-21). Clarifies which services are subject to the Prior Authorization Rules in Sections 507 - 515. Relocates appeal rules to ensure they apply to all prior authorization decisions instead of only the prior authorization of the plan of service (Section 513).

SECTION 508 (Pages 21-22). Removes duplicate and unneeded definitions. Clarifies the uses of a Department-Approved Assessment Tool. Updates section references.

SECTION 509 (Pages 22-24). Clarifies the purposes of assessment for eligibility and setting participant's budgets. Clarifies what the parts of an assessment are. Clarifies the types of assessments and when assessments will be completed.

SECTION 510 (Pages 24-25). Describes the criteria the department will use to set participant's budget, the reasons for budget modifications, and when budget determinations/re-determinations will be made.

SECTION 513 (Pages 26-30). Combines and deleted duplicate references about plan development and plan monitoring requirements previously included in Sections 513, and the Service Coordination Sub-Area in Sections 720-779). Updates provider implementation plan and status review requirements for new and existing provider types. Clarifies annual reauthorization process.

SECTION 514 (Pages 31-32). Removes description of how participant budgets are set from this provider reimbursement section and removes high and intense supported living language from this section. Rules about how participant's budgets are set and modified are included in Section 510.

SECTION 515 (Pages 32-33). Removes exception review language from the quality assurance section. Similar processes are described in Section 510 about budget modification. Deletes unneeded concurrent review process.

SECTION 584 (Pages 33-35). Modifies SIB-R scores currently used to determine ICF/ID Level of Care to Vineland-3 scores.

SECTIONS 645-699 (Pages 35-50). Reorganizes the existing 1915(i) adult developmental disability state plan home and community-based services (HCBS) rules to be similar to the organization of the 1915(c) waiver service rules (Sections 700-719). Clarifies eligibility requirements for the state plan HCBS services. Adds service descriptions and provider qualifications for the new community habilitation service and for non-medical transportation service (which is being moved from the waiver to the state plan HCBS services).

SECTIONS 700-719 (Pages 50-63). Clarifies eligibility requirements and re-determination process for waiver services. Modifies service definition, limitations and provider qualifications for residential habilitation. Adds prevocational and career planning service definitions, limitations, and provider qualifications. Removes Non-Medical Transportation from this section of rule because it was moved to the state plan HCBS services (Sections 645-699). Updates waiver provider record requirements.

SECTIONS 720-779 (Pages 63-74). Clarifies conflict of interests standards for plan developers. Deletes duplicate eligibility requirements. Deletes duplicate references about plan development and plan monitoring which have been moved to Sections 513. Aligns definition of crisis assistance provided by service coordinators with crisis support services that can be provided by other provider types as part of the state plan HCBS services. Modifies limitations of adult service coordination to allow for 12 hours of plan development per year and to allow unused service coordination hours to roll over from month-to-month during a plan year.

SUMMARY OF DRAFT RULE CHANGES FOR IDAPA 16.03.13

SECTION 135 (Pages 75). Clarifies Conflict of interest standards for support brokers.

SECTION 190 (Pages 76). Updates how self-direction budgets will be set and refers to IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 510.

16.03.10 – MEDICAID ENHANCED PLAN BENEFITS

[Sections Omitted]

09. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Criminal History Check. Agencies must verify that individuals working in the area listed in Subsection 009.03 of these rules whom are employed or whom they contract have complied with the provisions in IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." Except, through the duration of the declared COVID-19 public health emergency, if the individuals working in the area listed in this rule are unable to complete a criminal background check in accordance with the timeframes set forth in IDAPA 16.05.06, then agencies may allow newly hired direct care staff to begin rendering services prior to completion of the criminal background check in accordance with the requirements specified by the Department in a COVID-19 information release posted on the Department's website at Medicaid/InformationReleases/tabid/264/Default.aspx. (7-1-21)T

02. Additional Criminal Convictions. Once an individual has received a criminal history clearance, any additional criminal convictions must be reported by the agency to the Department when the agency learns of the conviction. (7-1-21)T

03. Providers Subject to Criminal History and Background Check Requirements. The following providers are required to have a criminal history and background check: (7-1-21)T

a. Adult Day Health Providers. The criminal history and background check requirements applicable to providers of adult day health as provided in Sections 329 and 705 of these rules. (7-1-21)T

b. Adult Residential Care Providers. The criminal history and background check requirements applicable to adult residential care providers as provided in Section 329 of these rules. (7-1-21)T

c. Attendant Care Providers. The criminal history and background check requirements applicable to attendant care providers as provided in Section 329 of these rules. (7-1-21)T

d. Behavior Consultation or Crisis Management Providers. The criminal history and background check requirements applicable to behavior consultation or crisis management providers as provided in Section 705 of these rules. (7-1-21)T

e. Career Planning and Prevocational Providers. The criminal history and background check requirements applicable to career planning and prevocational providers as provided in Section 705 of these rules. (XX-XX-XX)

~~e.~~f. Certified Family Home Providers and All Adults in the Home. The criminal history and background check requirements applicable to certified family homes are found in Sections 305, 329 and 705 of these rules, and as provided in IDAPA 16.03.19, "Rules Governing Certified Family Homes." (7-1-21)T

~~f.~~g. Chore Services Providers. The criminal history and background check requirements applicable to chore services providers as provided in Sections 329 and 705 of these rules. (7-1-21)T

~~g.~~h. Companion Services Providers. The criminal history and background check requirements applicable to companion services providers as provided in Section 329 of these rules. (7-1-21)T

i. Community Habilitation Providers. The criminal history and background check requirements applicable to community habilitation providers as provided in Section 650 of these rules. (XX-XX-XX)

~~h.~~j. Day Habilitation Providers. The criminal history and background check requirements applicable to day habilitation providers as provided in Section 329 of these rules. (XX-XX-XX)~~(7-1-21)T~~

~~i.~~k. Developmental Disabilities Agencies (DDA). The criminal history and background check for DDA and staff as provided in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," Section 009. (XX-XX-XX)~~(7-1-21)T~~

~~j.~~l. Homemaker Services Providers. The criminal history and background check requirements applicable to homemaker services providers as provided in Section 329 of these rules. (XX-XX-XX)~~(7-1-21)T~~

m. Non-Medical Transportation Providers. The criminal history and background check requirements applicable to non-medical transportation providers as provided in Sections 329 and 650 of these rules. (XX-XX-XX)

~~k.~~n. Personal Assistance Agencies Acting As Fiscal Intermediaries. The criminal history and background check requirements applicable to the staff of personal assistance agencies acting as fiscal intermediaries as provided in Subsection 329.02 of these rules. (XX-XX-XX)~~(7-1-21)T~~

~~l.~~o. Personal Care Providers. The criminal history and background check requirements applicable to personal care providers as provided in Subsection 305.06 of these rules. (XX-XX-XX)~~(7-1-21)T~~

~~m.~~p. Residential Habilitation Providers. The criminal history and background check requirements applicable to residential habilitation providers as provided in Sections 329 and 705 of these rules, and IDAPA 16.04.17 "Rules Governing Residential Habilitation Agencies," Sections 202 and 301.(XX-XX-XX)~~(7-1-21)T~~

~~n.~~q. Respite Care Providers. The criminal history and background check requirements applicable to respite care providers as provided in Sections 329, 665, and 705 of these rules. (XX-XX-XX)~~(7-1-21)T~~

~~o.~~r. Service Coordinators and Paraprofessionals. The criminal history and background check requirements applicable to service coordinators and paraprofessionals working for an agency as provided in Section 729 of these rules. (XX-XX-XX)~~(7-1-21)T~~

~~p.~~s. Skilled Nursing Providers. The criminal history and background check requirements applicable to skilled nursing providers as provided in Sections 329 and 705 of these rules. (XX-XX-XX)~~(7-1-21)T~~

~~q.~~t. Supported Employment Providers. The criminal history and background check requirements applicable to supported employment providers as provided in Sections 329 and 705 of these rules. (XX-XX-XX)~~(7-1-21)T~~

~~r.~~u. Therapeutic Consultant. The criminal history and background check requirements applicable to therapeutic consultation providers as provided in Section 685 of these rules. (XX-XX-XX)~~(7-1-21)T~~

[Sections Omitted]

079. MANAGED CARE FOR DUALS: COVERED SERVICES.

01. Coverage and Limitations. (7-1-21)T

a. Idaho Medicaid Plus covered services include Medicaid benefits as described in this chapter and IDAPA 16.03.09, "Medicaid Basic Plan Benefits." (7-1-21)T

b. Services for adults with developmental disabilities as described in Sections ~~511~~507, 580, and 703 of these rules are excluded from Idaho Medicaid Plus. (XX-XX-XX)~~(7-1-21)T~~

c. Services administered under the managed care or brokerage contracts as described in ~~Section 080 of these rules, and~~ IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections ~~870 through 872~~ 803 and 872 are excluded from Idaho Medicaid Plus. (XX-XX-XX)~~(7-1-21)T~~

02. Provider Reimbursement. Idaho Medicaid Plus participating health plans are required to reimburse network providers, at minimum, the established Medicaid fee schedule rates published on the Medicaid provider webpage and developed in accordance with Idaho Code and Department rule. (7-1-21)T

[Sections Omitted]

SUB AREA: HOME AND COMMUNITY-BASED SERVICES
(Sections 310-~~317~~319)

310. HOME AND COMMUNITY-BASED SERVICES.
Home and Community-Based Services (HCBS) are those services and supports that assist eligible participants to remain in their home and community. The federal authorities under 42 CFR 441.301, 42 CFR 441.710, and 42 CFR 441.725 require the state to deliver HCBS in accordance with the rules described in Sections 310 through 319 of these rules. HCBS include the following: (7-1-21)T

01. Children's Developmental Disability Services. Children's developmental disability services as defined in Sections 663 and 683 of these rules. (7-1-21)T

02. Adult Developmental Disability Services. Adult developmental disability services as defined in Sections ~~645 through 659~~647, 650, 703, ~~and~~ 705, 727, and 729 of these rules. (XX-XX-XX)~~(7-1-21)T~~

03. Consumer-Directed Services. Consumer-directed services as defined in IDAPA 16.03.13, "Consumer-Directed Services." (7-1-21)T

04. Aged and Disabled Waiver Services. Aged and disabled waiver services as defined in Section 326 of these rules. (7-1-21)T

05. Personal Care Services. Personal care services as defined in Section 303 of these rules. (7-1-21)T

06. Services for Children with Serious Emotional Disturbance (SED). SED services, as defined in Section ~~368~~638 of these rules, for children who are enrolled in the Medicaid SED program in support of Youth Empowerment Services (YES). (XX-XX-XX)~~(7-1-21)T~~

311. HCBS REQUIREMENTS AND DECISION-MAKING AUTHORITY.
HCBS requirements, contained in Sections 312 through Sections ~~317~~319 of these rules, do not supersede decision-making authority legally assigned to another individual or entity on the participant's behalf. This includes: (XX-XX-XX)~~(7-1-21)T~~

01. Payee. A representative payee appointed by the Social Security Administration; (7-1-21)T

02. Restrictions (Probation or Parole). Court-imposed restrictions related to probation or parole; (7-1-21)T

03. Restrictions (When Committed). Court-imposed restrictions when committed to the Director of Health and Welfare; and (7-1-21)T

04. Legal Guardians Who Retain Full Decision-making Authority. It is presumed that the parent or parents of participants birth through seventeen (17) years of age have full decision-making authority unless the minor child has another legally assigned decision-making authority. (7-1-21)T

[Sections Omitted]

317. HOME AND COMMUNITY-BASED PERSON-CENTERED SERVICE PLAN REQUIREMENTS.
All person-centered service plans must reflect the following components: (7-1-21)T

01. Services And Supports. Clinical services and supports that are important for the participant's behavioral, functional, and medical needs as identified through an assessment. (7-1-21)T

02. Service Delivery Preferences. Indication of what is important to the participant with regard to the service provider and preferences for the delivery of such services and supports. (7-1-21)T

03. Setting Selection. HCBS settings selected by the participant or the participant's decision-making authority are chosen from among a variety of setting options, as required in Section 313 of these rules. The person-centered service plan must identify and document the alternative home and community setting options that were considered by the participant, or the participant's decision-making authority. (7-1-21)T

04. Participant Strengths and Preferences. (7-1-21)T

05. Individually Identified Goals and Desired Outcomes. (7-1-21)T

06. Paid and Unpaid Services and Supports. Paid and unpaid services and supports that will assist the participant to achieve identified goals, and the providers of those services and supports, including natural supports. (7-1-21)T

07. Risk Factors. 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. (7-1-21)T

08. Understandable Language. 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 and persons who are limited English proficient, consistent with 42 CFR 435.905(b). (7-1-21)T

09. Plan Monitor. Identify the name of the individual or entity responsible for monitoring the plan. (7-1-21)T

10. Plan Signatures. Be 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 the plan developer and all individuals and providers responsible for its implementation indicating they will deliver services according to the authorized plan of service and consistent with home and community-based requirements. (XX-XX-XX)~~(7-1-21)T~~

a. Children's DD service providers responsible for implementation of the plan include the providers of those services defined in Section 523 of these rules. (7-1-21)T

b. Adult DD service providers responsible for implementation of the plan include those required to develop a provider implementation plan as defined in Sections 513 ~~and 654~~ of these rules. (XX-XX-XX)~~(7-1-21)T~~

c. Consumer-directed service providers responsible for implementation of the plan include the participant, Support Broker, and Fiscal Employment Agency as identified in IDAPA 16.03.13, "Consumer-Directed Services." (7-1-21)T

d. Personal Care and Aged and Disabled Waiver service providers responsible for the implementation of the plan include the providers of those services defined in Sections 303 and 326 of these rules. Alternate format signatures may be used; refer to Medicaid Information Release MA20-15 for guidance. (7-1-21)T

11. Plan Distribution. Be distributed to the participant and the participant's decision-making authority, if applicable, and other people involved in the implementation of the plan. At a minimum, the following providers will receive a copy of the plan: (7-1-21)T

a. Children's DD providers of services defined in Section 523 of these rules as identified on the plan of service developed by the family-centered planning team. (7-1-21)T

b. Adult DD service providers required to develop a provider implementation plan as defined in Sections 513 ~~and 654~~ of these rules. Additionally, the participant will determine during the person-centered planning process whether the service plan, in whole or in part, will be distributed to any other developmental disability service provider. (XX-XX-XX)~~(7-1-21)T~~

c. Consumer-Directed service providers as defined in IDAPA 16.03.13, "Consumer-Directed

Services," Section 110. Additionally, the participant, or the participant's decision-making authority will determine during the person-centered planning process whether the service plan, in whole or in part, will be distributed to any other community support worker or vendors. (7-1-21)T

d. Personal Care and Aged and Disabled Waiver service providers furnishing those services defined in Sections 303 and 326 of these rules. (7-1-21)T

12. Residential Requirements. For participants living in residential provider owned or controlled settings as described in Section 314 of these rules, the following additional requirements apply: (7-1-21)T

a. Options described in Subsection 317.03 of this rule must include a residential setting option that allows for private units. Selection of residential settings will be based on the participant's needs, preferences, and resources available for room and board. (7-1-21)T

b. Any exception to residential provider owned or controlled setting qualities as described in Section 314 of these rules must be documented in the person-centered plan as described in Section 315 of these rules. (7-1-21)T

[Sections Omitted]

326. AGED AND DISABLED WAIVER SERVICES: COVERAGE AND LIMITATIONS.

01. Adult Day Health. 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 outside the home of the participant in a non-institutional, community-based setting, and it encompasses health services, social services, recreation, supervision for safety, and assistance with activities of daily living needed to ensure the optimal functioning of the participant. Adult day health services provided under this waiver will not include room and board payments. (7-1-21)T

02. Adult Residential Care Services. Adult residential care services consist of a range of services provided in a homelike, non-institutional setting that include RALFs and CFHs. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. (7-1-21)T

a. Adult residential care services consist of a range of services provided in a congregate setting licensed under IDAPA 16.03.22, "Residential Assisted Living Facilities," that include: (7-1-21)T

i. Medication assistance, to the extent permitted under State law; (7-1-21)T

ii. Assistance with activities of daily living; (7-1-21)T

iii. Meals, including special diets; (7-1-21)T

iv. Housekeeping; (7-1-21)T

v. Laundry; (7-1-21)T

vi. Transportation; (7-1-21)T

vii. Opportunities for socialization; (7-1-21)T

viii. Recreation; and (7-1-21)T

ix. Assistance with personal finances. (7-1-21)T

x. Administrative oversight must be provided for all services provided or available in this setting. (7-1-21)T

xi. A documented individual service plan must be negotiated between the participant or their legal representative, and a facility representative. (7-1-21)T

b. Adult residential care services also consist of a range of services provided in a setting licensed under IDAPA 16.03.19, "Certified Family Homes," that include: (7-1-21)T

i. Medication assistance, to the extent permitted under State law; (7-1-21)T

ii. Assistance with activities of daily living; (7-1-21)T

iii. Meals, including special diets; (7-1-21)T

iv. Housekeeping; (7-1-21)T

v. Laundry; (7-1-21)T

vi. Transportation; (7-1-21)T

vii. Recreation; and (7-1-21)T

viii. Assistance with personal finances. (7-1-21)T

ix. Administrative oversight must be provided for all services provided or available in this setting. (7-1-21)T

x. A documented individual service plan must be negotiated between the participant or their legal representative, and a facility representative. (7-1-21)T

03. Specialized Medical Equipment and Supplies. (7-1-21)T

a. Specialized medical equipment and supplies include: (7-1-21)T

i. Devices, controls, or appliances that enable a participant to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live; and (7-1-21)T

ii. Items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. (7-1-21)T

b. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid State plan and exclude those items that are not of direct medical or remedial benefit to the participant. (7-1-21)T

04. Non-Medical Transportation. Non-medical transportation enables a waiver participant to gain access to waiver and other community services and resources. (7-1-21)T

a. Non-medical transportation is offered in addition to medical transportation required in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and will not replace it. (7-1-21)T

b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge, or public transit providers will be utilized. (7-1-21)T

05. Attendant Care. Services provided under a Medicaid Home and Community-Based Services waiver that involve personal and medically oriented tasks dealing with the functional needs of the participant and accommodating the participant's needs for long-term maintenance, supportive care, or activities of daily living (ADL). These services may include personal assistance and medical tasks that can be done by unlicensed persons, or delegated to an unlicensed person by a licensed health care professional or the participant. Services are based on the participant's

abilities and limitations, regardless of age, medical diagnosis, or other category of disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. (7-1-21)T

06. Chore Services. Chore services include the following services when necessary to maintain the functional use of the home, or to provide a clean, sanitary, and safe environment: (7-1-21)T

a. Intermittent assistance may include the following. (7-1-21)T

i. Yard maintenance; (7-1-21)T

ii. Minor home repair; (7-1-21)T

iii. Heavy housework; (7-1-21)T

iv. Sidewalk maintenance; and (7-1-21)T

v. Trash removal to assist the participant to remain in the home. (7-1-21)T

b. Chore activities may include the following: (7-1-21)T

i. Washing windows; (7-1-21)T

ii. Moving heavy furniture; (7-1-21)T

iii. Shoveling snow to provide safe access inside and outside the home; (7-1-21)T

iv. Chopping wood when wood is the participant's primary source of heat; and (7-1-21)T

v. Tacking down loose rugs and flooring. (7-1-21)T

c. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community volunteer, agency, or third-party payer is willing to provide them or is responsible for their provision. (7-1-21)T

d. In the case of rental property, the landlord's responsibility under the lease agreement will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (7-1-21)T

07. Companion Services. Companion services include non-medical care, supervision, and socialization provided to a functionally impaired adult. Companion services are in-home services to ensure the safety and well-being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergency situations, or other conditions that would require a person on-site. The service provider, who may live with the participant, may provide voice cuing and occasional assistance with toileting, personal hygiene, dressing, and other activities of daily living. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. However, the primary responsibility is to provide companionship and be there in case they are needed. (7-1-21)T

08. Consultation. Consultation services are services to a participant or family member. Services are provided by a Personal Assistance Agency to a participant or family member to increase their skills as an employer or manager of their own care. Such services are directed at achieving the highest level of independence and self-reliance possible for the participant and the participant's family. Services include consulting with the participant and family to gain a better understanding of the special needs of the participant and the role of the caregiver. (7-1-21)T

09. Home Delivered Meals. Home delivered meals are meals that are delivered to the participant's home to promote adequate participant nutrition. One (1) to two (2) meals per day may be provided to a participant who: (7-1-21)T

a. Rents or owns a home; (7-1-21)T

b. Is alone for significant parts of the day; (7-1-21)T

c. Has no caregiver for extended periods of time; and (7-1-21)T

d. Is unable to prepare a meal without assistance. (7-1-21)T

10. Homemaker Services. Homemaker services consist of performing for the participant, or assisting them with, or both, the following tasks: laundry, essential errands, meal preparation, and other routine housekeeping duties if there is no one else in the household capable of performing these tasks. (7-1-21)T

11. Environmental Accessibility Adaptations. Environmental accessibility adaptations include minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization or have a risk to health, welfare, or safety. Such adaptations may include: (7-1-21)T

a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but must exclude those adaptations or improvements to the home that are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. (7-1-21)T

b. Unless otherwise authorized by the Department, permanent environmental modifications are limited to a home that is the participant's principal residence, and is owned by the participant or the participant's non- paid family. (7-1-21)T

c. 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. (7-1-21)T

12. Personal Emergency Response System (PERS). PERS is an electronic device that enables a waiver participant to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. This service is limited to participants who: (7-1-21)T

a. Rent or own a home, or live with unpaid caregivers; (7-1-21)T

b. Are alone for significant parts of the day; (7-1-21)T

c. Have no caregiver for extended periods of time; and (7-1-21)T

d. Would otherwise require extensive, routine supervision. (7-1-21)T

13. Respite Care. Respite care includes short-term breaks from care giving responsibilities to non-paid caregivers. The caregiver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other services that are duplicative in nature. Respite care services provided under this waiver do not include room and board payments. Respite care services may be provided in the participant's residence, a CFH, a developmental disabilities agency, a RALF, or an adult day health facility. (7-1-21)T

14. Skilled Nursing. Skilled nursing includes intermittent or continuous oversight, training, or skilled care that is within the scope of the Nurse Practice Act. Such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a licensed registered nurse, licensed to practice in Idaho. These services are not appropriate if they are less cost effective than a Home Health visit. (7-1-21)T

~~**15. Habilitation.** Habilitation services assist the participant to reside as independently as possible in the community, or maintain family unity. (7-1-21)T~~

~~**a.**~~**15. Residential Habilitation.** Residential habilitation services consist of an integrated array of individually tailored services and supports furnished to eligible participants. These services and supports are designed to assist the participants to reside successfully in their own homes, with their families, or in certified family homes.

The services and supports that may be furnished consist of the following: (XX-XX-XX)~~(7-1-21)T~~

a. Habilitation services aimed at assisting the individual to acquire, retain, or improve their ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (XX-XX-XX)

i. Self-direction consists of identifying and responding to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (7-1-21)T

ii. Money management consists of training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (7-1-21)T

iii. Daily living skills consist of training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self-administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, as well as following home safety, first aid, and emergency procedures; (7-1-21)T

iv. Socialization consists of training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to their community. Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities, and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities that are merely diversional or recreational in nature; (7-1-21)T

v. Mobility consists of training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; or (7-1-21)T

vi. Behavior shaping and management consist of training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors, or extension of therapeutic services that consist of reinforcing physical, occupational, speech, and other therapeutic programs. (7-1-21)T

~~**vii.**~~**b.** Personal assistance services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the person or the person's primary caregiver(s) are unable to accomplish on their own behalf. ~~Personal assistance activities include direct assistance with grooming, bathing, and eating, assistance with medications that are ordinarily self-administered, supervision, communication assistance, reporting changes in the waiver participant's condition and needs, household tasks essential to health care at home to include general cleaning of the home, laundry, meal planning and preparation, shopping, and correspondence.~~ (XX-XX-XX)~~(7-1-21)T~~

c. Transportation integral to meeting the participant's goals, desired outcomes, and needs as specified in the plan. (XX-XX-XX)

d. Limitations. (XX-XX-XX)

i. Residential Habilitation services may be provided in the individual's home or in the community but not in a developmental disability facility, defined in Section 39-4604, Idaho Code, and must not duplicate other types of habilitation services provided to the individual. (XX-XX-XX)

ii. Transportation to and from the site of other discrete waiver services is not included in the residential habilitation rate, but may be provided as non-medical transportation (a separately billable service). (XX-XX-XX)

~~**b.**~~**16. Day Habilitation.** Day habilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting, separate from the home or facility in which the participant resides. Services will normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, unless provided as an adjunct to other day activities included in a participant's plan of care. Day habilitation services will focus on enabling the participant to attain or maintain their maximum functional level and will be coordinated with any physical therapy, occupational therapy, or speech-language pathology services listed in the plan of care. In addition, day habilitation services may

serve to reinforce skills or lessons taught in school, therapy, or other settings. (7-1-21)T

~~16.~~17. **Supported Employment.** Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work. (XX-XX-XX)~~(7-1-21)T~~

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. (7-1-21)T

b. Federal Financial Participation (FFP) cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize the employer's participation in a supported employment program, payments that are passed through to beneficiaries of a supported employment program, or payments for vocational training that is not directly related to a waiver participant's supported employment program. (7-1-21)T

~~17.~~18. **Transition Services.** Transition services include goods and services that enable a participant residing in a nursing facility, hospital, IMD, or ICF/ID to transition to a community-based setting. A participant is eligible to receive transition services immediately following discharge from a qualified institution after residing within that institution for a minimum of forty-five (45) Medicaid-reimbursed days. (XX-XX-XX)~~(7-1-21)T~~

a. Qualified Institutions include the following: (7-1-21)T

i. Skilled, or Intermediate Care Facilities; (7-1-21)T

ii. Nursing Facility; (7-1-21)T

iii. Licensed Intermediate Care Facility for the Persons with Intellectual Disabilities (ICF/ID); (7-1-21)T

iv. Hospitals; and (7-1-21)T

v. Institutions for Mental Diseases (IMD). (7-1-21)T

b. Transition services may include the following goods and services: (7-1-21)T

i. Security deposits that are required to obtain a lease on an apartment or home; (7-1-21)T

ii. Cost of essential household furnishings, including furniture, window coverings, food preparation items, and bed/bath linens; and (7-1-21)T

iii. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (7-1-21)T

iv. Services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (7-1-21)T

v. Moving expenses; and (7-1-21)T

vi. Activities to assess need, arrange for and procure transition services. (7-1-21)T

c. Excluded goods and services. Transition services do not include ongoing expenses, real property, ongoing utility charges, décor, or diversion/recreational items such as televisions, DVDs, and computers. (7-1-21)T

d. ~~Service limitations.~~ Limitations. Transition services are limited to a total cost of two thousand dollars ($2,000) per participant and can be accessed every two (2) years, contingent upon a qualifying transition from

an institutional setting. Transition services are furnished only to the extent that the person is unable to meet such expense or when the support cannot be obtained from other sources. (XX-XX-XX)~~(7-1-21)T~~

[Sections Omitted]

330. AGED AND DISABLED WAIVER SERVICES: PROVIDER REIMBURSEMENT.

The criteria used in reimbursing providers for waiver services are listed in Subsections 330.01 through 330.03 of these rules. (7-1-21)T

01. Fee for Services. Waiver service providers will be paid on a fee for service basis as established by the Department, or as agreed upon by the Department's contractor and the provider, depending on the type of service provided. Adult residential care and residential habilitation will be paid on a per diem basis, based on the number of hours and types of assistance required by the participant as identified in the ~~UAI~~ assessments.(XX-XX-XX)~~(7-1-21)T~~

02. Provider Claims. Provider claims for payment will be submitted on claim forms provided or approved by the Department or its contractor. Billing instructions will be provided by the Department's payment system contractor. (7-1-21)T

03. Calculation of Fees. The fees calculated for waiver services include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location when the participant is not being provided waiver or state plan transportation. (7-1-21)T

04. EVV Compliance. Provider claims for the following Aged and Disabled Waiver Services require EVV compliance as described in Section 041 of these rules in order to be eligible for payment: (7-1-21)T

a. Attendant Care; (7-1-21)T

b. Homemaker; and (7-1-21)T

c. Respite. (7-1-21)T

[Sections Omitted]

SUB PART: ENHANCED DEVELOPMENTAL DISABILITY SERVICES
(Sections 500-719)

500. DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS.
Prior to receiving developmental disability services as provided in Sections 507 through 719 of these rules, the participant must be determined to have a developmental disability. (7-1-21)T

501. DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS: ELIGIBILITY.
The definitions and standards in the table below must be used to determine whether a participant meets criteria as a person with a developmental disability under Section 66-402, Idaho Code.

TABLE 501 - DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS	
Definition	**Standards**
"Developmental Disability" means a chronic disability of a person that appears before the age of 22 years and:	Age of 22 means through the day before the individual's 22nd birthday. AND
(a) is attributable to an impairment, such as an intellectual disability;	"Is attributable to an impairment" means that there is a causal relationship between the presence of an impairing condition and the developmental disability. **Age 5 through Adult:** There is a presumption that an intellectual disability exists when a full scale IQ score up to 75 exists. (IQ of 70 with a standard error of measurement of 5 points.) **Birth to Age 5:** An IQ test score is not required below the age of 5. In these cases it may be necessary to rely on the results of a functional assessment. There is a presumption that an intellectual disability exists when there is a standard score of 75 or below or a delay of 30% overall.
cerebral palsy;	Medical Diagnosis that requires documentation.
epilepsy;	Medical Diagnosis that requires documentation. On medication controlled or uncontrolled. Does not include a person who is seizure-free and not on medication for 3 years.
autism;	Includes the diagnosis of ~~pervasive developmental disorder~~ autism spectrum disorder.
or other condition found to be closely related to or similar to one of these impairments that requires similar treatment or services;	For related or similar conditions, documentation must be present to show the causal relationship between the impairing condition and the developmental disability. (Does not include mental illness) **Intellectual Disability:** A full scale IQ score above 75 can in some circumstances be considered a related or similar condition to an intellectual disability when additional supporting documentation exists showing how the individual's functional limitations make their condition similar to an intellectual disability. **Cerebral Palsy:** Conditions related or similar to cerebral palsy include disorders that cause a similar disruption in motor function. **Epilepsy:** Conditions related or similar to epilepsy include disorders that interrupt consciousness.
or is attributable to dyslexia resulting from such impairments; and	AND

TABLE 501 - DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS	
Definition	**Standards**
(b) results in substantial functional limitations in three (3) or more of the following major life activities:	"Results in" means that the substantial limitation must be because of the impairment. ~~A "substantial" limitation is one in which the total effect of the limitation results in the need for a "combination and sequence of special, interdisciplinary, or generic care, treatment or other services that need to be individually planned and coordinated."~~ Listed below are standards for substantial functional limitations in each major life area. **Adult (Age 18+):** A score of 1.5 standard deviations below the mean on a Department-approved assessment tool creates a presumption of a substantial functional limitation. **Age 3 through ~~Adult~~ Age 17:** A score of 2 standard deviations below the mean creates a presumption of a functional limitation. **Birth to Age 3:** The following criteria must be utilized to determine a substantial functional limitations for children under 3: **a.** The child scores 30% below age norm; or **b.** The child exhibits a 6 month delay; or **c.** The child scores 2 standard deviations below the mean.
self care;	**Adult (Age 18+):** A substantial functional limitation is manifest when the person requires physical or non-physical assistance in performing eating, hygiene, grooming, dressing, or health care skills, or when the time required for a person to perform these skills him/her self is so substantial as to impair their ability to conduct other activities of daily living or retain employment. **Birth ~~to~~ through Age ~~21~~17:** A functional limitation is manifest when the child's skills are limited according to age-appropriate responses such that the parent, caregiver, or school personnel is required to provide care that is substantially beyond that typically required for a child of the same age (such as excessive time lifting, diapering, supervision).
receptive and expressive language;	**Age 3 through Adult:** A substantial functional limitation is manifest when a person is unable to communicate effectively without the aid of a third person, a person with special skills, or without an assistive device (such as sign language). **Birth to Age 3:** A substantial functional limitation is manifest when they have been diagnosed by a qualified professional who determines that the child performs 30% below age norm (adjusted for prematurity up to 2 years) or demonstrates at least 2 standard deviations below the mean in either area or 1 1/2 below in both areas of language development.
learning;	**Birth through Adult:** A substantial functional limitation is manifest when cognition, retention, reasoning, visual or aural communications, or other learning processes or mechanisms are impaired to the extent that special intervention (~~interventions that are~~ beyond those ~~that~~ an individual normally needs to learn) ~~intervention~~ is required for the development of social, self care, language, academic, or vocational skills.

TABLE 501 - DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS	
Definition	**Standards**
mobility;	**Adult (Age 18+):** A substantial functional limitation is manifest when fine or gross motor skills are impaired to the extent that the assistance of another person or an assistive device is required for movement from place to place. **Birth ~~to~~ through Age ~~21~~17:** A substantial limitation would be measured by an age appropriate instrument that compares the child's skills for postural control and movement and coordinated use of the small muscles with those skills expected of children of the same age.
self-direction;	**Adult (Age 18+):** A substantial functional limitation is manifest when a person requires assistance in managing their personal finances, protecting their self interest, or making decisions that may affect their well being. **Birth ~~to~~ through Age ~~21~~17:** A substantial limitation is manifest when the child is unable to help themself or cooperate with others age appropriate assistance to meet personal needs, learn new skills, follow rules, and adapt to environments.
capacity for independent living; or	**Adult (Age 18+):** A substantial functional limitation is manifest when, for a person's own safety or well-being, supervision or assistance is required, at least on a daily basis, in the performance of health maintenance, housekeeping, budgeting, or leisure time activities and in the utilization of community resources. **Birth ~~to~~ through Age ~~21~~17:** A substantial limitation would be measured by an age- appropriate instrument that compares the child's personal independence and social responsibility expected of children of comparable age and cultural group.
economic self-sufficiency; and	**Adult (Age 18+):** A substantial functional limitation is manifest when a person is unable to perform the tasks necessary for regular employment or is limited in productive capacity to the extent that their earned annual income, after extraordinary expenses occasioned by the disability, is insufficient for self-support. **Age 5 ~~to~~ through Age ~~21~~17:** Use the pre-vocational area of a standardized functional assessment to document a limitation in this area. **Birth to Age 5:** A substantial limitation in this area is evidenced by the child's eligibility for SSI, early intervention, or early childhood special education under the Individuals with Disabilities Education Act (IDEA). AND

TABLE 501 - DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS	
Definition	**Standards**
(c) reflects the needs for a combination and sequence of special, interdisciplinary or generic care, treatment or other services that are of life-long or extended duration and individually planned and coordinated.	**Age 5 through Adult:** The existence of a substantial functional limitation in three (3) or more major life activities creates the presumption that an individual has a need for a "combination and sequence of special interdisciplinary, or generic care, treatment or other services that need to be individually planned and coordinated." ~~Life-long or extended duration means the~~ A developmental disability ~~is one~~ that has ~~the~~ a reasonable likelihood of continuing for a protracted period of time, including a reasonable likelihood that it will continue throughout life creates the presumption that the individual will need services for a life-long or extended duration. **Birth to Age 5:** The expected duration may be frequently unclear. Therefore, determination of eligibility by a multi-disciplinary team for early intervention services through SSI, an IFSP, child study team or early childhood special education services through an IEP will be an indicator of this criteria.

(XX-XX-XX)~~(7-1-21)T~~

502. (RESERVED)

503. DEVELOPMENTAL DISABILITY DETERMINATION: TEST INSTRUMENTS.
A variety of standardized test instruments are available. Tests used to determine a developmental disability must reflect the current functional status of the individual being evaluated. Tests over one (1) year old must be verified to reflect the current status of the individual by an appropriate professional. Instruments designed only for screening purposes must not be used to determine eligibility. (7-1-21)T

01. Test Instruments For Adults. A Department-approved assessment tool for conducting cognitive and functional assessments must be used to determine eligibility. (7-1-21)T

02. Test Instruments for Children. The assessments utilized to determine eligibility must be based on age appropriate criteria. Evaluations must be performed by qualified personnel with experience and expertise with children; selected evaluation tools and practices should be age appropriate, based on consideration of the child's language and motor skills. A Department-approved assessment tool for conducting cognitive and functional assessments must be used with children. (7-1-21)T

504. -- 506. (RESERVED)

507. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION (PA).
The purpose of adult developmental disability services prior authorization is to assure the provision of the right care, in the right place, at the right price, and with the right outcomes ~~in order~~ to maintain or enhance health and safety, and to promote participants' rights, self-determination, and independence. Prior authorization involves the assessment of the need for services, development of a budget, development of a plan of services, prior approval of services, and a quality improvement program. ~~Services are reimbursable if they are identified on the authorized plan of service and are consistent with the purpose and rule for prior authorization as well as rules for the specific service.~~ (XX-XX-XX)~~(7-1-21)T~~

01. The scope of these rules defines prior authorization for the following Medicaid developmental disability services for adults: (XX-XX-XX)

a. Adult DD State Plan Home and Community-Based Services. Adult DD state plan home and community-based services as described in Sections 645 through 699 of these rules; (XX-XX-XX)

b. Adult DD Waiver Services. Adult DD waiver services as described in Sections 700 through 719 of these rules; and (XX-XX-XX)

c. Adult DD Service Coordination. Adult DD service coordination services as described in Sections 720 through 779 of these rules. (XX-XX-XX)

02. Complaints and Administrative Appeals. (XX-XX-XX)

a. Participant complaints about the assessment process, eligibility determination, plan development, quality of service, and other relevant concerns may be referred to the Division of Medicaid. (XX-XX-XX)

b. A participant who disagrees with a Department decision regarding program eligibility, individual assigned budget, or authorization of services under these rules may file an appeal. Administrative appeals are governed by provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." (XX-XX-XX)

508. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: DEFINITIONS.
For the purposes of these rules the following terms are used as defined below. (7-1-21)T

01. Adult. A person who is eighteen (18) years of age or older. (7-1-21)T

02. Assessment. A process that is described in Section 509 of these rules ~~for program eligibility and in Section 512 of these rules for plan of service~~. (XX-XX-XX)~~(7-1-21)T~~

03. Clinical Review. A process of professional review that validates the need for continued services. (7-1-21)T

~~**04. Community Crisis Support**. Intervention for participants who are at risk of losing housing, employment or income, or who are at risk of incarceration, physical harm, family altercations or other emergencies. (7-1-21)T~~

~~**05. Concurrent Review**. A clinical review to determine the need for continued prior authorization of services. (7-1-21)T~~

~~**06.**~~**04. Department-Approved Assessment Tool**. Any standardized assessment tool approved by the Department for use in determining developmental disability eligibility, adult DD state plan HCBS eligibility, adult DD waiver eligibility, level of support, participant's budget, and skill level to identify the participant's needs for the plan of service~~, and for determining the participant's budget~~. (XX-XX-XX)~~(7-1-21)T~~

~~**07. Exception Review**. A clinical review of a plan that falls outside the established standards. (7-1-21)T~~

~~**08.**~~**05. Interdisciplinary Team**. For purposes of these rules, the interdisciplinary team is a team of professionals, determined by the Department, that reviews requests for reconsideration. (XX-XX-XX)~~(7-1-21)T~~

~~**09.**~~**06. Level of Support**. An assessment score derived from a Department-approved assessment tool that indicates types and amounts of services and supports necessary to allow the individual to live independently and safely in the community. (XX-XX-XX)~~(7-1-21)T~~

~~**10.**~~**07. Person-Centered Planning Process**. A meeting ~~facilitated by the participant or plan developer, comprised of family and individuals significant to the participant who collaborate with the participant~~ to develop the plan of service that is conducted in accordance with the person-centered planning requirements described in Sections 316 and 317. (XX-XX-XX)~~(7-1-21)T~~

~~**11.**~~**08. Person-Centered Planning Team**. The group who develops the plan of service. This group includes, at a minimum, the participant and the service coordinator or plan developer chosen by the participant. The person-centered planning team may include others identified by the participant ~~or agreed upon by the participant and the Department as important to the process~~ in accordance with the person-centered planning requirements described in Sections 316 and 317. (XX-XX-XX)~~(7-1-21)T~~

~~**12.**~~**09. Plan Developer**. A paid or non-paid person identified by the participant who is responsible for developing one (1) plan of service and subsequent addenda that cover all services and supports, based on a person-centered planning process. (XX-XX-XX)~~(7-1-21)T~~

~~13.~~10. **Plan Monitor**. A person who oversees the provision of services on a paid or non-paid basis. (XX-XX-XX)~~(7-1-21)T~~

~~14.~~11. **Plan of Service**. An initial or annual plan that identifies all services and supports and includes all components described in Sections 316 and 317, which is based on a person-centered planning process. Plans are authorized annually every three hundred sixty-five (365) days. (XX-XX-XX)~~(7-1-21)T~~

~~15.~~12. **Prior Authorization (PA)**. A process for determining a participant's eligibility for services and medical necessity prior to the delivery or payment of services as provided by these rules. (XX-XX-XX)~~(7-1-21)T~~

~~16.~~13. **Provider Status Review**. The written documentation that identifies the participant's progress toward goals defined in the plan of service. (XX-XX-XX)~~(7-1-21)T~~

~~17.~~14. **Right Care**. Accepted treatment for defined diagnosis, functional needs and abilities to achieve the desired outcome. The right care is consistent with best practice and continuous quality improvement. (XX-XX-XX)~~(7-1-21)T~~

~~18.~~15. **Right Place**. Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. (XX-XX-XX)~~(7-1-21)T~~

~~19.~~16. **Right Price**. The most integrated and least expensive services that are sufficiently intensive to address the participant's needs. The amount is based on the individual's needs for services and supports as identified in the assessment.(XX-XX-XX)~~(7-1-21)T~~

~~20.~~17. **Right Outcomes**. Services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant. (XX-XX-XX)~~(7-1-21)T~~

~~21. Service Coordination. Service coordination is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual. (7-1-21)T~~

~~22. Service Coordinator. An individual who provides service coordination to a Medicaid eligible participant, is employed by a service coordination agency, and meets the training, experience, and other requirements under Sections 729 through 732 of these rules. (7-1-21)T~~

~~23.~~18. **Services**. Services paid for by the Department that enable the individual to reside safely and effectively in the community. (XX-XX-XX)~~(7-1-21)T~~

~~24.~~19. **Supports**. Formal or informal services and activities, not paid for by the Department, that enable the individual to reside safely and effectively in the setting of their choice. (XX-XX-XX)~~(7-1-21)T~~

509. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: ~~ELIGIBILITY DETERMINATION~~ASSESSMENT.

The Department will make the final determination of an individual's eligibility and level of support, based upon the assessments and evaluations administered by the Department, or its contractor. Initial and annual assessments will be performed by the Department, or its contractor. (XX-XX-XX)

01. Purposes of Assessment. The ~~purpose~~ purposes of the assessment ~~is~~ are to: (XX-XX-XX)

a. ~~determine~~ Determine a participant's eligibility for developmental disabilities services in accordance with Section 66-402, Idaho Code, and Sections 500 through 506 of these rules; (XX-XX-XX)

b. Determine a participant's eligibility for adult DD state plan home and community-based services in accordance with Section 646 of these rules; (XX-XX-XX)

c. Determine a participant's eligibility for adult DD waiver services in accordance with Section 702 of these rules, including determination of ~~and for~~ ICF/ID level of care for adult DD waiver services in accordance with Section 584 of these rules.; (XX-XX-XX)~~(7-1-21)T~~

d. Assign level of support and participant budgets in accordance with Section 510 of these rules; and (XX-XX-XX)

e. Assist in the development of plans of service in accordance with Section 513 of these rules. (XX-XX-XX)

02. Components of the Assessment. The assessment is required for all participants prior to the development of the plan of service. The assessment must include the following components: (XX-XX-XX)

a. Physician's History and Physical. A physician's history and physical is required to be completed within the year prior to the initiation of services and thereafter on a frequency determined by the physician. Documentation of diagnosis is required for participants whose eligibility is based on developmental disabilities other than an intellectual disability. For participants in Healthy Connections: (XX-XX-XX)

i. The Healthy Connections physician may delegate to the Department the authority to approve developmental disability services. (XX-XX-XX)

ii. The Healthy Connections physician must conduct the history and physical, and may refer the participant for other evaluations. (XX-XX-XX)

b. Medical, Social, and Developmental History. The medical, social and developmental history is used to document the participant's medical social and developmental history information. A current medical s ocial and developmental history must be evaluated prior to the initiation of services and must be reviewed annually to assure it continues to reflect accurate information about the participant's status. (XX-XX-XX)

c. Psychometric Testing. Participants must provide the results of psychometric testing if eligibility for developmental disabilities services is based on an intellectual disability and they have no prior testing or prior testing is inconclusive. (XX-XX-XX)

d. Functional Assessment Tools. One or more Department-approved assessment tools will be administered in their entirety, by the Department or its contractor prior to the initiation of services, and at least every three years thereafter. During the intervening years, the results of the Department-approved assessment tools will be reviewed annually, by the Department or its contractor to assure the assessment continues to accurately describe the functional status of the participant. If an assessment does not accurately describe the functional status of the participant, then a Department-approved assessment tool will be re-administered in its entirety. (XX-XX-XX)

i. During any program-wide transition to a new Department-approved assessment tool, the Department, or its contractor, will administer the Department-approved assessment tools in their entirety to all participants on a schedule established by the Department. (XX-XX-XX)

ii. Providers must obtain and utilize the assessment results identified by the Department or its contractor when one is necessary for program or plan development. (XX-XX-XX)

e. Medical Condition Documentation. The participant's medical conditions, risk of deterioration, living conditions, and individual goals will be documented. (XX-XX-XX)

f. Behavioral or Psychiatric Needs Documentation. Behavioral or psychiatric needs that require special consideration will be documented. (XX-XX-XX)

03. Types of Assessments. (XX-XX-XX)

~~01.~~ **a. Initial Assessment**. For new applicants, an assessment will be completed within thirty (30) days from the date a completed application is submitted. (XX-XX-XX)~~(7-1-21)T~~

~~02.~~ **b. Annual Assessments**. Assessments will ~~also~~ be completed for current participants at the time of their annual ~~eligibility~~ redetermination. The ~~assessor~~ Department or its contractor will conduct a focused review of the participant's most recent assessment to evaluate whether ~~assessments~~ the assessment components are current and accurately describe the status of the participant. If an assessment component is not current or does not accurately describe the status of the participant, the Department, or its contractor, will update the assessment components or re-administer functional assessment tools in accordance with these rules. At least sixty (60) days before the expiration of the current plan of service: (XX-XX-XX)~~(7-1-21)T~~

~~a.~~ i. The assessment process will be completed; and (7-1-21)T

~~b.~~ ii. The ~~assessor~~ Department or its contractor will provide the results of the assessment to the participant. (XX-XX-XX)~~(7-1-21)T~~

c. Other Assessments. Assessments will be completed upon the request of current participants when there are documented changes in the participant's condition resulting in a need for services that meet medical necessity criteria, and this is not reflected on the most recent assessment. The Department or its contractor will conduct a focused review of the participants most recent assessment to evaluate whether the assessment components are current and accurately describe the status of the participant. If the assessment is not current or does not accurately describe the status of the participant, the Department, or its contractor, will update the assessment components or re-administer functional assessment tools in accordance with these rules. Upon completion, the Department or its contractor will provide the results of the assessment to the participant. (XX-XX-XX)

~~**03. Determination of Developmental Disability Eligibility.** The evaluations or assessments that are required for determining developmental disabilities for a participant's eligibility for developmental disabilities services will include a medical/social history and a functional assessment. Participants must provide the results of psychometric testing if eligibility for developmental disabilities services is based on an intellectual disability and they have no prior testing or prior testing is inconclusive. Documentation of diagnosis is required for participants whose eligibility is based on developmental disabilities other than an intellectual disability. A Department approved assessment tool will be administered by the Department for use in this determination. (7-1-21)T~~

~~**04. ICF/ID Level of Care Determination for Waiver Services.** The assessor will determine ICF/ID level of care for adults in accordance with Section 584 of these rules. (7-1-21)T~~

510. ~~(RESERVED)~~ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PARTICIPANT BUDGETS. (XX-XX-XX)

01. Participant Budget Annual Determinations. Each participant will be assigned a budget prior to the initiation of services, and each participant's budget will be re-determined and assigned annually thereafter. (XX-XX-XX)

02. Participant Budget Assignment Criteria. (XX-XX-XX)

a. Each participant will be assigned an annual budget based on the following criteria established by the Department and more particularly described in the [Program Manual]: (XX-XX-XX)

i. Assessed general support needs or verified extraordinary support needs; (XX-XX-XX)

ii. Type of in-home habilitation services selected by the participant; and (XX-XX-XX)

iii. Service delivery approach (state plan HCBS only, waiver traditional, or waiver self-directed). (XX-XX-XX)

b. The Department will provide sixty (60) days prior notice and opportunity to comment on any substantive changes to the participant budget assignment criteria described in the [Program Manual]. (XX-XX-XX)

03. Participant Budget Modifications. The Department will complete a review of plans or addendums requesting services that exceed the participant's assigned budget. Requests for budget modification will be authorized when one (1) of the following conditions are met: (XX-XX-XX)

a. Services are determined by the Department to be services that address health or safety needs, the participant meets the service specific-criteria determined by the Department, and the services are requested on the plan of service or addendum; (XX-XX-XX)

b. Services are needed to assure the health or safety of participants and the services are requested on the plan of service or addendum; or (XX-XX-XX)

c. Community supported employment services as defined in Section 703 of these rules are needed for the participant to obtain or maintain employment and the services are requested on the plan of service or addendum. (XX-XX-XX)

04. Participant Budget Re-Determinations. At the request of the participant, the Department will re-determine the participant's assigned budget when there is a change to the participant's budget assignment criteria as described in this section of rule. (XX-XX-XX)

05. Participant Budget Notifications. The Department, or its contractor, will notify each participant of their assigned budget as part of the eligibility determination, annual redetermination, or other re-assessment process. The notification will include how the participant may appeal the assigned budget amount. (XX-XX-XX)

511. (RESERVED)~~ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: COVERAGE AND LIMITATIONS.~~

~~The scope of these rules defines prior authorization for the following Medicaid developmental disability services for adults: (7-1-21)T~~

~~**01. DD Waiver Services.** DD Waiver services as described in Sections 700 through 719 of these rules; and (7-1-21)T~~

~~**02. Developmental Therapy.** Developmental therapy as described in Sections 649 through 657 of these rules and IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)"; and (7-1-21)T~~

~~**03. Service Coordination.** Service Coordination for persons with developmental disabilities as described in Sections 720 through 779 of these rules. (7-1-21)T~~

512. (RESERVED)~~ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PROCEDURAL REQUIREMENTS.~~

~~**01. Assessment for Plan of Service.** The assessment for a plan of service is required for all participants prior to the development of the plan of service. This assessment must include the following in Subsections 512.02 through 512.06 of these rules. (7-1-21)T~~

~~**02. Physician's History and Physical.** The history and physical must include a physician's referral for nursing services under the DD waivers and for developmental disabilities agencies' services, if they are anticipated to be part of the plan of service. A physician's history and physical is required within the year prior to the initiation of service and thereafter on a frequency determined by the physician. For participants in Healthy Connections: (7-1-21)T~~

~~**a.** The Healthy Connections physician may delegate to the Department the authority to approve developmental disability services. (7-1-21)T~~

~~**b.** The Healthy Connections physician must conduct the history and physical, and may refer the participant for other evaluations. (7-1-21)T~~

~~**03. Medical, Social, and Developmental History.** The medical, social and developmental history is used to document the participant's medical social and developmental history information. A current medical social and developmental history must be evaluated prior to the initiation of developmental therapy and must be reviewed annually to assure it continues to reflect accurate information about the participant's status. (7-1-21)T~~

~~**a.** A medical, social and developmental history for each adult participant is completed by the Department or its contractor. (7-1-21)T~~

~~**b.** Providers should obtain and utilize the medical, social developmental history documents generated by the Department or its contractor when one is necessary for adult program or plan development. (7-1-21)T~~

~~04. Department-Approved Assessment Tool. The results of a Department-approved assessment tool are used to determine the level of support for the participant. A current Department-approved assessment will be evaluated prior to the initiation of service and reviewed annually to assure it continues to reflect the functional status of the participant. A department-approved assessment tool for adults is completed by the Department or its contractor. Providers must obtain and utilize the document generated by the Department or its contractor when one is necessary for program or plan development. (7-1-21)T~~

~~05. Medical Condition. The participant's medical conditions, risk of deterioration, living conditions, and individual goals. (7-1-21)T~~

~~06. Behavioral or Psychiatric Needs. Behavioral or psychiatric needs that require special consideration. (7-1-21)T~~

513. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PLAN OF SERVICE.

In collaboration with the participant, the Department will assure that the participant has one (1) plan of service. This plan of service is based on the ~~individualized~~ participant budget referred to in Section ~~514~~510 of these rules and must identify all services and supports. ~~Participants may develop their own plan or designate a paid or non-paid plan developer. In developing the plan of service, the plan developer and the participant must identify services and supports available outside of Medicaid-funded services that can help the participant meet desired goals.~~ Authorized services must be delivered by providers who are selected by the participant. (XX-XX-XX)~~(7-1-21)T~~

01. ~~Qualifications of a Paid~~ Plan Developer. The participant 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. Individuals responsible for facilitating the person-centered planning meeting and writing the person-centered service plan must meet the conflict of interest standards as defined in Section 721 of these rules. ~~Neither a provider of direct service to the participant nor the assessor may be chosen to be the paid plan developer. Family members and all others who wish to~~ To be paid for plan development, an individual must be employed as a service coordinator as defined in Section 729 ~~Sections 729 through 732~~ of these rules, or be a support broker as defined in IDAPA 16.03.13, "Consumer-Directed Services." (XX-XX-XX)~~(7-1-21)T~~

02. Plan Development. ~~All participants must direct the development of their service plan through a person-centered planning process. Individuals invited to participate in the person-centered planning process will be identified by the participant and may include family members, guardian, or individuals who are significant to the participant.~~ In developing the plan of service, the plan developer ~~and participant~~ must~~:~~ ~~identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals and outcomes.~~ (XX-XX-XX)~~(7-1-21)T~~

a. Identify the participant's needs by: (XX-XX-XX)

i. Reviewing the participant's history; and (XX-XX-XX)

ii. Gathering relevant information from the participant and other sources such as family members, medical providers, social workers, educators and the independent assessment provider. (XX-XX-XX)

b. Link the participant with service providers that are capable of providing needed services to address identified needs and achieve goals specified in the plan of service; (XX-XX-XX)

c. Ensure plan development process meets the person-centered planning requirements described in Section 316 of these rules and the plan developer may refer conflicts that cannot be resolved among person-centered planning members to the Bureau of Developmental Disability Services to negotiate a resolution with members of the planning team; (XX-XX-XX)

d. Develop a written plan of service in accordance with the requirements described in Section 317 of these rules and the plan developer must: (XX-XX-XX)

i. Ensure all services that require prior authorization outside of these rules are submitted to the appropriate unit of the Department; (XX-XX-XX)

ii. Ensure there is no duplication of services. Duplicate services will not be authorized; and (XX-XX-XX)

iii. Provide and document that they have provided information and support to the participant prior to plan development to maximize the participant's ability to make informed choices and provide informed consent regarding the services and supports they receive and from whom. Unless the participant has a guardian who retains full decision-making authority, the participant must make decisions regarding the type and amount of services required; (XX-XX-XX)

e. Coordinate the submission of the plan of service to the Department for review and prior authorization; and ~~The plan of service must be submitted within forty-five (45) days prior to the expiration of the existing plan of service unless delayed because of participant unavailability due to extenuating circumstances. If the plan is not submitted within this time period, authorization for provider payments may be terminated.~~ (XX-XX-XX)~~(7-1-21)T~~

f. Distribute a copy of the approved plan of service, in whole or part, to any other HCBS provider identified on the plan of service. (XX-XX-XX)

~~**b.** The plan development process must meet the person-centered planning requirements described in Section 316 of these rules. (7-1-21)T~~

~~**c.** The participant may facilitate their own person-centered planning meeting, or designate a paid or non-paid plan developer to facilitate the meeting. Individuals responsible for facilitating the person-centered planning meeting cannot be providers of direct services to the participant. (7-1-21)T~~

~~**03. Prior Authorization Outside of These Rules.** The plan developer must ensure that all services that require prior authorization outside of these rules are submitted to the appropriate unit of the Department. These services include: (7-1-21)T~~

~~**a.** Durable Medical Equipment (DME); (7-1-21)T~~

~~**b.** Transportation; and (7-1-21)T~~

~~**c.** Physical therapy, occupational therapy, and speech-language pathology services. (7-1-21)T~~

~~**04. No Duplication of Services.** The plan developer will ensure that there is no duplication of services. Duplicate services will not be authorized. (7-1-21)T~~

03. Review and Prior Authorization. The plan of service will be reviewed and prior authorized by the Department in accordance with the requirements in Section 507 through Section 519 and this section of rules. (XX-XX-XX)

~~05.~~04. Plan Monitoring. ~~The participant, service coordinator or plan monitor must monitor the plan.~~ The plan developer is the plan monitor unless there is a service coordinator, in which case the service coordinator assumes the roles of both service coordinator and plan monitor. The planning team must identify the frequency of monitoring, which must be at least every ninety (90) days. (XX-XX-XX)

a. Plan monitoring must include the following: (XX-XX-XX)~~(7-1-21)T~~

~~**a.**~~i. A face-to-face encounter with the participant to determine if services are being provided according to the participant's plan, services in the plan are adequate, and if changes need to be made to the plan of service. ~~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.~~ The face-to-face encounter may occur via synchronous interaction telehealth, as defined in Title 54, Chapter 57, Idaho Code; (XX-XX-XX)~~(7-1-21)T~~

~~**b.**~~ii. Contact with service providers to identify barriers to service provision; (XX-XX-XX)~~(7-1-21)T~~

~~**c.** Discuss with participant satisfaction regarding quality and quantity of services; and (7-1-21)T~~

~~d.~~iii. Review of provider status reviews. (XX-XX-XX)~~(7-1-21)T~~

~~e.~~b. The ~~provider~~ plan monitor will 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, the adult protection authority, and any other entity identified under Section 39-5303, Idaho Code, or federal law. (XX-XX-XX)~~(7-1-21)T~~

~~06. Provider Status Reviews. Service providers, with exceptions identified in Subsection 513.09 of these rules, must report the participant's progress toward goals to the plan monitor on the provider status review when the plan has been in effect for six (6) months and at the annual person-centered planning meeting. The semi-annual and annual reviews must include: (7-1-21)T~~

~~a. The status of supports and services to identify progress; (7-1-21)T~~

~~b. Maintenance; or (7-1-21)T~~

~~c. Delay or prevention of regression. (7-1-21)T~~

~~07. Content of the Plan of Service. The plan of service must identify the type of service to be delivered, goals to be addressed within the plan year, frequency of supports and services, and identified service providers. The plan of service must include activities to promote progress, maintain functional skills, or delay or prevent regression. (7-1-21)T~~

~~a. The written plan of service must meet the person-centered planning requirements described in Section 317 of these rules. (7-1-21)T~~

~~b. The written plan of service must be finalized and agreed to according to procedural requirements described in Section 704 of these rules. (7-1-21)T~~

~~c. The Department will distribute a copy of the plan of service to adult DD service providers defined in Section 317 of these rules. Additionally, the plan developer will be responsible to distribute a copy of the plan of service, in whole or part, to any other developmental disability service provider identified by the participant during the person-centered planning process. (7-1-21)T~~

~~08. Informed Consent. Unless the participant has a guardian who retains full decision-making authority, the participant must make decisions regarding the type and amount of services required. Prior to plan development, the plan developer must document that they have provided information and support to the participant to maximize their ability to make informed choices regarding the services and supports they receive and from whom. During plan development and amendment, planning team members must each indicate whether they believe the plan meets the needs of the participant, and represents the participant's choice. If there is a conflict that cannot be resolved among person-centered planning members or if a member does not believe the plan meets the participant's needs or represents the participant's choice, the plan or amendment may be referred to the Bureau of Developmental Disability Services to negotiate a resolution with members of the planning team. (7-1-21)T~~

~~09.~~05. **Provider Implementation Plans and Status Reviews**. Each provider of Medicaid services must develop an implementation plan that complies with ~~home and community-based setting requirements and identifies specific objectives that relate to goals finalized and agreed to in the participant's authorized plan of service. These objectives must demonstrate how the provider will assist the participant to meet the participant's goals, desired outcomes, and needs identified in the plan of service~~ the requirements outlined in the Idaho Medicaid Provider Handbook available at www.idmedicaid.com. The Department will provide sixty (60) days prior notice of any substantive changes to the provider implementation plan requirements outlined in its provider handbook. (XX-XX-XX)~~(7-1-21)T~~

a. Exceptions. An implementation plan is not required for ~~waiver~~ providers of: (XX-XX-XX)~~(7-1-21)T~~

i. Specialized medical equipment; (7-1-21)T

ii. Home delivered meals; (7-1-21)T

iii. Environmental accessibility adaptations; (7-1-21)T

iv. Non-medical transportation; (7-1-21)T

v. Personal emergency response systems (PERS); (7-1-21)T

vi. Respite care; ~~and~~ (XX-XX-XX)~~(7-1-21)T~~

vii. Chore services~~.~~; (XX-XX-XX)~~(7-1-21)T~~

viii. Community crisis support services; and (XX-XX-XX)

ix. Adult DD service coordination. (XX-XX-XX)

b. Time for Completion. Implementation plans must be completed within fourteen (14) days of receipt of the authorized plan of service or the service start date, whichever is later. (7-1-21)T

i. If the authorized plan of service is received after the service start date, service providers must support billing by documenting service provision as agreed to by the participant and consistent with Section 704 of these rules. (7-1-21)T

ii. Implementation plan revision must be based on changes to the needs of the participant. (7-1-21)T

c. Documentation of Changes. Documentation of Implementation Plan changes will be included in the participant's record. This documentation must include, at a minimum, the reason for the change, documentation of coordination with other service providers (where applicable), the date the change was made, the signature of the person making the change complete with the date and title. (7-1-21)T

d. Provider Status Reviews. Service providers that are required by these rules to develop and implementation plan must also report the participant's progress toward goals to the plan monitor for provider status review when the plan has been in effect for six (6) months and at the annual person-centered planning meeting. The semi-annual and annual reviews must include: (XX-XX-XX)

i. The status of supports and services to identify progress; (XX-XX-XX)

ii. Maintenance; or (XX-XX-XX)

iii. Delay or prevention of regression. (XX-XX-XX)

~~**10. Home and Community-Based Services Plan of Service Signature.** Upon receipt of the authorized plan of service, HCBS providers responsible for the implementation of the plan as identified in Section 317 of these rules must sign the plan indicating they will deliver services according to the finalized and authorized plan of service, and consistent with home and community-based requirements. Each HCBS provider responsible for the implementation of the plan must maintain their signed plan in the participant's record. Documentation of signature must include the signature of the professional responsible for service provision complete with their title and the date signed. Provider signature will be completed each time an initial or annual plan of service is implemented.~~ ~~(7-1-21)T~~

~~11.~~06. Addendum to the Plan of Service. (XX-XX-XX)~~(7-1-21)T~~

a. A plan of service 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. Additional assessments or information may be clinically necessary. Adjustment of the plan of service is subject to prior authorization by the Department. (7-1-21)T

b. When a service plan has been adjusted, the Department will distribute a copy of the addendum to HCBS providers responsible for the implementation of the plan of service as identified in Section 317 of these rules. (7-1-21)T

c. Upon receipt of the addendum, the HCBS provider must sign the addendum indicating they have reviewed the plan adjustment and will deliver services accordingly. Documentation must include the signature of the professional responsible for service provision complete with their title and the date signed, and must be maintained in the participant's record. Provider signature will be completed each time an addendum is authorized. (7-1-21)T

~~12.~~07. **Annual Reauthorization of Services**. A participant's plan of service must be reauthorized annually. The Department will review and authorize the new plan of service prior to the expiration of the current plan. (XX-XX-XX)~~(7-1-21)T~~

a. Annual Assessment Results. An annual assessment will be completed in accordance with Section 509 of these rules. (XX-XX-XX)

b. Annual Participant Budget Determination. A participant's budget will be re-determined annually in accordance with Section 510 of these rules. (XX-XX-XX)

~~a.~~c. Plan Developer Responsibilities for Annual Reauthorization. A new plan of service must be provided to the Department by the plan developer at least forty-five (45) days prior to the expiration date of the current plan, unless delayed because of participant unavailability due to extenuating circumstances. If the plan is not submitted within this time period, authorization for provider payments may be terminated. Prior to ~~this~~ submission, the plan developer must: (XX-XX-XX)~~(7-1-21)T~~

i. Notify the providers who appear on the plan of service of the annual review date. (7-1-21)T

ii. Obtain a copy of the current annual provider status review from each provider for use by the person-centered planning team. Each provider status review must meet the requirements in Subsection ~~513.06~~ 513.05 of these rules. (XX-XX-XX)~~(7-1-21)T~~

iii. Convene the person-centered planning team to develop a new plan of service; inviting individuals to participate that have been identified by the participant. (7-1-21)T

iv. Develop the new plan of service in accordance with Subsection 513.02 of these rules. (XX-XX-XX)

~~b.~~d. Evaluation and Prior Authorization of the Plan of Service. The plan of service will be ~~evaluated~~ reviewed and prior authorized in accordance with the requirements in Sections 507 ~~and 513~~ through Section 514 of these rules. (XX-XX-XX)~~(7-1-21)T~~

~~c. Adjustments to the Annual Budget and Services. The annual budget and services may be adjusted by the Department based on demonstrated outcomes, progress toward goals and objectives, and benefit of services. (7-1-21)T~~

~~d.~~e. Annual Status Reviews Requirement. If the provider's annual status reviews are not submitted to the plan developer with the annual plan, services ~~will~~ may not be authorized at the time of the annual reauthorization. These services may be added to the plan of service only by means of an addendum to the plan in accordance with Subsection 513.~~10~~06 of these rules. (XX-XX-XX)~~(7-1-21)T~~

~~e.~~f. Reapplication After a Lapse in Service. For participants who are re-applying for service after a lapse in service, the assessor will evaluate whether assessments are current and accurately describe the status of the participant. (XX-XX-XX)~~(7-1-21)T~~

~~f. Annual Assessment Results. An annual assessment will be completed in accordance with Section 512 of these rules. (7-1-21)T~~

~~13. Complaints and Administrative Appeals. (7-1-21)T~~

~~a. Participant complaints about the assessment process, eligibility determination, plan development, quality of service, and other relevant concerns may be referred to the Division of Medicaid. (7-1-21)T~~

~~b. A participant who disagrees with a Department decision regarding program eligibility and authorization of services under these rules may file an appeal. Administrative appeals are governed by provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." (7-1-21)T~~

514. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PROVIDER REIMBURSEMENT.

01. Providers are reimbursed on a fee for service basis based on a participant budget.

(XX-XX-XX)~~(7-1-21)T~~

02. Services are reimbursable if they are identified on the authorized plan of service and are consistent with the purpose and rule for prior authorization as well as rules for the specific service. (XX-XX-XX)

~~**01. Individualized Budget Beginning on October 1, 2006.** Beginning October 1, 2006, for DD waiver participants, and beginning January 1, 2007, for all other adult DD participants, the Department sets an individualized budget for each participant according to an individualized measurement of the participant's functional abilities, behavioral limitations, and medical needs, related to the participant's disability. Using these specific participant factors, the budget setting methodology will correlate a participant's characteristics with the participant's individualized budget amount, so participants with higher needs will be assigned a higher individualized budget amount. (7-1-21)T~~

~~**a.** The Department notifies each participant of their set budget amount as part of the eligibility determination process or annual redetermination process. The notification will include how the participant may appeal the set budget amount. (7-1-21)T~~

~~**b.** Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate 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, and this is not reflected on the current inventory of individual needs. (7-1-21)T~~

~~**02. Residential Habilitation - Supported Living Acuity-Based Levels of Support.** Reimbursement for residential habilitation - supported living is based on the participant's assessed level of support need. All plans of service that include supported living must include community integration goals that provide for maintained or enhanced independence, quality of life, and self-determination. As a participant's independence increases and they are less dependent on supports, they must transition to less intense supports. (7-1-21)T~~

~~**a.** High support is for those participants who require twenty-four (24) hour per day supports and supervision as determined by a Department-approved assessment tool. High support allows for a blend of one-to-one and group staffing. Participants authorized at the high support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the high support daily rate.(7-1-21)T~~

~~**b.** Intense support is for those exceptional participants who require intense, twenty-four (24) hour per day supports and supervision. This support level typically requires one-on-one staffing, but requests for a blend of one-on-one and group staffing will be reviewed on a case by case basis. Participants authorized at the intense support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the intense support daily rate. To qualify for this level of support, participants must be evaluated to meet one or more of the following criteria: (7-1-21)T~~

~~i. Recent felony convictions or charges for offenses related to the serious injury or harm of another person. These participants must have been placed in a supported living setting directly from incarceration or directly after being diverted from incarceration. (7-1-21)T~~

~~ii. History of predatory sexual offenses and are at high risk to re-offend based on a sexual offender risk assessment completed by an appropriate professional. (7-1-21)T~~

~~iii. Documented, sustained history of serious aggressive behavior showing a pattern of causing harm to themselves or others. The serious aggressive behavior must be such that the threat or use of force on another person makes that person reasonably fear bodily harm. The participant must also have the capability to carry out such a threat. The frequency and intensity of this type of aggressive behavior must require continuous monitoring to prevent injury to themselves or others. (7-1-21)T~~

iv. Chronic or acute medical conditions that are so complex or unstable that one-to-one staffing is required to provide frequent interventions and constant monitoring. Without this intervention and monitoring the participant would require placement in a nursing facility, hospital, or ICF/ID with twenty-four (24) hour on-site nursing. Verification of the complex medical condition and the need for this level of service requires medical documentation. (7-1-21)T

c. Hourly support is for those individuals that do not meet criteria for either high or intense supports or those individuals who qualify for a daily rate but whose needs can be met with less than twenty-four (24) per day support. The combination of hourly supported living, developmental therapy, community supported employment, and adult day care will not be authorized to exceed the maximum set daily amount established by the Department except when all of the following conditions are met: (7-1-21)T

i. The participant is eligible to receive the high support daily rate; (7-1-21)T

ii. Community supported employment is included in the plan and is causing the combination to exceed the daily limit; (7-1-21)T

iii. There is documentation that the Person-Centered Planning team has explored other options including using lower cost services and natural supports; and (7-1-21)T

iv. The participant's health and safety needs will be met using hourly services despite having been assessed to qualify for twenty-four (24) hour care. (7-1-21)T

515. ADULT DEVELOPMENTAL DISABILITY SERVICES: QUALITY ASSURANCE AND IMPROVEMENT.

01. Quality Assurance. Quality Assurance consists of audits and reviews to assure compliance with the Department's rules and regulations. If problems are identified during the review or audit, the provider must implement a corrective action plan within forty-five (45) days after the results are received. The Department may take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with the corrective action plan, any term or provision of the provider agreement, or any applicable state or federal regulation. (7-1-21)T

02. Quality Improvement. The Department may gather and utilize information from providers to evaluate customer satisfaction, participant satisfaction, participant experience related to home and community-based setting qualities, outcomes monitoring, care management, quality assurance, quality improvement activities, and health and safety. These findings may lead to quality improvement activities to improve provider processes and outcomes for participants. (7-1-21)T

03. Exception Review. The Department will complete an exception review of plans or addendums requesting services that exceed the assigned budget authorized by the assessor. Requests for these services will be authorized when one (1) of the following conditions are met: (7-1-21)T

a. Services are needed to assure the health or safety of participants and the services requested on the plan or addendum are required based on medical necessity as defined in Section 012 of these rules. (7-1-21)T

b. Supported employment services as defined in Section 703 of these rules are needed for the participant to obtain or maintain employment. The request must be submitted on the Department-approved Exception Review Form and is reviewed and approved based on the following: (7-1-21)T

i. A supported employment service recommendation must be submitted that includes: recommended amount of service, level of support needed, employment goals, and a transition plan. When the participant is transitioned from the Idaho Division of Vocational Rehabilitation (IDVR) services, the recommendation must be completed by IDVR. When a participant is in an established job, the recommendation must be completed by the supported employment agency identified on the plan of service or addendum; (7-1-21)T

ii. The participant's plan of service was developed by the participant and their person-centered planning team and includes a goal for supported employment services. Prior to the submission of an exception review with an addendum, a comprehensive review of all services on the participant's plan must occur. The participant's

~~combination of services must support the increase or addition of supported employment services; and (7-1-21)T~~

~~iii. An acknowledgment signed by the participant and their legal guardian, if one exists, that additional budget dollars approved to purchase supported employment services must not be reallocated to purchase any other Medicaid service. (7-1-21)T~~

~~**04. Concurrent Review.** The Department will obtain the necessary information to determine that participants continue to meet eligibility criteria, participant rights are maintained services continue to be clinically necessary, services continue to be the choice of the participant, services support participant integration, and services constitute appropriate care to warrant continued authorization or need for the service. (7-1-21)T~~

~~05.~~**03.** **Abuse, Fraud, or Substandard Care**. Reviewers finding suspected abuse, fraud, or substandard care must refer their findings for investigation to the Department and other regulatory or law enforcement agencies for investigation. (XX-XX-XX)~~(7-1-21)T~~

516. -- 519. (RESERVED)

[Sections Omitted]

584. ICF/ID: CRITERIA FOR DETERMINING ELIGIBILITY.
Individuals who have intellectual disabilities or a related condition as defined in Section 66-402, Idaho Code, and Sections 500 through ~~503~~506 of these rules, must be determined by an interdisciplinary team to need the consistent, intense, frequent services including active treatment provided in an ICF/ID or receive services under one of Idaho's programs to assist individuals with intellectual disabilities or a related condition to avoid institutionalization in an ICF/ID, as indicated in Section 584.02 of these rules. To meet Title XIX and Title XXI entitlement for ICF/ID level of care and be eligible for services provided in an ICF/ID. The following must be met in Subsections 584.01 through 584.08 of these rules. (7-1-21)T

01. Diagnosis. Persons must be financially eligible for Medicaid; must have a primary diagnosis of being intellectually disabled or have a related condition defined in Section 66-402, Idaho Code and Section 500 through 506 of these rules; and persons must qualify based on functional assessment, maladaptive behavior, a combination of both, or medical condition. (7-1-21)T

02. Active Treatment. Persons living in an ICF/ID, must require and receive intensive inpatient active treatment as defined in Section 010 of these rules, to advance or maintain their functional level. (7-1-21)T

a. Active treatment does not include: parenting activities directed toward the acquisition of age-appropriate developmental milestones; services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous active treatment program or services; interventions that address age-appropriate limitations; or general supervision of children whose age is such that such supervision is required by all children of the same age. (7-1-21)T

b. The following criteria/components will be utilized when evaluating the need for active treatment: (7-1-21)T

i. Evaluation. Complete medical, social, and psychological evaluations. These evaluations must clearly indicate the functional level of the participant and the interventions needed; and (7-1-21)T

ii. Plan of Care. A written plan of care which sets forth initial goals and objectives, specifies further evaluations to be done, and training programs to be developed. (7-1-21)T

03. Require Certain Level of Care. Persons living in the community must require the level of care provided in an ICF/ID, including active treatment, and in the absence of available intensive alternative services in the community, would require institutionalization, other than services in an institution for mental disease, in the near future. (7-1-21)T

04. Care for a Child. The department may provide Medicaid to a child eighteen (18) years of age or younger, who would be eligible for Medicaid if they were in a medical institution and who are receiving, while living at home, medical care that would be provided in a medical institution, if the Department determines that the child requires the level of care provided in an ICF/ID. (7-1-21)T

05. Functional Limitations. (7-1-21)T

a. Persons Sixteen Years of Age or Older. Persons sixteen (16) years of age or older may qualify based on their functional skills. Persons with an ~~age equivalency composite score of eight (8) years and zero (0) months or less~~ adaptive behavior composite standard score of less than sixty (60) on a full scale functional assessment using ~~a Department-approved assessment tool~~ the Vineland Adaptive Behavior Scales (Third Edition) assessment tool would qualify; or (XX-XX-XX)~~(7-1-21)T~~

b. Persons Under Sixteen Years of Age. Persons under sixteen (16) years of age qualify if their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; or (7-1- 21)T

06. Maladaptive Behavior. (7-1-21)T

a. A ~~Minus Twenty-Two (-22) or Below~~ Twenty-One (21) or Greater Score. Individuals may qualify for ICF/ID level of care based on maladaptive behavior. Persons will be eligible if their ~~General Maladaptive Index~~ internalizing or externalizing maladaptive behavior v-scale score on ~~a Department-approved assessment tool~~ the Vineland Adaptive Behavior Scales (Third Edition) assessment tool is ~~minus twenty-two (-22)~~ twenty-one (21) or ~~less~~ greater; or (XX-XX-XX)~~(7-1-21)T~~

b. ~~Above a Minus Twenty-Two (-22)~~ A Below Twenty-One (21) Score. Individuals ~~who score above minus twenty-two (-22)~~ whose internalizing and externalizing maladaptive behavior v-scale score on the Vineland Adaptive Behavior Scales (Third Edition) assessment tool is below twenty-one (21) may qualify for ICF/ID level of care if: (XX-XX-XX)

i. The individual scores a two for at least one internalizing or externalizing maladaptive behavior critical item on the Vineland Adaptive Behavior Scales (Third Edition) assessment tool, or the individual scores a one on at least two internalizing or externalizing maladaptive behavior critical item on the Vineland Adaptive Behavior Scales (Third Edition) assessment tool; and (XX-XX-XX)

ii. ~~they engage~~ The individual engages 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 the person requires active treatment to control or decrease the behavior; or (XX-XX-XX)~~(7-1-21)T~~

07. Combination Functional and Maladaptive Behaviors. Persons may qualify for ICF/ID level of care if they display a combination of criteria as described in Subsections 584.05 and 584.06 of these rules at a level that is significant and it can been determined they are in need of the level of services provided in an ICF/ID, including active treatment services. Significance would be defined as: (7-1-21)T

a. Persons Sixteen Years of Age or Older. For persons sixteen (16) years of age or older, an ~~overall age equivalency up to eight and one-half (8 1/2) years~~ adaptive behavior composite standard score between sixty (60) and sixty-three (63) inclusive is significant in the area of functionality when combined with ~~a General Maladaptive Index on a Department-approved assessment tool up to minus seventeen (-17), minus twenty-two (-22) inclusive~~ an internalizing and externalizing maladaptive behavior v-scale score on the Vineland Adaptive Behavior Scales (Third Edition) assessment tool is between nineteen (19) and twenty (20) inclusive; or (XX-XX-XX)~~(7-1-21)T~~

b. Persons Under Sixteen Years of Age. For persons under sixteen (16) years of age, an overall age equivalency up to fifty-three percent (53%) of their chronological age is considered significant when combined with a General Maladaptive Index on a Department-approved assessment tool between minus seventeen (-17), and minus twenty-one (-21) inclusive; or (7-1-21)T

08. Medical Condition. Individuals may meet ICF/ID level of care based on their medical condition if the medical condition significantly affects their functional level/capabilities and it can be determined that they are in need of the level of services provided in an ICF/ID, including active treatment services. (7-1-21)T

09. Annual Redetermination for ICF/ID Level of Care for Community Services. The ~~BLTC staff~~ Department or its contractor will redetermine the participant's continuing need for ICF/ID level of care for community services. Documentation will consist of the completion of a redetermination statement ~~on the "Level of Care" form HW0083~~. Such documentation will be accomplished no later than every three hundred sixty-five (365) days from the most recent determination. (XX-XX-XX)~~(7-1-21)T~~

a. Home Care for Certain Disabled Children (HCDC). Persons receiving HCDC Medicaid services through ICF/ID eligibility, will receive services until the end of the month in which the redetermination was made. These individuals must receive ten (10) days notification of termination of services. If the redetermination is made less than ten (10) days from the end of the month, payment continues until the end of the following month. (7-1-21)T

b. Developmentally Disabled Waiver. Individuals receiving developmentally disabled waiver services will have thirty (30) days from the time of the determination to transition to other community supports. (7-1-21)T

[Sections Omitted]

ADULT DEVELOPMENTAL DISABILITIES STATE PLAN HOME AND COMMUNITY BASED SERVICES (HCBS) ~~STATE PLAN OPTION~~ BENEFIT

(Sections 645-~~659~~699)

~~645. HOME AND COMMUNITY BASED SERVICES (HCBS) STATE PLAN OPTION.~~

~~Home and community based services are provided through the HCBS State Plan option as allowed in Section 1915(i) of the Social Security Act for adults with developmental disabilities who do not meet the ICF/ID level of care. HCBS state plan option services must comply with Sections 310 through 319, and Sections 645 through 657 of these rules. Through the duration of the COVID-19 public health emergency, the Department reserves the right to temporarily alter requirements and processes related to the Adult Developmental Disabilities HCBS State Plan Option program to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS approved 1135 waiver or a state plan amendment to the existing Adult Developmental Disabilities HCBS State Plan Option benefit. In the event additional changes are required in the future, guidance will be posted on the Medicaid Information Releases webpage. (7-1-21)T~~

~~646. COMMUNITY CRISIS SUPPORTS.~~

~~Community crisis supports are interventions for participants who have been determined eligible for developmental disability services and who are at risk of losing housing, employment, or income, or are at risk of incarceration, physical harm, family altercation, or other emergencies. (7-1-21)T~~

~~647. COMMUNITY CRISIS SUPPORTS: ELIGIBILITY.~~

~~Prior to receiving community crisis supports, an individual must be determined by the Department or its contractor to have a developmental disability under Sections 500 through 506 of these rules and Section 66-402, Idaho Code, be eighteen (18) years of age or older, and live in the community. (7-1-21)T~~

~~648. COMMUNITY CRISIS SUPPORTS COVERAGE AND LIMITATIONS.~~

~~Community crisis support may be authorized the following business day after the intervention if there is a documented need for immediate intervention, no other means of support are available, and the services are appropriate to rectify the crisis. Community crisis support is limited to a maximum of twenty (20) hours during any consecutive five (5) day period. (7-1-21)T~~

~~**01. Emergency Room.** Crisis services may be provided in an emergency room during the ER evaluation process if the goal is to prevent hospitalization and return the participant to the community. (7-1-21)T~~

02. Before Plan Development. Community crisis support may be provided before or after the completion of the assessment and plan of service. If community crisis support is provided before the completion of the assessment and plan of service, the plan of service must include an identification of the factors contributing to the crisis and a strategy for addressing those factors in the future. (7-1-21)T

03. Crisis Resolution Plan. After community crisis support has been provided, the provider of the community crisis support service must complete a crisis resolution plan and submit it to the Department for approval within seventy-two (72) hours of providing the service. (7-1-21)T

649. DEVELOPMENTAL THERAPY.
The Department will pay for developmental therapy provided by facilities that have entered into a provider agreement with the Department and are certified as developmental disabilities agencies by the Department. (7-1-21)T

650. DEVELOPMENTAL THERAPY: ELIGIBILITY.
Prior to receiving developmental therapy in a DDA, an individual must be determined by the Department or its contractor to have a developmental disability under Sections 500 through 506 of these rules and Section 66-402, Idaho Code be eighteen (18) years of age or older, and live in the community. (7-1-21)T

651. DEVELOPMENTAL THERAPY: COVERAGE REQUIREMENTS AND LIMITATIONS.
Developmental therapy must be recommended by a physician or other practitioner of the healing arts. (7-1-21)T

01. Requirements to Deliver Developmental Therapy. Developmental therapy may be delivered in a developmental disabilities agency center-based program, the community, or the home of the participant. Developmental therapy includes individual developmental therapy and group developmental therapy. Developmental therapy must be delivered by Developmental Specialists or paraprofessionals qualified in accordance with these rules, based on an assessment completed prior to the delivery of developmental therapy. (7-1-21)T

a. Areas of Service. These services must be directed toward the rehabilitation or habilitation of physical or developmental disabilities in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. (7-1-21)T

b. Age-Appropriate. Developmental therapy includes instruction in daily living skills the participant has not gained at the normal developmental stages in their life, or is not likely to develop without training or therapy. Developmental therapy must be age-appropriate. (7-1-21)T

c. Tutorial Activities and Educational Tasks are Excluded. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the participant's disability. (7-1-21)T

d. Settings for Developmental Therapy. Developmental Therapy may be provided in home and community-based settings as described in Section 312 of these rules. Developmental therapy, in both individual and group formats, must be available in both community-based and home-based settings, and be based on participant needs, interests, or choices. (7-1-21)T

e. Staff-to-Participant Ratio. When group developmental therapy is center-based, there must be a minimum of one (1) qualified staff, who may be a paraprofessional or a Developmental Specialist, providing direct services for every twelve (12) participants. The community-based services must occur in integrated, inclusive settings and with no more than three (3) participants per qualified staff at each session. Additional staff must be added, as necessary, to meet the needs of each individual served. (7-1-21)T

02. Excluded Services. The following services are excluded for Medicaid payments: (7-1-21)T

a. Vocational services; (7-1-21)T

b. Educational services; and (7-1-21)T

c. Recreational services. (7-1-21)T

03. Limitations on Developmental Therapy. Developmental therapy may not exceed the limitations as follows: only one (1) type of therapy will be reimbursed during a single time period by the Medicaid program. Developmental therapy will not be reimbursed during periods when the participant is being transported to and from the agency. (7-1-21)T

652. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS FOR INDIVIDUALS WITH AN ISP.

01. Eligibility Determination. Prior to the delivery of developmental therapy, the person must be determined by the Department or its contractor to be eligible as defined under Section 66-402, Idaho Code, be eighteen (18) years of age or older, and live in the community. (7-1-21)T

02. Intake. Prior to the delivery of developmental therapy: (7-1-21)T

a. A DDA will obtain a participant's current medical, social, and developmental information from the Department or its designee. (7-1-21)T

b. The participant must have an ISP that is authorized in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 507 through 515. Developmental therapy provided by the DDA must be included on the plan of service and be prior authorized by the Department or its designee before a participant can receive the service from the agency. (7-1-21)T

03. Documentation of Plan Changes. Documentation of changes in the required plan of service or Program Implementation Plan must be included in the participant's record. This documentation must include, at a minimum, the reason for the change, the date the change was made, and the signature of the professional making the change complete with date, credential, and title. If there are changes to a Program Implementation Plan that affect the type or amount of service on the plan of service, an addendum to the plan of service must be completed. (7-1-21)T

653. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS FOR INDIVIDUALS WITH AN IPP.

01. Eligibility Determination. Prior to the delivery of developmental therapy, the person must be determined by the Department or its contractor to be eligible as defined under Section 66-402, Idaho Code, be eighteen (18) years of age or older, and live in the community. (7-1-21)T

02. Intake. Individuals using the Home and Community-Based Services (HCBS) waiver for the Aged and Disabled (A&D) or State Plan Personal Care Services and only requesting DDA services, have the option to access services through an Individual Program Plan. Individuals who select this option are not required to have a developmental disability plan developer. Services delivered through an Individual Program Plan must be authorized by the Department or its contractor and be based on the Aged and Disabled written Individual Service Plan as defined in Section 328 of these rules. Prior to the delivery of developmental therapy, a DDA must complete an Individual Program Plan (IPP) that meets the standards described below. (7-1-21)T

03. Individual Program Plan (IPP) Definitions. The delivery of developmental therapy on a written plan of care must be defined in terms of the type, amount, frequency, and duration of the service. (7-1-21)T

a. Type of service refers to the kind of service described in terms of: (7-1-21)T

i. Group, individual, or family; and (7-1-21)T

ii. Whether the service is home, community, or center based. (7-1-21)T

b. Amount of service is the total number of service hours during a specified period of time. This is typically indicated in hours per week. (7-1-21)T

c. Frequency of service is the number of times service is offered during a week or month. (7-1-21)T

d. Duration of service is the length of time. This is typically the length of the plan year. For ongoing services, the duration is one (1) year; services that end prior to the end of the plan year must have a specified end date. (7-1-21)T

04. Individual Program Plan (IPP). (7-1-21)T

a. The IPP must be developed following obtainment or completion of all applicable assessments consistent with the requirements of this chapter. (7-1-21)T

b. The planning process must include the participant, their legal guardian if one exists, and others the participant or their legal guardian chooses. The participant and their legal guardian if one exists must sign the IPP indicating they directed the person-centered planning process. The participant and their legal guardian if one exists must be provided a copy of the completed IPP by the DDA. A physician or other practitioner of the healing arts, the participant, and their legal guardian if one exists, must sign the IPP prior to initiation of any services identified within the plan. (7-1-21)T

c. The planning process must occur at least annually, or more often if necessary, to review and update the plan to reflect any changes in the needs or status of the participant. Revisions to the IPP requiring a change in type, amount, or duration of the service provided must be recommended by the physician or other practitioner of the healing arts prior to implementation of the change. Such recommendations require written authorization by the participant, their legal guardian if one exists, and must be maintained in the participant's file. (7-1-21)T

d. The IPP must be supported by the documentation required in the participant's record in accordance with IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)" record requirements. (7-1-21)T

e. The IPP must promote self-sufficiency, the participant's choice in program objectives and activities, encourage the participant's participation and inclusion in the community, and contain objectives that are age-appropriate. The IPP must include: (7-1-21)T

i. The participant's name and medical diagnosis; (7-1-21)T

ii. The name of the assigned Developmental Specialist, the date of the planning meeting, and the names and titles of those present at the meeting; (7-1-21)T

iii. The dated signature of the physician or other practitioner of the healing arts indicating their recommendation of the services on the plan; (7-1-21)T

iv. The type, amount, frequency, and duration of therapy to be provided. For developmental therapy, the total hours of services provided cannot exceed the amount recommended on the plan. The amount and frequency of the type of therapy must not deviate from the IPP more than twenty percent (20%) over a period of a four (4) weeks, unless there is documentation of a participant-based reason; (7-1-21)T

v. A list of the participant's current personal goals and desired outcomes, interests, and choices; (7-1-21)T

vi. An accurate, current, and relevant list of the participant's specific developmental and behavioral strengths and needs. The list will identify which needs are priority based on the participant's choices and preferences. An IPP objective must be developed for each priority need; (7-1-21)T

vii. A list of measurable behaviorally stated objectives that correspond to the list of priority needs. A Program Implementation Plan must be developed for each objective; (7-1-21)T

viii. The Developmental Specialist responsible for each objective; (7-1-21)T

ix. The target date for completion of each objective; (7-1-21)T

x. The review date; and (7-1-21)T

xi. A transition plan. The transition plan is designed to facilitate the participant's independence, personal goals, and interests. The transition plan must specify criteria for participant transition into less restrictive, more integrated settings. These settings may include community-based organizations and activities, vocational training, supported or independent employment, volunteer opportunities, or other less restrictive settings. The implementation of some components of the plan may necessitate decreased hours of service or discontinuation of services from a DDA. (7-1-21)T

05. Documentation of Plan Changes. Documentation of required Program Implementation Plan changes must be included in the participant's record. This documentation must include, at a minimum: (7-1-21)T

a. The reason for the change; (7-1-21)T

b. Documentation of coordination with other services providers, where applicable; (7-1-21)T

c. The date the change was made; and (7-1-21)T

d. The signature of the professional making the change complete with date, credential, and title. Changes to the IPP require documented notification of the participant and their legal guardian if one exists. Changes in type, amount, or duration of services must be recommended by a physician or other practitioner of the healing arts. Such recommendations require written authorization by the participant and their legal guardian if one exists prior to the change. If the signatures of the participant or their legal guardian cannot be obtained, then the agency must document in the participant's record the reason the signatures were not obtained. (7-1-21)T

06. Home and Community-Based Person-Centered Planning. Individual Program Plans completed by a DDA must meet the person-centered planning requirements described in Sections 316 and 317 of these rules and must be included in the participant's individual service plan as described in Section 328 of these rules. (7-1-21)T

654. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS.

01. Assessment and Diagnostic Services. DDAs must obtain assessments required under Sections 507 through 515 of these rules. Four (4) hours is the maximum Medicaid reimbursable time allowed for the combination of all assessment, evaluation, or diagnostic services provided in any calendar year. The following assessment and diagnostic services are reimbursable when provided in accordance with these rules: (7-1-21)T

a. Comprehensive Developmental Assessment; and (7-1-21)T

b. Specific Skill Assessment. (7-1-21)T

02. Comprehensive Developmental Assessments. Assessments must be conducted by qualified professionals defined under Section 655 of these rules. (7-1-21)T

a. Comprehensive Assessments. A comprehensive assessment must: (7-1-21)T

i. Determine the necessity of the service; (7-1-21)T

ii. Determine the participant's needs; (7-1-21)T

iii. Guide treatment; (7-1-21)T

iv. Identify the participant's current and relevant strengths, needs, and interests when these are applicable to the respective discipline; and (7-1-21)T

b. Date, Signature, and Credential Requirements. Assessments must be signed and dated by the professional completing the assessment and include the appropriate professional credential or qualification of that person. (7-1-21)T

c. Requirements for Current Assessments. Assessments must accurately reflect the current status of the participant. To be considered current, assessments must be completed or updated at least every two (2) years for

service areas in which the participant is receiving services on an ongoing basis. (7-1-21)T

d. Comprehensive Developmental Assessment. A comprehensive developmental assessment must reflect a person's developmental status in the following areas: (7-1-21)T

i. Self-care; (7-1-21)T

ii. Receptive and expressive language; (7-1-21)T

iii. Learning; (7-1-21)T

iv. Gross and fine motor development; (7-1-21)T

v. Self-direction; (7-1-21)T

vi. Capacity for independent living; and (7-1-21)T

vii. Economic self-sufficiency. (7-1-21)T

03. Specific Skill Assessments. Specific skill assessments must: (7-1-21)T

a. Further assess an area of limitation or deficit identified on a comprehensive assessment. (7-1-21)T

b. Be related to a goal on the IPP or ISP. (7-1-21)T

c. Be conducted by qualified professionals. (7-1-21)T

d. Be conducted for the purposes of determining a participant's skill level within a specific domain. (7-1-21)T

e. Be used to determine baselines and develop the program implementation plan. (7-1-21)T

04. DDA Program Documentation Requirements. Each DDA must maintain records for each participant the agency serves. Each participant's record must include documentation of the participant's involvement in and response to the services provided. (7-1-21)T

a. General Requirements for Program Documentation. For each participant the following program documentation is required: (7-1-21)T

i. Daily entry of all activities conducted toward meeting participant objectives. (7-1-21)T

ii. Sufficient progress data to accurately assess the participant's progress toward each objective; and (7-1-21)T

iii. A review of the data, and, when indicated, changes in the daily activities or specific implementation procedures by the qualified professional. The review must include the qualified professional's dated initials. (7-1-21)T

iv. Documentation of six (6) month and annual reviews by the Developmental Specialist that includes a written description of the participant's progress toward the achievement of therapeutic goals, and the reason(s) why they continue to need services. (7-1-21)T

v. Signed, authorized plan as described in Section 513 of these rules. (7-1-21)T

b. DDAs must also submit provider status reviews to the plan monitor in accordance with Sections 507 through 515 of these rules. (7-1-21)T

05. DDA Program Implementation Plan Requirements. For each participant, the DDA must develop a Program Implementation Plan for each DDA objective included on the participant's required plan of service. All Program Implementation Plans must be related to a goal or objective on the participant's plan of service. The Program

Implementation Plan must be developed within fourteen (14) days from the plan of service start date or receipt of the authorized plan of service and be revised whenever participant needs change. If the Program Implementation Plan is not completed within this time frame, the participant's records must contain participant-based documentation justifying the delay. If consistent with the timeframes above, a participant's annual Program Implementation Plan is completed after the start date of the annual plan of service, the provider will address goals and objectives as agreed to by the participant until the annual Program Implementation Plan is complete and must document service provision related to these interim goals and objectives consistent with Section 654 of these rules. The Program Implementation Plan must include the following requirements: (7-1-21)T

a. Name. The participant's name. (7-1-21)T

b. Baseline Statement. A baseline statement addressing the participant's skill level and abilities related to the specific skill to be learned. (7-1-21)T

c. Objectives. Measurable, behaviorally stated objectives that correspond to those goals or objectives authorized and agreed to in the required plan of service. (7-1-21)T

d. Written Instructions to Staff. These instructions may include curriculum, interventions, task analyses, activity schedules, type and frequency of reinforcement, and data collection including probe, directed at the achievement of each objective. These instructions must be individualized and revised as necessary to promote participant progress toward the stated objective. (7-1-21)T

e. Service Environments. Identification of the type of environment(s) where services will be provided. (7-1-21)T

f. Target Date. Target date for completion. (7-1-21)T

g. Results of the Psychological or Psychiatric Assessment. When a participant has had a psychological or psychiatric assessment, the results of the psychological or psychiatric assessment must be used when developing objectives to ensure therapies provided in the DDA accommodate the participant's mental health needs and to ensure that none of the therapeutic methods are contra-indicated or delivered in a manner that presents a risk to the participant's mental health status. (7-1-21)T

h. Home and Community-Based Services Requirements. All program implementation plans must meet home and community-based setting qualities defined in Section 313 of these rules. (7-1-21)T

655. DEVELOPMENTAL THERAPY: PROVIDER QUALIFICATIONS AND DUTIES.

01. Developmental Specialist for Adults. To be qualified as a Developmental Specialist for adults, a person must have a minimum of two hundred forty (240) hours of professionally supervised experience with individuals who have developmental disabilities and either: (7-1-21)T

a. Possess a bachelor's or master's degree in special education, early childhood special education, speech and language pathology, applied behavioral analysis, psychology, physical therapy, occupational therapy, social work, or therapeutic recreation; or (7-1-21)T

b. Possess a bachelor's or master's degree in an area not listed above in Subsection 657.05.a. of this rule and have: (7-1-21)T

i. Completed a competency course jointly approved by the Department and the Idaho Association of Developmental Disabilities Agencies that relates to the job requirements of a Developmental Specialist; and (7-1-21)T

ii. Passed a competency examination approved by the Department. (7-1-21)T

c. Any person employed as a Developmental Specialist in Idaho prior to May 30, 1997, unless previously disallowed by the Department, will be allowed to continue providing services as a Developmental Specialist as long as there is not a gap of more than three (3) years of employment as a Developmental Specialist. (7-1-21)T

d. Through the duration of the COVID-19 public health emergency, Development Specialists for adults may begin rendering services prior to completing the training requirements provided that they complete the training requirements within thirty (30) days of first rendering services, advise the participant or legal guardian that the individual has not yet completed the applicable trainings, and comply with any other requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. (7-1-21)T

02. Developmental Therapy Paraprofessionals. Paraprofessionals, such as aides or therapy technicians, may be used by an agency to provide developmental therapy if they are under the supervision of a Developmental Specialist. A developmental therapy paraprofessional must be at least seventeen (17) years of age. (7-1-21)T

03. Requirements for Collaboration with Other Providers. When participants are receiving rehabilitative or habilitative services from other providers, each DDA must coordinate each participant's DDA program with these providers to maximize skill acquisition and generalization of skills across environments, and to avoid duplication of services. The DDA must maintain documentation of this collaboration. This documentation includes other plans of services such as the Individual Education Plan (IEP), Personal Care Services (PCS) plan, Residential Habilitation plan, and the outpatient behavioral health service plan. The participant's file must also reflect how these plans have been integrated into the DDA's plan of service for each participant. (7-1-21)T

656. GENERAL STAFFING REQUIREMENTS.

01. Standards for Paraprofessionals Providing Developmental Therapy. When a paraprofessional provides developmental therapy, the agency must ensure adequate supervision by a qualified professional during its service hours. All paraprofessionals must meet the training requirements under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," Section 410 and must meet the qualifications under Section 655 of these rules. A paraprofessional providing developmental therapy must be supervised by a Developmental Specialist. For paraprofessionals to provide developmental therapy in a DDA, the agency must adhere to the following standards: (7-1-21)T

a. Limits to Paraprofessional Activities. The agency must ensure that paraprofessionals do not conduct participant assessments, establish a plan of service or develop a Program Implementation Plan. These activities must be conducted by a professional qualified to provide the service. (7-1-21)T

b. Frequency of Supervision. The agency must ensure that a professional qualified to provide the service must, for all paraprofessionals under their supervision, on a weekly basis or more often if necessary: (7-1-21)T

i. Give instructions; (7-1-21)T

ii. Review progress; and (7-1-21)T

iii. Provide training on the program(s) and procedures to be followed. (7-1-21)T

c. Professional Observation. The agency must ensure that a professional qualified to provide the service must, on a monthly basis or more often if necessary, observe and review the work performed by the paraprofessional under their supervision, to ensure the paraprofessional has been trained on the program(s) and demonstrates the necessary skills to correctly implement the program(s). (7-1-21)T

02. General Staffing Requirements for Agencies. Each DDA must have an agency administrator who is accountable for all service elements of the agency and who must be employed on a continuous and regularly scheduled basis. The agency administrator is accountable for the overall operations of the agency including ensuring compliance with this chapter of rules, overseeing and managing staff, developing and implementing written policies and procedures, and overseeing the agency's quality assurance program. (7-1-21)T

a. When the administrator is not a Developmental Specialist as defined in these rules, the DDA must employ a Developmental Specialist on a continuous and regularly scheduled basis who is responsible for the service elements of the agency; and (7-1-21)T

~~**b.** The Developmental Specialist responsible for the service elements of the agency must have two (2) years of supervisory or management experience providing developmental disabilities services to individuals with developmental disabilities. (7-1-21)T~~

~~**657. DEVELOPMENTAL THERAPY: PROVIDER REIMBURSEMENT.**~~

~~Payment for developmental therapy provided by a DDA must be in accordance with rates established by the Department. (7-1-21)T~~

~~**658. COVID-19 PUBLIC HEALTH EMERGENCY RESIDENTIAL HABILITATION.**~~

~~Through the duration of the COVID-19 public health emergency, the Department will pay for residential habilitation services, as described in Subsection 703.01 of these rules, provided by facilities that have entered into a provider agreement with the Department and are certified as developmental disabilities agencies by the Department. Prior to receiving residential habilitation services from a DDA, an individual must be determined by the Department, or its contractor, to have a developmental disability under Sections 500 through 506 of these rules and Section 66-402, Idaho Code, be eighteen (18) years of age or older, and live in the community. DDA's providing residential habilitation services must comply with any additional requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. (7-1-21)T~~

645. ADULT DEVELOPMENTAL DISABILITIES (DD) STATE PLAN HOME AND COMMUNITY-BASED SERVICES (HCBS) BENEFIT.

As authorized under Section 1915(i) of the Social Security Act, the Department provides state plan home and community-based services to eligible adult participants who do not meet the ICF/ID level of care. (XX-XX-XX)

646. ADULT DD STATE PLAN HCBS: ELIGIBILITY.

Adult DD State Plan HCBS eligibility will be determined by the Department based on the requirements described in this section of rules and in accordance with the assessment procedures as described in Section 509 of these rules. (XX-XX-XX)

01. Eligibility Requirements. The Department or its contractor must determine that: (XX-XX-XX)

a. The participant is eligible for Medicaid as described in IDAPA 16.03.05, "Eligibility for Aid for the Aged, Blind, and Disabled (AABD); (XX-XX-XX)

b. The participant is eighteen (18) years of age or older; (XX-XX-XX)

c. The participant has a developmental disability as set forth in Sections 500 through 506 of these rules and Section 66-402, Idaho Code; and (XX-XX-XX)

d. The participant meets the following needs-based criteria; (XX-XX-XX)

i. Requires assistance due to substantial limitations in three (3) or more of the following major life activities – self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency and as described in Section 500 of these rules; and (XX-XX-XX)

ii. Has a need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are life-long or of extended duration and individually planned and coordinated due to a delay in developing age-appropriate skills occurring before the age of 22 and as described in Section 500 of these rules. (XX-XX-XX)

02. Redetermination Process. Case Redetermination will be conducted at least annually by the Department or its contractor. The redetermination process will verify that the participant continues to meet the eligibility requirements described in this section of rules and the participant's continued need for State Plan HCBS. (XX-XX-XX)

647. ADULT DD STATE PLAN HCBS: COVERAGE AND LIMITATIONS.

01. Community Crisis Services. Community crisis services are interventions used to assist participants ~~to access community resources to resolve a crisis.~~ (XX-XX-XX)

a. A crisis is an unanticipated event, circumstance or life situation that places a participant at risk of at least one (1) of the following: (XX-XX-XX)

i. Hospitalization; (XX-XX-XX)

ii. Loss of housing; (XX-XX-XX)

iii. Loss of employment or major source of income; (XX-XX-XX)

iv. Incarceration; or (XX-XX-XX)

v. Physical harm to self or others, including family altercation or other emergencies. (XX-XX-XX)

b. Community Crisis services may be provided in an emergency room during the ER evaluation process if the goal is to prevent hospitalization and return the participant to the community. (XX-XX-XX)

c. Community crisis services may be provided before or after the completion of the assessment and plan of service. If crisis assistance is provided before the completion of the assessment and plan of service, the plan of service must include an identification of the factors contributing to the crisis and a strategy for addressing those factors in the future. (XX-XX-XX)

d. Authorization for community crisis services may be requested retroactively if there is a documented need for immediate intervention, no other means of support are available, and the services are appropriate to resolve the crisis. For retroactive authorizations, the provider must complete a crisis resolution plan and submit a request for crisis services to the Department within five (5) business days of the last day of providing the crisis service. (XX-XX-XX)

e. Limitations on Community Crisis Services. Community crisis services are limited to a maximum of twenty (20) hours during any consecutive five (5) day period. (XX-XX-XX)

02. Developmental Therapy. Developmental therapy includes instruction in daily living skills the participant has not gained at the normal developmental stages in their life, or is not likely to develop without training or therapy. These services must be directed toward the rehabilitation or habilitation of physical or developmental disabilities in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. Developmental therapy must be age-appropriate. (XX-XX-XX)

a. Referrals and Prior Evaluation. Developmental therapy must be referred by a physician or other practitioner of the healing arts, delivered by Developmental Specialists or paraprofessionals qualified in accordance with these rules, and based on a developmental therapy evaluation completed prior to the delivery of services. (XX-XX-XX)

b. Settings for Developmental Therapy. Developmental Therapy may be provided in the following settings: (XX-XX-XX)

i. Participant's home and community-based settings as described in Section 312 of these rules; or (XX-XX-XX)

ii. Developmental disability agency's center-based setting. (XX-XX-XX)

iii. Participants receiving residential habilitation in a certified family home must not receive home-based developmental therapy in a certified family home. (XX-XX-XX)

c. Exclusions. Developmental therapy excludes: (XX-XX-XX)

i. Tutorial activities or assistance with educational tasks associated with educational needs that result from the participant's disability; (XX-XX-XX)

ii. Vocational services; (XX-XX-XX)

iii. Educational services; and (XX-XX-XX)

iv. Recreational services. (XX-XX-XX)

d. Limitations. Only one (1) type of therapy will be reimbursed during a single time period by the Medicaid program. Developmental therapy will not be reimbursed during periods when the participant is being transported to and from the agency. (XX-XX-XX)

03. Developmental Therapy Evaluation. A comprehensive development assessment and a specific skills assessment are reimbursable when provided in accordance with these rules: (XX-XX-XX)

a. Comprehensive Developmental Assessments. Assessments must be conducted by qualified professionals defined under Section 650 of these rules. A comprehensive assessment must: (XX-XX-XX)

i. Determine the necessity of the service; (XX-XX-XX)

ii. Determine the participant's needs; (XX-XX-XX)

iii. Guide treatment; (XX-XX-XX)

iv. Identify the participant's current and relevant strengths, needs, and interests when these are applicable to the respective discipline; and (XX-XX-XX)

v. Date, Signature, and Credential Requirements. Assessments must be signed and dated by the professional completing the assessment and include the appropriate professional credential or qualification of that person. (XX-XX-XX)

vi. Requirements for Current Assessments. Assessments must accurately reflect the current status of the participant. To be considered current, assessments must be completed or updated at least every two (2) years for service areas in which the participant is receiving services on an ongoing basis. (XX-XX-XX)

vii. Comprehensive Developmental Assessment. A comprehensive developmental assessment must reflect a person's developmental status in the following areas: Self-care, Receptive and expressive language; Learning; Gross and fine motor development; Self-direction; Capacity for independent living; and Economic self-sufficiency. (XX-XX-XX)

b. Specific Skill Assessments. Specific skill assessments must: (XX-XX-XX)

i. Further assess an area of limitation or deficit identified on a comprehensive assessment. (XX-XX-XX)

ii. Be related to a goal on the IPP or ISP. (XX-XX-XX)

iii. Be conducted by qualified professionals. (XX-XX-XX)

iv. Be conducted for the purposes of determining a participant's skill level within a specific domain. (XX-XX-XX)

v. Be used to determine baselines and develop the program implementation plan. (XX-XX-XX)

04. Community Habilitation. Community habilitation supports an individual's interests, goals, and needs related to community participation in an integrated setting as identified in their person-centered Medicaid service plan. This service promotes the discovery and identification of skills, interests, and potential for community contribution and people and places where a person's interest, culture, and talent can be contributed and shared with others with similar interests. This service will promote socialization, peer interaction, and achievement of habilitative goals. (XX-XX-XX)

a. Community habilitation may include: (XX-XX-XX)

i. Teaching and fostering the acquisition, retention, or improvement of skills related to use of community resources, community safety, and other social and adaptive skills to participate in community activities as specified in the person-centered Medicaid service plan; (XX-XX-XX)

ii. Training and education in self-determination and self-advocacy to enable the individual to enjoy a full range of activities by providing opportunities for developing, enhancing, and maintaining competency in personal, social and community activities; (XX-XX-XX)

iii. Participating in social events/clubs, and/or recreational activities; (XX-XX-XX)

iv. Volunteering; and (XX-XX-XX)

v. Participating in organized worship, or spiritual activities. (XX-XX-XX)

b. Within this service, there is an expectation for individuals to interact with the broader community, including supporting individuals to engage directly with people who are not paid to provide them with services. (XX-XX-XX)

c. These services are provided only in integrated settings in the community. They are not provided in the individual's place of residence, and they are not facility-based. (XX-XX-XX)

d. Personal assistance may be a component of Community Habilitation, but may not comprise the entirety of the service. Activities that develop skills related to activities of daily living (ADLs) and instrumental activities of daily living (IADLs) may also be a component, but not the entirety of, this service. (XX-XX-XX)

e. Transportation integral to meeting the participant's goals, desired outcomes, and needs specified in the provider implementation plan (required by Section 513 of these rules). (XX-XX-XX)

f. Limitations. (XX-XX-XX)

i. This service may be offered on an individual basis or in groups of no more than three (3). Group service is only to be offered when individuals have interests and goals outlined in their person-centered plans which significantly overlap and are the focus of the service. (XX-XX-XX)

ii. This service may be delivered during the day, the evening, and/or the weekends. (XX-XX-XX)

iii. This service must not duplicate or be provided at the same period of the day as any other service that is being delivered face-to-face with the participant. (XX-XX-XX)

iv. Transportation to and from the site of other discrete waiver services is not included in the community habilitation rate, but may be provided as non-medical transportation (a separately billable service). (XX-XX-XX)

05. Non-Medical Transportation. Non-medical transportation enables an adult DD state plan HCBS participant to gain access to adult DD state plan HCBS and other community services and resources. (XX-XX-XX)

a. Non-medical transportation is offered in addition to medical transportation required in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and will not replace it. (XX-XX-XX)

b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge or public transit providers will be utilized. (XX-XX-XX)

06. Place of Service Delivery. Adult DD state plan HCBS may be provided in home and community settings as described in Section 312 of these rules. Approved places of services include the participant's personal residence, a certified family home, day habilitation/supported employment program, or community. The following living situations are specifically excluded as a place of service for state plan HCBS: (XX-XX-XX)

a. Licensed skilled, or intermediate care facilities, certified nursing facility (NF) or hospital; and (XX-XX-XX)

b. Licensed Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID); and (XX-XX-XX)

c. Residential Assisted Living Facility. (XX-XX-XX)

d. Additional limitations to specific services are listed under that service definition. (XX-XX-XX)

648. ADULT DD STATE PLAN HCBS: PROCEDURAL REQUIREMENTS FOR INDIVIDUALS WITH AN ISP.

01. Authorization of Services on a Written Plan. All adult DD state plan HCBS must be identified on the plan of service and authorized by the process described in Sections 507 through 519 of these rules. (XX-XX-XX)

02. Assessment and Diagnostic Services. (XX-XX-XX)

a. Developmental Therapy providers must obtain a participant's current medical, social, and developmental information from the Department or its designee; and (XX-XX-XX)

b. Developmental Therapy providers must obtain assessments required under Sections 507 through 519 and Section 647 of these rules. Four (4) hours is the maximum Medicaid reimbursable time allowed for the combination of all assessment, evaluation, or diagnostic services provided in any calendar year. (XX-XX-XX)

03. Provider Records. Four (4) types of record information will be maintained on all participants receiving adult DD state plan HCBS: (XX-XX-XX)

a. Direct Service Provider Information that includes written documentation of each visit made or service provided to the participant, and will record at a minimum the following information: (XX-XX-XX)

i. Date and time of visit; and (XX-XX-XX)

ii. Services provided during the visit; and (XX-XX-XX)

iii. A statement of the participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and (XX-XX-XX)

iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the participant is determined by the Service Coordinator to be unable to do so, the delivery will be verified by the participant as evidenced by their signature on the service record. (XX-XX-XX)

v. A copy of the above information will be maintained in the participant's home unless authorized to be kept elsewhere by the Department. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. (XX-XX-XX)

b. The copy of the plan of service authorized by the Department in accordance with the process described in Sections 507 through 519 of these rules. A copy of the most current plan of service must be maintained in the participant's home and must be available to all service providers and the Department. (XX-XX-XX)

c. The provider implementation plan (if required by Section 513 of these rules). A copy of the most current provider implementation plan must be maintained in the participant's home and must be available to all service providers and the Department. (XX-XX-XX)

d. In addition to the plan of service, all adult DD state plan HCBS providers required to develop a provider implementation plan must submit a provider status review six (6) months after the start date of the plan of service and annually to the plan monitor as described in Section 513 of these rules. Such provider status reviews must be maintained in the participant's record. (XX-XX-XX)

04. Provider Responsibility for Notification. It is the responsibility of the service provider to notify the service coordinator or plan developer when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. (XX-XX-XX)

05. Records Maintenance. Provider agencies will be responsible to retain their participant's records for five (5) years following the date of service. (XX-XX-XX)

649. (RESERVED).

650. ADULT DD STATE PLAN HCBS: PROVIDER QUALIFICATIONS.

All providers of adult DD state plan HCBS must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (XX-XX-XX)

01. Community Crisis Services. Providers of community crisis services must meet the following: (XX-XX-XX)

a. Be one of the following: (XX-XX-XX)

i. A residential habilitation agency that meets the standards identified in IDAPA 16.04.17 "Residential Habilitation Agencies;" (XX-XX-XX)

ii. A developmental disabilities agency that meets the standards in IDAPA 16.03.21 "Developmental Disabilities Agencies;" (XX-XX-XX)

iii. A certified family home that meets the standards identified in IDAPA 16.03.19 " Certified Family Homes;" or (XX-XX-XX)

iv. A supported employment provider that meets the requirements identified in Section 705.08 "Supported Employment" of these rules. (XX-XX-XX)

v. A behavioral consultation provider that meets the requirements identified in Section 705.14 "Behavior Consultation or Crisis Management" of these rules. (XX-XX-XX)

b. Community crisis service providers who provide direct care or services must: (XX-XX-XX)

i. Be eighteen (18) years of age or older; (XX-XX-XX)

ii. Be a high school graduate or have a GED; and (XX-XX-XX)

iii. Satisfactorily complete a criminal history check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." (XX-XX-XX)

02. Developmental Therapy and Developmental Therapy Evaluation. (XX-XX-XX)

a. Developmental therapy evaluation must be provided by a developmental disabilities agency, and the agency must meet the standards in IDAPA 16.03.21 "Developmental Disabilities Agencies." (XX-XX-XX)

b. General Staffing Requirements for Agencies. Each DDA must have an agency administrator who is accountable for all service elements of the agency and who must be employed on a continuous and regularly scheduled basis. The agency administrator is accountable for the overall operations of the agency including ensuring compliance with this chapter of rules, overseeing and managing staff, developing and implementing written policies and procedures, and overseeing the agency's quality assurance program. (XX-XX-XX)

i. When the administrator is not a Developmental Specialist as defined in these rules, the DDA must employ a Developmental Specialist on a continuous and regularly scheduled basis who is responsible for the service elements of the agency; and (XX-XX-XX)

ii. The Developmental Specialist responsible for the service elements of the agency must have two (2) years of supervisory or management experience providing developmental disabilities services to individuals with developmental disabilities. (XX-XX-XX)

c. Developmental Specialist for Adults. To be qualified as a Developmental Specialist for adults, a person must have a minimum of two hundred forty (240) hours of professionally-supervised experience with individuals who have developmental disabilities and either: (XX-XX-XX)

i. Possess a bachelor's or master's degree in special education, early childhood special education, speech and language pathology, applied behavioral analysis, psychology, physical therapy, occupational therapy,

social work, or therapeutic recreation; or (XX-XX-XX)

ii. Possess a bachelor's or master's degree in an area not listed above in Subsection 650.02.c.i of this rule and have completed a competency course jointly approved by the Department and the Idaho Association of Developmental Disabilities Agencies that relates to the job requirements of a Developmental Specialist; and passed a competency examination approved by the Department. (XX-XX-XX)

iii. Any person employed as a Developmental Specialist in Idaho prior to May 30, 1997, unless previously disallowed by the Department, will be allowed to continue providing services as a Developmental Specialist as long as there is not a gap of more than three (3) years of employment as a Developmental Specialist. (XX-XX-XX)

d. Developmental Therapy Paraprofessionals. Paraprofessionals, such as aides or therapy technicians, may be used by an agency to provide developmental therapy if they are under the supervision of a Developmental Specialist. A developmental therapy paraprofessional must be at least seventeen (17) years of age. When a paraprofessional provides developmental therapy, the agency must ensure adequate supervision by a qualified professional during its service hours. All paraprofessionals must meet the training requirements under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," Section 410 and must meet the qualifications in this section of rules. A paraprofessional providing developmental therapy must be supervised by a Developmental Specialist. For paraprofessionals to provide developmental therapy in a DDA, the agency must adhere to the following standards: (XX-XX-XX)

i. Limits to Paraprofessional Activities. The agency must ensure that paraprofessionals do not conduct participant assessments, establish a plan of service or develop a Program Implementation Plan. These activities must be conducted by a professional qualified to provide the service. (XX-XX-XX)

ii. Frequency of Supervision. The agency must ensure that a professional qualified to provide the service must, for all paraprofessionals under their supervision, on a weekly basis or more often if necessary: give instructions, review progress and provide training on the program(s) and procedures to be followed. (XX-XX-XX)

iii. Professional Observation. The agency must ensure that a professional qualified to provide the service must, on a monthly basis or more often if necessary, observe and review the work performed by the paraprofessional under their supervision, to ensure the paraprofessional has been trained on the program(s) and demonstrates the necessary skills to correctly implement the program(s). (XX-XX-XX)

e. Requirements for Collaboration with Other Providers. When participants are receiving rehabilitative or habilitative services from other providers, each DDA must coordinate each participant's DDA program with these providers to maximize skill acquisition and generalization of skills across environments, and to avoid duplication of services. The DDA must maintain documentation of this collaboration. This documentation includes other plans of services such as the Individual Education Plan (IEP), Personal Care Services (PCS) plan, Residential Habilitation plan, and the outpatient behavioral health service plan. The participant's file must also reflect how these plans have been integrated into the DDA's plan of service for each participant. (XX-XX-XX)

03. Community Habilitation. Providers of community habilitation must meet the following: (XX-XX-XX)

a. Be one of the following: (XX-XX-XX)

i. A residential habilitation agency that meets the standards identified in IDAPA 16.04.17 "Residential Habilitation Agencies;" or (XX-XX-XX)

ii. A developmental disabilities agency that meets the standards in IDAPA 16.03.21 "Developmental Disabilities Agencies." (XX-XX-XX)

b. Community habilitation providers who provide direct care or services must: (XX-XX-XX)

i. Be eighteen (18) years of age or older; (XX-XX-XX)

ii. Be a high school graduate or have a GED or demonstrate the ability to provide services according to a plan of service; (XX-XX-XX)

~~iii. Have current CPR and First Aid certifications; (XX-XX-XX)~~

iv. Satisfactorily complete a criminal history check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." (XX-XX-XX)

v. Be free from communicable diseases; and (XX-XX-XX)

vi. Have a current and valid driver's license and vehicle insurance. (XX-XX-XX)

04. Non-Medical Transportation. Providers of non-medical transportation services must: (XX-XX-XX)

a. Possess a valid driver's license; and (XX-XX-XX)

b. Possess valid vehicle insurance. (XX-XX-XX)

c. Satisfactorily complete a criminal history check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks."

651. ADULT DD STATE PLAN HCBS: PROVIDER REIMBURSEMENT.

01. Fee for Service. Adult DD state plan HCBS providers will be paid on a fee for service basis based on the type of service provided as established by the Department. (XX-XX-XX)

02. Claim Forms. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (XX-XX-XX)

03. Rates. Payment for adult DD state plan HCBS will be made in accordance with rates established by the Department. (XX-XX-XX)

652. -- 699. (RESERVED)

ADULTS WITH DEVELOPMENTAL DISABILITIES WAIVER SERVICES (Sections 700-719)

700. ADULTS WITH DEVELOPMENTAL DISABILITIES WAIVER SERVICES.

~~Under 42 CFR Section 440.180, it is the intention of~~ As authorized under Section 1915(c) of the Social Security Act, the Department ~~to provide~~ provides waiver services to eligible adult participants to prevent unnecessary institutional placement, provide for the greatest degree of independence possible, enhance the quality of life, encourage individual choice, and achieve and maintain community integration. ~~For an adult participant to be eligible, the Department must find that the participant requires services due to a developmental disability that impairs their mental or physical function or independence, is capable of being maintained safely and effectively in a non-institutional setting, and would, in the absence of such services, need to reside in an ICF/ID. Through the duration of the COVID-19 public health emergency, the Department reserves the right to temporarily alter requirements and processes related to the Adult DD waiver program to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS approved 1135 waiver or HCBS Attachment K amendment to the existing Adult Developmental Disability waiver. In the event additional changes are required in the future, guidance will be posted on the Medicaid Information Releases webpage.~~ (XX-XX-XX)~~(7-1-21)T~~

701. (RESERVED)

702. ADULT DD WAIVER SERVICES: ELIGIBILITY.

Waiver eligibility will be determined by the Department based on the requirements described in this section of rules and in accordance with the assessment procedures as described in Section 509 of these rules. ~~The participant must be financially eligible for Medical Assistance as described in IDAPA 16.03.05, "Eligibility for Aid for the Aged, Blind, and Disabled (AABD)," Section 787. The cited chapter implements and is in accordance with the Financial Eligibility Section of the Idaho State Plan. In addition, waiver participants must meet the following requirements:~~ (XX-XX-XX)~~(7-1-21)T~~

~~**01. Age of Participants.** DD waiver participants must be eighteen (18) years of age or older.(7-1-21)T~~

02.01. ~~Eligibility Determinations.~~ Eligibility Requirements. The Department or its contractor must determine that: (XX-XX-XX)~~(7-1-21)T~~

a. The participant is eligible for Medicaid as described in IDAPA 16.03.05, "Eligibility for Aid for the Aged, Blind, and Disabled (AABD); (XX-XX-XX)

b. The participant is eighteen (18) years of age or older; (XX-XX-XX)

c. The participant has a developmental disability as set forth in Sections 500 through 506 of these rules and Section 66-402, Idaho Code; (XX-XX-XX)

~~a.~~d. The participant would qualify for ICF/ID level of care as set forth in Section 584 of these rules, if the waiver services listed in Section 703 of these rules were not made available; and (XX-XX-XX)~~(7-1-21)T~~

~~b.~~e. The participant could be safely and effectively maintained in the requested or chosen community residence with appropriate waiver services. This determination must: be made by a team of individuals with input from the person-centered planning team; and prior to any denial of services on this basis, be determined by the plan developer that services to correct the concerns of the team are not available. (XX-XX-XX)~~(7-1-21)T~~

~~**c.** The average annual cost of waiver services and other medical services to the participant would not exceed the average annual cost to Medicaid of ICF/ID care and other medical costs. (7-1-21)T~~

~~03.~~02. **Home and Community-Based Services Waiver Eligible Participants**. A participant who is determined by the Department to be eligible for services under the Home and Community-Based Services Waivers for DD may elect not to utilize waiver services but may choose admission to an ICF/ID. (7-1-21)T

~~**04. Processing Applications.** The participant's self-reliance staff will process the application in accordance with IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," as if the application was for admission to an ICF/ID, except that the self-reliance staff will forward potentially eligible applications immediately to the Department for review. The Medicaid application process cited above conforms to all statutory and regulatory requirements relating to the Medicaid application process. (7-1-21)T~~

~~**05. Transmitted Decisions to Self-Reliance Staff.** The decisions of the Department regarding the acceptance of the participants into the waiver program will be transmitted to the self-reliance staff. (7-1-21)T~~

~~06.~~03. **~~Case~~ Redetermination Process**. Case Redetermination will be conducted at least annually by the Department or its contractor. The redetermination process will verify that the participant continues to meet the eligibility requirements described in this section of rules and the participant's continued need for waiver services. (XX-XX-XX)

~~**a.** Financial redetermination will be conducted pursuant to IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." Medical redetermination will be made at least annually by the Department, or sooner at the request of the participant, the self-reliance staff, provider agency, or physician. The sections cited implement and are in accordance with Idaho's approved State Plan with the exception of deeming of income provisions. (7-1-21)T~~

~~**b.** The redetermination process will assess the following factors: (7-1-21)T~~

~~i. The participant's continued need and eligibility for waiver services; and (7-1-21)T~~

~~ii. Discharge from the waiver services program. (XX-XX-XX)(7-1-21)T~~

~~07.~~04. **Home and Community-Based Waiver Participant Limitations**. The number of Medicaid participants to receive waiver services under the home and community-based waiver for developmentally disabled participants will be limited to the projected number of users contained in the Department's approved waiver. Individuals who apply for waiver services after the waiver maximum has been reached will be placed on a waiting list and will have their applications processed after September 30th for the DD waiver of each new waiver year. (XX-XX-XX)~~(7-1-21)T~~

703. ADULT DD WAIVER SERVICES: COVERAGE AND LIMITATIONS.

01. Residential Habilitation. Residential habilitation services consist of an integrated array of individually tailored services and supports furnished to eligible participants. These services and supports are designed to assist the participants to reside successfully in their own homes, with their families, or in certified family homes. The services and supports that may be furnished consist of the following: (7-1-21)T

a. Habilitation services aimed at assisting the individual to acquire, retain, or improve their ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (7-1-21)T

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;(7-1-21)T

ii. Money management including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (7-1-21)T

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; (7-1-21)T

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 assisting the participant to identify activities of interest, working out arrangements to participate in such activities and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in non-therapeutic activities that are merely diversional or recreational in nature); (7-1-21)T

v. Mobility, including 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; (7-1-21)T

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 that consist of reinforcing physical, occupational, speech and other therapeutic programs. (7-1-21)T

b. Personal Assistance Services necessary to assist the individual in 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. (7-1-21)T

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. (7-1-21)T

d. Transportation integral to meeting the participant's goals, desired outcomes, and needs specified in the provider implementation plan (required by Section 513 of these rules). (XX-XX-XX)

e. Limitations. (XX-XX-XX)

i. Residential Habilitation services may be provided in the individual's home or in the community but not in a developmental disability facility, defined in Section 39-4604, Idaho Code, and must not duplicate other types of habilitation services provided to the individual. (XX-XX-XX)

ii. Transportation to and from the site of other discrete waiver services is not included in the residential habilitation rate, but may be provided as non-medical transportation (a separately billable service). (XX-XX-XX)

02. Chore Services. Chore services include the following services when necessary to maintain the functional use of the home or to provide a clean, sanitary, and safe environment. (7-1-21)T

a. Intermittent Assistance may include the following:

i. Yard maintenance;

ii. Minor home repair;

iii. Heavy housework;

iv. Sidewalk maintenance; and

v. Trash removal to assist the participant to remain in the home.

b. Chore activities may include the following:

i. Washing windows;

ii. Moving heavy furniture;

iii. Shoveling snow to provide safe access inside and outside the home;

iv. Chopping wood when wood is the participant's primary source of heat; and

v. Tacking down loose rugs and flooring.

c. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community volunteer, agency, or third-party payer is willing to provide them, or is responsible for their provision. (7-1-21)T

d. In the case of rental property, the landlord's responsibility under the lease agreement will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (7-1-21)T

03. Respite Care. Respite care includes short-term breaks from care giving responsibilities to non-paid caregivers. The caregiver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other services that are duplicative in nature. Respite care services provided under this waiver do not include room and board payments. Respite care services may be provided in the participant's residence, the private home of the respite provider, the community, a developmental disabilities agency, or an adult day health facility. (7-1-21)T

~~12.~~**04. Adult Day Health**. 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 outside the home of the participant in a non-institutional, community-based setting, and it encompasses health services, social services, recreation, supervision for safety, and assistance with activities of daily living needed to ensure the optimal functioning of the participant. Adult day health services provided under this waiver will not include room and board payments. ~~Adult day health cannot exceed thirty (30) hours per week, either alone or in combination with developmental therapy and occupational therapy.~~ (XX-XX-XX)~~(7-1-21)T~~

05. Prevocational. Prevocational services provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Prevocational services include activities that are not primarily directed at teaching skills to perform a particular job, but at underlying habilitative goals (e.g., attention span, motor skills, interpersonal relations with co-workers and supervisors) that are associated with building skills necessary to perform competitive work in community-integrated employment. Personal assistance services may be a component of prevocational supports, but may not comprise the entirety of the service. (XX-XX-XX)

a. Services are provided over a defined period of time and with specific outcomes to be achieved as determined by the individual and their planning team through an ongoing person-centered planning process. (XX-XX-XX)

b. Prevocational services may be furnished in a variety of locations in the community in situations that enable the individual to transfer employment-related, but not job-task-specific skills. The setting for the delivery of services ~~must be aligned with the individualized assessed need, and that which is most conducive in developing the specific and~~

measurable outcomes contained within the individual support plan. Services should be provided in the community whenever possible. In cases where service cannot be provided in the community due to an individual's needs, services may be provided in the participant's home. (XX-XX-XX)

c. A person receiving prevocational supports may pursue employment opportunities at any time to enter the general work force. Participation in prevocational supports is not a prerequisite for receiving Supported Employment Services under the waiver. (XX-XX-XX)

d. Prevocational services rendered under the 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 verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973 as amended, or the IDEA. (XX-XX-XX)

e. Limitations. (XX-XX-XX)

i. The duration of this service shall not exceed one year. (XX-XX-XX)

ii. This service may be offered on an individual basis or in groups of no more than four (4). When offered in small groups the focus of the service should apply to the individualized assessed needs and goals of all individuals in the group. The decision to provide services in a group setting must be based on individualized assessed need and be supported in the person-centered plan. (XX-XX-XX)

06. Career Planning. Career planning is an individualized, person-centered, comprehensive employment planning and support service that provides consultation, evaluation, and assistance for individuals to attain or advance in competitive integrated employment. Career planning is a focused and time-limited service engaging an individual in self-discovery, identification of a career direction, and development of a plan for achieving competitive integrated employment at or above the state's minimum wage. (XX-XX-XX)

a. The outcome of this service is documentation of the individual's stated career objective and a career plan used to guide individual employment support. This career plan should include all pertinent information about the individual's skills and interests, job preferences, relevant benefit considerations, possible contributions to an employer, a list of useful social networks and/or a resume. (XX-XX-XX)

b. Career planning may be provided in a variety of settings but shall not be furnished in the individual's residence or other living arrangement except for a home visit conducted as part of the observation and assessment of an individual's skills, interests, and activities of daily life. (XX-XX-XX)

c. Career planning services rendered under the 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 verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973 as amended, or the IDEA. (XX-XX-XX)

d. Limitations. (XX-XX-XX)

i. This service is limited to four (4) hours per week. (XX-XX-XX)

ii. This service may be offered only on an individual basis. (XX-XX-XX)

~~04.~~**07. Supported Employment**. Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work. (7-1-21)T

a. Supported employment services rendered under the 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. (7-1-21)T

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 waiver participant's supported employment program. (7-1-21)T

~~05. Non-Medical Transportation. Non-medical transportation enables a waiver participant to gain access to waiver and other community services and resources. (7-1-21)T~~

~~a. Non-medical transportation is offered in addition to medical transportation required in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and will not replace it. (7-1-21)T~~

~~b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge or public transit providers will be utilized. (7-1-21)T~~

~~06.~~08. **Environmental Accessibility Adaptations**. Environmental accessibility adaptations include minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization or have a risk to health, welfare, or safety. Such adaptations may include: (XX-XX-XX)~~(7-1-21)T~~

a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but must exclude those adaptations or improvements to the home that are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. (7-1-21)T

b. Unless otherwise authorized by the Department, permanent environmental modifications are limited to a home that is the participant's principal residence, and is owned by the participant or the participant's non- paid family. (7-1-21)T

c. 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. (7-1-21)T

~~07.~~09. **Specialized Medical Equipment and Supplies**. (XX-XX-XX)~~(7-1-21)T~~

a. Specialized medical equipment and supplies include: (7-1-21)T

i. Devices, controls, or appliances that enable a participant to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live; and (7-1-21)T

ii. Items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. (7-1-21)T

b. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid State Plan and exclude those items that are not of direct medical or remedial benefit to the participant. (7-1-21)T

~~08.~~10. **Personal Emergency Response System (PERS)**. PERS is an electronic device that enables a waiver participant to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. This service is limited to participants who: (XX-XX-XX)~~(7-1-21)T~~

a. Rent or own a home, or live with unpaid caregivers; (7-1-21)T

b. Are alone for significant parts of the day; (7-1-21)T

c. Have no caregiver for extended periods of time; and (7-1-21)T

d. Would otherwise require extensive, routine supervision. (7-1-21)T

~~09.~~11. **Home Delivered Meals**. Home delivered meals are meals that are delivered to a participant's home

to promote adequate participant nutrition. One (1) to two (2) meals per day may be provided to a participant who: (XX-XX-XX)~~(7-1-21)T~~

a. Rents or owns a home; (7-1-21)T

b. Is alone for significant parts of the day; (7-1-21)T

c. Has no caregiver for extended periods of time; and (7-1-21)T

d. Is unable to prepare a meal without assistance. (7-1-21)T

~~**10.**~~**12. Skilled Nursing**. Skilled nursing includes intermittent or continuous oversight, training, or skilled care that is within the scope of the Nurse Practice Act. Such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a licensed registered nurse licensed to practice in Idaho. Nursing Services must be referred by a physician or other practitioner of the healing arts as defined in these rules. (XX-XX-XX)~~(7-1-21)T~~

~~**11.**~~**13. Behavior Consultation/Crisis Management**. Behavior Consultation/Crisis Management services that provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also provide emergency back-up involving the direct support of the participant in crisis. (XX-XX-XX)~~(7-1-21)T~~

~~**13.**~~**14. Self-Directed Community Supports**. Participants eligible for the DD Waiver may choose to self-direct their individualized budget rather than receive the traditional waiver services described in this section of rule. The requirements for this option are outlined in IDAPA 16.03.13, "Consumer-Directed Services." (XX-XX-XX)~~(7-1-21)T~~

~~**14.**~~**15. Place of Service Delivery**. Waiver services may be provided in home and community settings as described in Section 312 of these rules. Approved places of services include the participant's personal residence, a certified family home, day habilitation/supported employment program, or community. The following living situations are specifically excluded as a place of service for waiver services: (XX-XX-XX)~~(7-1-21)T~~

a. Licensed skilled, or intermediate care facilities, certified nursing facility (NF) or hospital; and (7-1-21)T

b. Licensed Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID); and (7-1-21)T

c. Residential Assisted Living Facility. (7-1-21)T

d. Additional limitations to specific services are listed under that service definition. (7-1-21)T

~~**15.**~~**16. Transition Services**. Transition Services include goods and services that enable a participant residing in a nursing facility, hospital, IMD, or ICF/ID to transition to a community-based setting. A participant is eligible to receive transition services immediately following discharge from a qualified institution after residing within that institution for a minimum of forty-five (45) Medicaid-reimbursed days. (XX-XX-XX)~~(7-1-21)T~~

a. Qualified Institutions include the following: (7-1-21)T

i. Skilled, or Intermediate Care Facilities; (7-1-21)T

ii. Nursing Facility; (7-1-21)T

iii. Licensed Intermediate Care Facility for the Persons with Intellectual Disabilities (ICF/ID); (7-1-21)T

iv. Hospitals; and (7-1-21)T

v. Institutions for Mental Diseases (IMD). (7-1-21)T

b. Transition services may include the following goods and services: (7-1-21)T

i. Security deposits that are required to obtain a lease on an apartment or home; (7-1-21)T

ii. Cost of essential household furnishings, including furniture, window coverings, food preparation items, and bed/bath linens; and (7-1-21)T

iii. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (7-1-21)T

iv. Services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (7-1-21)T

v. Moving expenses; and (7-1-21)T

vi. Activities to assess need, arrange for and procure transition services. (7-1-21)T

c. Excluded goods and services. Transition services do not include ongoing expenses, real property, ongoing utility charges, décor, or diversion/recreational items such as televisions, DVDs, and computers. (7-1-21)T

d. Service limitations. Transition services are limited to a total cost of two thousand dollars ($2,000) per participant and can be accessed every two (2) years, contingent upon a qualifying transition from an institutional setting. Transition services are furnished only to the extent that the person is unable to meet such expense or when the support cannot be obtained from other sources. (7-1-21)T

704. ADULT DD WAIVER SERVICES: PROCEDURAL REQUIREMENTS.

01. Authorization of Services on a Written Plan. All waiver services must be identified on the plan of service and authorized by the process described in Sections 507 through ~~520~~ 519 of these rules. ~~The plan of service must be reviewed by a plan monitor or targeted service coordinator at a frequency determined by the person-centered planning team, but at least every ninety (90) days.~~ (XX-XX-XX)~~(7-1-21)T~~

02. Provider Records. ~~Three (3)~~ Four (4) types of record information will be maintained on all participants receiving waiver services: (XX-XX-XX)~~(7-1-21)T~~

a. Direct Service Provider Information that includes written documentation of each visit made or service provided to the participant, and will record at a minimum the following information: (7-1-21)T

i. Date and time of visit; and (7-1-21)T

ii. Services provided during the visit; and (7-1-21)T

iii. A statement of the participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and (7-1-21)T

iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the participant is determined by the Service Coordinator to be unable to do so, the delivery will be verified by the participant as evidenced by their signature on the service record. (7-1-21)T

v. A copy of the above information will be maintained in the participant's home unless authorized to be kept elsewhere by the Department. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. (7-1-21)T

b. ~~The plan of service developed by the plan developer and the person-centered planning team must specify which services are required by the participant.~~ A copy of the plan of service authorized by the Department in accordance with the process described in Sections 507 through 519 of these rules. ~~The plan of service must contain all elements required by Subsection 704.01 of these rules and a~~ A copy of the most current plan of service must be maintained in the participant's home and must be available to all service providers and the Department.
(XX-XX-XX)~~(7-1-21)T~~

c. The provider implementation plan (if required by Section 513 of these rules. A copy of the most current provider implementation plan must be maintained in the participant's home and must be available to all service providers and the Department. (XX-XX-XX)~~(7-1-21)T~~

~~**c.**~~**d.** In addition to the plan of service, all providers, ~~with the exception of chore, non-medical transportation, and enrolled Medicaid vendors~~ who are required to develop a Provider Implementation Plan, must submit a provider status review six (6) months after the start date of the plan of service and annually to the plan monitor as described in ~~Sections 507 through 520~~ Section 513 of these rules. Such provider status reviews must be maintained in the participant's record.

(XX-XX-XX)~~(7-1-21)T~~

03. Provider Responsibility for Notification. It is the responsibility of the service provider to notify the service coordinator or plan developer when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. (7-1-21)T

04. Records Maintenance. ~~In order to provide continuity of services, when a participant changes service providers, plan developers, or service coordinators, all of the foregoing participant records will be delivered to and held by the Department until a replacement service provider, plan developer, or service coordinator is selected by the participant. When a participant leaves the waiver services program, the records will be retained by the Department as part of the participant's closed case record.~~ Provider agencies will be responsible to retain their participant's records for five (5) years following the date of service. (XX-XX-XX)~~(7-1-21)T~~

705. ADULT DD WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
All providers of waiver services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (7-1-21)T

01. Residential Habilitation -- Supported Living. When residential habilitation services are provided by an agency, the agency must be certified by the Department as a Residential Habilitation Agency under IDAPA 16.04.17, "Residential Habilitation Agencies," and must supervise the direct services provided. Individuals who provide residential habilitation services in the home of the participant (supported living) must be employed by a Residential Habilitation Agency. Providers of residential habilitation services must meet the following requirements: (7-1-21)T

a. Direct service staff must meet the following minimum qualifications: (7-1-21)T

i. Be at least eighteen (18) years of age; (7-1-21)T

ii. Be a high school graduate, or have a GED, or demonstrate the ability to provide services according to a plan of service; (7-1-21)T

iii. Have current CPR and First Aid certifications; (7-1-21)T

iv. Be free from communicable disease; (7-1-21)T

v. If transporting participants, have a current and valid driver's license and vehicle insurance; (XX-XX-XX)~~(7-1-21)T~~

~~v.~~vi. Each staff person assisting with participant medications has successfully completed 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. (XX-XX-XX)~~(7-1-21)T~~

~~vi.~~vii. Residential habilitation service providers who provide direct care or services satisfactorily completed a criminal background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." (XX-XX-XX)~~(7-1-21)T~~

~~vii.~~viii. Have appropriate certification or licensure if required to perform tasks that require certification or licensure. (XX-XX-XX)~~(7-1-21)T~~

b. 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. (7-1-21)T~~

c. Prior to delivering services to a participant, agency direct service staff must complete an orientation program. The orientation program must include the following subjects: (7-1-21)T

i. Purpose and philosophy of services; (7-1-21)T

ii. Service rules; (7-1-21)T

iii. Policies and procedures; (7-1-21)T

iv. Proper conduct in relating to waiver participants; (7-1-21)T

v. Handling of confidential and emergency situations that involve the waiver participant; (7-1-21)T

vi. Participant rights; (7-1-21)T

vii. Methods of supervising participants; (7-1-21)T

viii. Working with individuals with developmental disabilities; and (7-1-21)T

ix. Training specific to the needs of the participant. (7-1-21)T

d. Additional training requirements must be completed within six (6) months of employment with the residential habilitation agency and include at a minimum: (7-1-21)T

i. Instructional techniques: Methodologies for training in a systematic and effective manner; (7-1-21)T

ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; (7-1-21)T

iii. Feeding; (7-1-21)T

iv. Communication; (7-1-21)T

v. Mobility; (7-1-21)T

vi. Activities of daily living; (7-1-21)T

vii. Body mechanics and lifting techniques; (7-1-21)T

viii. Housekeeping techniques; and (7-1-21)T

ix. Maintenance of a clean, safe, and healthy environment. (7-1-21)T

e. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed. (7-1-21)T

f. Through the duration of the COVID-19 public health emergency, agency direct service staff may begin rendering services prior to completing the training requirements, provided that they complete the training requirements within thirty (30) days of first rendering services, advise the participant or legal guardian that the individual has not yet completed the applicable trainings, and comply with any other requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. (7-1-21)T

02. Residential Habilitation -- Certified Family Home (CFH). (7-1-21)T

a. An individual who provides direct residential habilitation services in their own home must be certified by the Department to operate a certified family home 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 they provide. (7-1-21)T

b. CFH providers providing residential habilitation services as a DD Waiver provider must meet the following minimum qualifications: (7-1-21)T

i. Be at least eighteen (18) years of age; (7-1-21)T

ii. Be a high school graduate, have a GED, or demonstrate the ability to provide services according to a plan of service; (7-1-21)T

iii. Have current CPR and First Aid certifications; (7-1-21)T

iv. Be free from communicable disease; (7-1-21)T

v. If transporting participants, have a current and valid driver's license and vehicle insurance; (XX-XX-XX)~~(7-1-21)T~~

~~v.~~vi. Each CFH provider of residential habilitation services assisting with participant medications has successfully completed 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. (XX-XX-XX)~~(7-1-21)T~~

~~vi.~~vii. CFH providers of residential habilitation services who provide direct care and services have satisfactorily completed a criminal history check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks;" and (XX-XX-XX)~~(7-1-21)T~~

~~vii.~~viii. Have appropriate certification or licensure if required to perform tasks that require certification or licensure. (XX-XX-XX)~~(7-1-21)T~~

c. All skill training for CFH providers who are providing residential habilitation services must be provided through the Department or its contractor by qualified intellectual disabilities professional (QIDP) who has demonstrated experience in writing skill training programs. (7-1-21)T

d. 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, or its contractor or both, and include the following areas: (7-1-21)T

i. Purpose and philosophy of services; (7-1-21)T

ii. Service rules; (7-1-21)T

iii. Policies and procedures; (7-1-21)T

iv. Proper conduct in relating to waiver participants; (7-1-21)T

v. Handling of confidential and emergency situation that involve the waiver participant; (7-1-21)T

vi. Participant rights; (7-1-21)T

vii. Methods of supervising participants; (7-1-21)T

viii. Working with individuals with developmental disabilities; and (7-1-21)T

ix. Training specific to the needs of the participant. (7-1-21)T

e. Additional training requirements for CFH providers providing residential habilitation waiver services must be completed by the CFH provider within six (6) months of certification date and include a minimum of the following: (7-1-21)T

i. Instructional Techniques: Methodologies for training in a systematic and effective manner; (7-1-21)T

ii. Managing behaviors: techniques and strategies for teaching adaptive behaviors; (7-1-21)T

iii. Feeding; (7-1-21)T

iv. Communication; (7-1-21)T

v. Mobility; (7-1-21)T

vi. Activities of daily living; (7-1-21)T

vii. Body mechanics and lifting techniques; (7-1-21)T

viii. Housekeeping techniques; and (7-1-21)T

ix. Maintenance of a clean, safe, and healthy environment. (7-1-21)T

f. The Department or its contractor will be responsible for providing on-going training to the CFH provider of residential habilitation specific to the needs of the participant as needed. (7-1-21)T

g. Through the duration of the COVID-19 public health emergency, CFH providers may begin rendering services prior to completing the training requirements, provided that they complete the training requirements within thirty (30) days of first rendering services, advise the participant or legal guardian that the individual has not yet completed the applicable trainings, and comply with any other requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. (7-1-21)T

03. Chore Services. Providers of chore services must meet the following minimum qualifications: (7-1-21)T

a. Be skilled in the type of service to be provided; and (7-1-21)T

b. Demonstrate the ability to provide services according to a plan of service. (7-1-21)T

c. Chore service providers who provide direct care and services have satisfactorily completed a criminal history and background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." (7-1-21)T

04. Respite Care. Providers of respite care services must meet the following minimum qualifications: (7-1-21)T

a. Have received care giving instructions in the needs of the person who will be provided the service; (7-1-21)T

b. Demonstrate the ability to provide services according to a plan of service; (7-1-21)T

c. Be free of communicable disease; and (7-1-21)T

d. Respite care service providers who provide direct care and services have satisfactorily completed a criminal history and background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." (7-1-21)T

~~13.~~05. **Adult Day Health**. Providers of adult day health must meet the following requirements: (XX-XX-XX)~~(7-1-21)T~~

a. Services provided in a facility must be provided in a facility that meets the building and health standards identified in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)"; (7-1-21)T

b. Services provided in a home must be provided in a home that meets the standards of home certification identified in IDAPA 16.03.19, "Certified Family Homes"; (7-1-21)T

c. Adult day health providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks"; (7-1-21)T

d. Providers of adult day health must notify the Department on behalf of the participant, if the adult day health is provided in a certified family home other than the participant's primary residence. The adult day health provider must provide care and supervision appropriate to the participant's needs as identified on the plan. (7-1-21)T

e. Adult day health providers who provide direct care or services must be free from communicable disease. (7-1-21)T

06. Prevocational. Prevocational services must be provided by an agency that supervises the direct service and is accredited by the Commission on Accreditation of Rehabilitation Facilities or other comparable standards, or meets State requirements to be a State-approved provider. Prevocational service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." (XX-XX-XX)

07. Career Planning. Career planning services must be provided by an agency that supervises the direct service and is accredited by the Commission on Accreditation of Rehabilitation Facilities or other comparable standards, or meets State requirements to be a State-approved provider. Career planning service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." (XX-XX-XX)

~~05.~~08. **Supported Employment**. Supported employment services must be provided by an agency that supervises the direct service and is accredited by the Commission on Accreditation of Rehabilitation Facilities or other comparable standards, or meets State requirements to be a State-approved provider. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." (XX-XX-XX)~~(7-1-21)T~~

~~06. Non-Medical Transportation. Providers of non-medical transportation services must: (7-1-21)T~~

~~a. Possess a valid driver's license; and (7-1-21)T~~

~~b. Possess valid vehicle insurance. (7-1-21)T~~

~~07.~~09. **Environmental Accessibility Adaptations**. All services must be provided in accordance with applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. (XX-XX-XX)~~(7-1-21)T~~

~~08.~~10. **Specialized Medical Equipment and Supplies**. Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. Providers must ensure all items meet applicable standards of manufacture, design, and installation. Preference will be given to equipment and supplies that are the most cost-effective option to meet the participant's needs. (XX-XX-XX)~~(7-1-21)T~~

~~09.~~11. **Personal Emergency Response System**. Personal emergency response system providers must demonstrate that the devices installed in a waiver participant's home meet Federal Communications Standards, or Underwriter's Laboratory standards, or equivalent standards. (XX-XX-XX)~~(7-1-21)T~~

~~10.~~12. **Home Delivered Meals**. Providers of home-delivered meals must be a public agency or private business, and must exercise supervision to ensure that: (XX-XX-XX)~~(7-1-21)T~~

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; (7-1-21)T

b. Meals are delivered in accordance with the service plan, in a sanitary manner, and at the correct temperature for the specific type of food; (7-1-21)T

c. A Registered Dietitian documents the review and approval of menus, menu cycles, and any changes or substitutions; and (7-1-21)T

d. The agency or business is inspected and licensed as a food establishment under IDAPA 16.02.19, "Idaho Food Code." (7-1-21)T

~~11.~~13. **Skilled Nursing.** Skilled nursing service providers must be licensed in Idaho as a licensed registered nurse or licensed practical nurse in good standing, or must be practicing on a federal reservation and be licensed in another state. Skilled nursing providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." (XX-XX-XX)~~(7-1-21)T~~

~~12.~~14. **Behavior Consultation or Crisis Management**. Behavior Consultation or Crisis Management Providers must meet the following: (XX-XX-XX)~~(7-1-21)T~~

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 (7-1-21)T

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 (7-1-21)T

c. Be a licensed pharmacist; or (7-1-21)T

d. Be a Qualified Intellectual Disabilities Professional (QIDP). (7-1-21)T

e. Emergency back-up providers must meet the minimum residential habilitation provider qualifications described under IDAPA 16.04.17, "Residential Habilitation Agencies." (7-1-21)T

f. Behavior consultation or crisis management providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." (7-1-21)T

~~14. **Service Supervision.** The plan of service that includes all waiver services is monitored by the plan monitor or targeted service coordinator. (7-1-21)T~~

~~15.~~15. **Transition Services**. Transition managers as described in Section 350.01 of these rules are responsible for administering transition services. (XX-XX-XX)~~(7-1-21)T~~

706. ADULT DD WAIVER SERVICES: PROVIDER REIMBURSEMENT.

01. Fee for Service. Waiver service providers will be paid on a fee for service basis based on the type of service provided as established by the Department. (7-1-21)T

02. Claim Forms. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (7-1-21)T

03. Rates. The reimbursement rates calculated for waiver services include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location when the participant is not being provided transportation. (7-1-21)T

707. -- 719. (RESERVED)

SUB AREA: SERVICE COORDINATION SERVICES
(Sections 720-779)

720. SERVICE COORDINATION.
The Department will purchase service coordination for persons eligible for Enhanced Benefits who are unable, or have limited ability to gain access, coordinate or maintain services on their own or through other means. These rules are

not applicable to behavioral health service coordination, also known as case management services, provided under the Idaho Behavioral Health Plan (IBHP) included in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." (7-1-21)T

721. SERVICE COORDINATION: DEFINITIONS.
The following definitions apply for Sections 721 through 736 of these rules. (7-1-21)T

01. Agency. An agency is a business entity that provides management, supervision, and quality assurance for service coordination and includes at least two (2) individuals, one (1) supervisor and a minimum of one (1) service coordinator. (7-1-21)T

02. Brokerage Model. Referral or arrangement for services identified in an assessment. This model does not include the provision of direct services. (7-1-21)T

03. Conflict of Interest Standard. ~~A situation in which an agency or person directly or indirectly influences, or appears to influence the direction of a participant to other services for financial gain.~~ Individuals and agency employees or contractors who develop a participant's plan of service as described in Section 513 of these rules will not be: (XX-XX-XX)~~(7-1-21)T~~

a. Related by blood or marriage to the participant, or to any paid caregiver of the participant; (XX-XX-XX)

b. Financially responsible for the participant; (XX-XX-XX)

c. Empowered to make financial or health-related decisions on behalf of the participant; (XX-XX-XX)

d. Hold financial interests in any entity that is paid to provide care for the participant; or (XX-XX-XX)

e. A provider of state plan HCBS or waiver services for the participant, or have an interest in or are employed by a provider of state plan HCBS or waiver services. (XX-XX-XX)

04. Crisis. An unanticipated event, circumstance or life situation that places a participant at risk of at least one (1) of the following: (7-1-21)T

a. Hospitalization; (7-1-21)T

b. Loss of housing; (7-1-21)T

c. Loss of employment or major source of income; (7-1-21)T

d. Incarceration; or (7-1-21)T

e. Physical harm to self or others, including family altercation or ~~psychiatric relapse~~ or other emergencies. (XX-XX-XX)~~(7-1-21)T~~

05. Human Services Field. A particular area of academic study in health care, social services, education, behavioral science or counseling. (7-1-21)T

06. Paraprofessional. An adult with a high school diploma or equivalency who has at least twelve (12) months supervised work experience with the population to whom they will be providing services. (7-1-21)T

~~**07. Person-Centered Planning**. A planning process facilitated by the service coordinator that includes the participant and individuals significant to the participant, to collaborate and develop a plan based on the expressed needs and desires of the participant. For children, this planning process must involve the child's family. (7-1-21)T~~

~~**08.**~~**07. Practitioner of the Healing Arts**. For purposes of this rule, a nurse practitioner, physician assistant or clinical nurse specialist. (XX-XX-XX)~~(7-1-21)T~~

~~09.~~08. **Service Coordination**. Service coordination is a case management activity that assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of the individual. Service coordination is a brokerage model of case management. (XX-XX-XX)~~(7-1-21)T~~

~~10. Service Coordination Plan. The service coordination plan, also known in these rules as the "plan," includes two components: (7-1-21)T~~

~~a. An assessment that identifies the participant's need for service coordination as described in Section 730 of these rules; and (7-1-21)T~~

~~b. A plan that documents the supports and services required to meet the service coordination needs of the participant as described in Section 731 of these rules. (7-1-21)T~~

~~11. Service Coordination Plan Development. An assessment and planning process performed by a service coordinator using person-centered planning principles that results in a written service coordination plan. The plan must accurately reflect the participant's need for assistance in accessing and coordinating supports and services. (7-1-21)T~~

~~12.~~09. **Service Coordinator**. An individual, excluding a paraprofessional, who provides service coordination to a Medicaid eligible participant, is employed by or contracts with a service coordination agency, and meets the training, experience, and other requirements in Section 729 of these rules. (XX-XX-XX)~~(7-1-21)T~~

~~13.~~10. **Supports**. Formal and informal services and activities that are not paid for by the Department and that enable an individual to reside safely in the setting of their choice. (XX-XX-XX)~~(7-1-21)T~~

722. SERVICE COORDINATION SERVICES: ELIGIBILITY.
Participants identified in Sections 723 through 726 of these rules, who do not receive hospice services or live in hospitals, nursing facilities, or intermediate care facilities for persons with intellectual disabilities, are eligible for service coordination. (7-1-21)T

723. TARGETED SERVICE COORDINATION: ELIGIBILITY: INDIVIDUALS WITH A DEVELOPMENTAL DISABILITY.
An individual is eligible to receive targeted service coordination if they meet the following requirements: ~~in this rule.~~ (XX-XX-XX)~~(7-1-21)T~~

01. Age. An adult eighteen (18) years of age or older. (7-1-21)T

02. Diagnosis. ~~Is diagnosed with~~ Determined to have a developmental disability~~, defined~~ in accordance with Section 66-402, Idaho Code and ~~Section~~ Sections 500 through 506 of these rules~~, that:~~ (XX-XX-XX)~~(7-1-21)T~~

~~a. Is attributable to an impairment, such as an intellectual disability, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one (1) of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments; (7-1-21)T~~

~~b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (7-1-21)T~~

~~c. Reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services that are of lifelong or extended duration and individually planned and coordinated. (7-1-21)T~~

~~03. Need Assistance. Requires and chooses assistance to access services and supports necessary to maintain their independence in the community. (7-1-21)T~~

724. -- 725. (RESERVED)

726. SERVICE COORDINATION: ELIGIBILITY: INDIVIDUALS UP TO THE AGE OF TWENTY-ONE.

To be eligible for children's service coordination, a participant must meet the following requirements in Subsections 726.01 through 726.03. Eligibility is determined initially and annually by the Department based on information provided by the service coordination agency or the family. All information necessary to make the eligibility determination must be received by the Department twenty (20) business days prior to the anticipated start date of any service coordination services. The eligibility determination will be made by the Department prior to the initiation of initial and ongoing plan development and services. (7-1-21)T

01. Age. From the age of thirty-seven (37) months through the month in which their twenty-first birthday occurs. (7-1-21)T

02. Diagnosis. Must have special health care needs requiring medical and multidisciplinary rehabilitation services identified by a physician or other practitioner of the healing arts to prevent or minimize a disability. (7-1-21)T

03. Need Assistance. Medicaid-reimbursed service coordination services are not available for participants whose needs can be met by other service coordination or case management resources, including paid and non-paid sources. The participant must have needs for service coordination for one (1) or more of the following problems: (7-1-21)T

a. The condition has resulted in a level of functioning below normal age level in one (1) or more life areas such as school, child care setting, family, or community; (7-1-21)T

b. The child is at risk of placement in a more restrictive environment or the child is returning from an out of home placement as a result of the condition; (7-1-21)T

c. There is danger to the health or safety of the child or the parent is unable to meet the needs of the child; (7-1-21)T

d. Further complications may occur as a result of the condition without provision of service coordination services; or (7-1-21)T

e. The child requires multiple service providers and treatments. (7-1-21)T

727. SERVICE COORDINATION: COVERAGE AND LIMITATIONS.

Service coordination consists of services provided to assist individuals in gaining access to needed services. Service coordination includes the following activities described in Subsections 727.01 through 727.~~10~~07 of this rule. (XX-XX-XX)~~(7-1-21)T~~

~~**01. Plan Assessment and Periodic Reassessment.** Activities that are required to determine the participant's needs by development of a plan assessment and periodic reassessment as described in Section 730 of these rules. These activities include: (7-1-21)T~~

~~**a.** Taking a participant's history; (7-1-21)T~~

~~**b.** Identifying the participant's needs and completing related documentation; and (7-1-21)T~~

~~**c.** Gathering information from other sources such as family members, medical providers, social workers, and educators, to form a complete assessment of the participant. (7-1-21)T~~

~~**02.**01. ~~**Development of the Plan**~~ **Plan Development Activities**. ~~Development and revision of a specific plan, described in Section 731 of these rules that includes information collected through the assessment and specifies goals and actions needed by the participant.~~ Plan development activities are as described in Section 513 of these rules. The plan of service must be updated at least annually (or extended through the duration of the declared COVID- 19 public health emergency) and as needed to meet the needs of the participant as described in Section 513 of these rules. (XX-XX-XX)~~(7-1-21)T~~

~~03. Referral and Related Activities.~~ ~~Activities that help link the participant with service providers that are capable of providing needed services to address identified needs and achieve goals specified in the service coordination plan.~~ ~~(7-1-21)T~~

~~04.~~02. **Monitoring and Follow-Up Activities**. ~~Monitoring and follow-up contacts that are necessary to ensure the plan is implemented and adequately addresses the participant's needs. These activities may be with the participant, family members, providers, or other entities or individuals and conducted as frequently as necessary. These activities must include at least one face-to-face contact with the participant at least every ninety (90) days (the face-to-face encounter may occur via synchronous interaction telehealth, as defined in Title 54, Chapter 57, Idaho Code), to determine whether the following conditions are met:~~ Monitoring and follow-up activities are as described in Section 513 of these rules. (XX-XX-XX)~~(7-1-21)T~~

~~a. Services are being provided according to the participant's plan;~~ ~~(7-1-21)T~~

~~b. Services in the plan are adequate; and~~ ~~(7-1-21)T~~

~~c. Whether there are changes in the needs or status of the participant, and if so, making necessary adjustments in the plan and service arrangements with providers.~~ ~~(7-1-21)T~~

~~05.~~03. **Crisis Assistance.** Crisis assistance is service coordination used to assist a participant to access community resources in order to resolve a crisis. Crisis service coordination does not include crisis counseling, transportation to emergency service providers, or direct skill-building services. The need for all crisis assistance hours must meet the definition of crisis in Section 721 of these rules. (XX-XX-XX)~~(7-1-21)T~~

~~a. Crisis Assistance for Children's Service Coordination. Crisis hours are not available until four and a half (4.5) hours of service coordination have already been provided in the month. Crisis hours for children's service coordination must be authorized by the Department.~~ ~~(7-1-21)T~~

~~b. Crisis Assistance for Adults With a Developmental Disability. Crisis hours are not available until four and a half (4.5) hours of service coordination have already been provided in the month. Crisis assistance for adults with a developmental disability must be authorized by the Department and is based on community crisis supports as found in Section 646 through 648 of these rules.~~ ~~(7-1-21)T~~

a. Crisis assistance may be provided in an emergency room during the ER evaluation process if the goal is to prevent hospitalization and return the participant to the community. (XX-XX-XX)

b. Crisis assistance may be provided before or after the completion of the assessment and plan of service. If crisis assistance is provided before the completion of the assessment and plan of service, the plan of service must include an identification of the factors contributing to the crisis and a strategy for addressing those factors in the future. (XX-XX-XX)

c. Authorization for crisis assistance hours may be requested retroactively as a result of a crisis, defined in Section 721 of these rules, when a participant's service coordination benefits have been exhausted and no other means of support is available to the participant. In retroactive authorizations, the service coordinator must complete a crisis resolution plan and submit a request for crisis services to the Department within ~~seventy-two (72) hours~~ five (5) business days of the last day of providing the service. (XX-XX-XX)~~(7-1-21)T~~

~~06.~~04. **Contacts for Assistance**. Service coordination may include contacts with non-eligible individuals only when the contact is directly related to identifying the needs and supports to help the participant access services. (XX-XX-XX)~~(7-1-21)T~~

~~07.~~05. **Exclusions**. Service coordination does not include activities that are: (XX-XX-XX)~~(7-1-21)T~~

a. An integral component of another covered Medicaid service; (7-1-21)T

b. Integral to the administration of foster care programs; (7-1-21)T

c. Integral to the administration of another non-medical program for which a participant may be eligible. This exclusion does not apply to case management provided as part of the individualized education program

or individualized family service plan required by the Individuals with Disabilities Education Act. (7-1-21)T

~~**08. Limitations on the Provision of Direct Services.** Providers of service coordination services may only provide both service coordination and direct services to the same Medicaid participant when the participant is receiving children's service coordination. The service coordination provider must document that the participant has made a free choice of service coordinators and direct service providers. (7-1-21)T~~

~~**09.**~~**06. Limitations on Service Coordination for Adults with Developmental Disabilities.**
(XX-XX-XX)~~(7-1-21)T~~

a. Unless otherwise approved by the Department, service coordination plan development activities are limited to twelve (12) hours per year. (XX-XX-XX)

b. Service coordination monitoring and follow-up activities ~~is~~ are limited to four and a half (4.5) hours per month. Unused hours may be used during the remaining months of the individuals current plan of service. (XX-XX-XX)~~(7-1-21)T~~

~~**10. Limitations on Service Coordination Plan Assessment and Plan Development.** Reimbursement for the annual assessment and plan development cannot exceed six (6) hours per year. (7-1-21)T~~

07. Limitations on Service Coordination for Children. (XX-XX-XX)

a. Service coordination plan development activities are limited to six (6) hours per year. (XX-XX-XX)

b. Service coordination monitoring and follow-up activities are limited to four and a half (4.5) hours per month. (XX-XX-XX)

c. Crisis hours are not available until four and a half (4.5) hours of service coordination have already been provided in the month. Crisis hours for children's service coordination must be authorized by the Department. (XX-XX-XX)

728. SERVICE COORDINATION: PROCEDURAL REQUIREMENTS.

01. Prior Authorization for Service Coordination Services. Services must be prior authorized by the Department according to the direction provided in the Medicaid Provider Handbook available at www.idmedicaid.com. (7-1-21)T

~~**02. Service Coordination Plan Development.** (7-1-21)T~~

~~**a.** A written plan, described in Section 731 of these rules, must be developed and implemented within sixty (60) days after the participant chooses a service coordinator. (7-1-21)T~~

~~**b.** The plan must be updated at least annually (or extended through the duration of the declared COVID-19 public health emergency) and amended as necessary. (7-1-21)T~~

~~**c.** The plan must address the service coordination needs of the participant as identified in the assessment described in Section 730 of these rules. (7-1-21)T~~

~~**d.** The plan must be developed prior to ongoing service coordination being provided. (7-1-21)T~~

~~**03.**~~**02. Documentation of Service Coordination**. Agencies must maintain records that contain documentation describing the services provided, review of the continued need for service coordination, and progress toward each service coordination goal. Documentation must be completed as required in Section 56-209(h), Idaho Code. All active records must be immediately available. Documentation must include all of the following:

(XX-XX-XX)~~(7-1-21)T~~

a. The name of the eligible participant. (7-1-21)T

b. The name of the provider agency and the person providing the services. (7-1-21)T

c. The date, time, duration, and place the service was provided. (7-1-21)T

d. The nature, content, units of the service coordination received and whether goals specified in the plan have been achieved. (7-1-21)T

e. Whether the participant declined any services in the plan. (7-1-21)T

f. The need for and occurrences of coordination with any non-Medicaid case managers. (7-1-21)T

g. The timeline for obtaining needed services. (7-1-21)T

h. The timeline for re-evaluation of the plan. (7-1-21)T

i. A copy of the assessment or prior authorization from the Department that documents eligibility for service coordination services, and a dated and signed plan. (7-1-21)T

j. Agency records must contain documentation describing details of the service provided signed by the person who delivered the service. (7-1-21)T

k. Documented review of participant's continued need for service coordination and progress toward each service coordination goal. A review must be completed at least every one hundred eighty (180) days after the plan development or update. Progress reviews must include the date of the review, and the signature of the service coordinator completing the review. (7-1-21)T

l. Documentation of the participant's, family's, or legal guardian's satisfaction with service. (7-1-21)T

m. A copy of the informed consent form signed by the participant, parent, or legal guardian that documents that the participant has been informed of the purposes of service coordination, their rights to refuse service coordination, and their right to choose their service coordinator and other service providers. (7-1-21)T

n. ~~A plan that is signed by the participant, parent, or legal guardian, and the service coordinator. The plan must reflect person-centered planning principles and document the participant's inclusion in the development of the plan. The service coordinator must also document that a copy of the plan was given to the participant or their legal representative. The plan must be updated and authorized when required, but at least annually. Children's service coordination plans cannot be effective before the date that the child's parent or legal guardian has signed the plan.~~ A copy of the plan of service authorized by the Department in accordance with the process described in Sections 507 through 519 of these rules. A copy of the most current plan of service must be maintained in the participant's home and must be available to all service providers and the Department. (XX-XX-XX)~~(7-1-21)T~~

~~04.~~03. **Documentation Completed by a Paraprofessional**. Each entry completed by a paraprofessional must be reviewed by the participant's service coordinator and include the date of review and the service coordinator's signature on the documentation. (XX-XX-XX)~~(7-1-21)T~~

~~05.~~04. **Participant Freedom of Choice**. A participant must have freedom of choice when selecting from the service coordinators available to them. The service coordinator cannot restrict the participant's choice of other health care or home and community based services providers. (XX-XX-XX)~~(7-1-21)T~~

~~06.~~05. **Service Coordinator Contact and Availability**. The frequency of contact, mode of contact, and person or entity to be contacted must be identified in the plan and must meet the needs of the participant. The contacts must verify the participant's well being and whether services are being provided according to the written plan. ~~At least every ninety (90) days, service coordinators must have face-to-face contact with each participant. The face-to-face encounter may occur via synchronous interaction telehealth, as defined in Title 54, Chapter 57, Idaho Code.~~ (XX-XX-XX)~~(7-1-21)T~~

~~**a.** When it is necessary for the children's service coordinator to conduct a face-to-face contact with a child participant without the parent or legal guardian present, the service coordinator must notify the parent or legal guardian prior to the face-to-face contact with the participant. Notification must be documented in the participant's file. (7-1-21)T~~

~~b.~~a. Service coordinators do not have to be available on a twenty-four (24) hour basis, but must include an individualized objective on the plan of service 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 situation. (XX-XX-XX)~~(7-1-21)T~~

~~07. Service Coordinator Responsibility Related to Conflict of Interest. Service coordinators have a primary responsibility to the participant whom they serve, to respect and promote the right of the participant to self-determination, and preserve the participant's freedom to choose services and providers. In order to assure that participant rights are being addressed, service coordinators must: (7-1-21)T~~

~~a. Be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. (7-1-21)T~~

~~b. Inform the participant parent, or legal guardian when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the participant's interests primary and protects the participant's interests to the greatest extent possible. (7-1-21)T~~

~~08.~~06. ~~Agency Responsibility~~ Responsibilities Related to Conflict of Interest. To assure that participants are protected from restrictions to their self-determination rights because of ~~conflict~~ conflicts of interest, the service coordinator and the agency must guard against ~~conflict~~ conflicts of interest, and inform all participants and guardians of the risk. (XX-XX-XX)~~(7-1-21)T~~

a. Each service coordinator will: (XX-XX-XX)

i. Be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment; and (XX-XX-XX)

ii. Inform the participant parent, or legal guardian when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the participant's interests primary and protects the participant's interests to the greatest extent possible. (XX-XX-XX)

b. Each agency must:

i. Ensure its employees and contractors meet the conflict of interest standards as defined in Section 721 of these rules; and

ii. Have a document in each participant's file that contains ~~the following information:~~

~~a. The~~ the definition of conflict of interest as defined in Section 721 of these rules; ~~(7-1-21)T~~

~~b. A~~ a signed statement by the agency representative verifying that the concept of conflict of interest was reviewed and explained to the participant parent, or legal guardian; and ~~(7-1-21)T~~

~~c. The~~ the participant's, parent's, or legal guardian's signature on the document. (XX-XX-XX)~~(7-1-21)T~~

729. SERVICE COORDINATION: PROVIDER QUALIFICATIONS.
Service coordination services must be provided by an agency as defined in Section 721 of these rules. (7-1-21)T

01. Provider Agreements. Service coordinators must be employees or contractors of an agency that has a valid provider agreement with the Department. (7-1-21)T

02. Supervision. The agency must provide supervision to all service coordinators and paraprofessionals. The agency must clearly document: (7-1-21)T

a. Each supervisor's ability to address concerns about the services provided by employees and contractors under their supervision, and (7-1-21)T

b. That a paraprofessional is not a supervisor. (7-1-21)T

03. Agency Supervisor Required Education and Experience. (7-1-21)T

a. Master's Degree in a human services field from a nationally accredited university or college, and have twelve (12) months supervised work experience with the population being served; or (7-1-21)T

b. Bachelor's degree in a human services field from a nationally accredited university or college, and have twenty-four (24) months supervised work experience with the population being served. (7-1-21)T

c. Be a licensed registered nurse (RN) and have twenty-four (24) months supervised work experience with the population being served. (7-1-21)T

04. Service Coordinator Education and Experience. (7-1-21)T

a. 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 (7-1-21)T

b. Be a licensed registered nurse (RN) and have twelve (12) months work experience with the population being served. (7-1-21)T

c. When an individual meets the education or licensing requirements in Subsections 729.04.a. or 729.04.b. of this rule, 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. (7-1-21)T

05. Paraprofessional Education and Experience. Under the supervision of a qualified service coordinator, a paraprofessional may be used to assist in the implementation of the plan. Paraprofessionals must have the following qualifications: (7-1-21)T

a. Be at least eighteen (18) years of age and have a minimum of a high school diploma or equivalency; (7-1-21)T

b. Be able to read and write at an appropriate level to process the required paperwork and forms involved in the provision of the service; and (7-1-21)T

c. Have twelve (12) months supervised work experience with the population being served. (7-1-21)T

06. Limitations on Services Delivered by Paraprofessionals. Paraprofessionals must not conduct assessments, evaluations, person-centered planning meetings, ninety (90) day face-to-face contacts described in Section ~~728.06~~ 513.04 of these rules, one hundred eighty (180) day progress reviews, plan development, or plan changes. Paraprofessionals cannot be identified as the service coordinator on the plan and they cannot supervise service coordinators or other paraprofessionals. (XX-XX-XX)~~(7-1-21)T~~

07. Criminal History Check Requirements. Service coordination agencies must verify that each service coordinator and paraprofessional they employ or with whom they contract has complied with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." (7-1-21)T

08. Conflict of Interest Standards. Service coordinators and the agency must meet the conflict of interest standards defined in Section 721 of these rules. (XX-XX-XX)

~~08.~~09. Health, Safety and Fraud Reporting. Service coordinators are required to report any concerns about health and safety to the appropriate governing agency and to the Department. Service coordinators must also report fraud, including billing of services that were not provided, to the Department unit responsible for authorizing the service; and to the Surveillance and Utilization Review Unit (SUR) within the Department or its toll-free Medicaid fraud hotline. (XX-XX-XX)~~(7-1-21)T~~

~~09.~~10. Individual Service Coordinator Case Loads. The total caseload of a service coordinator must assure quality service delivery and participant satisfaction. (XX-XX-XX)~~(7-1-21)T~~

~~**730. SERVICE COORDINATION: PLAN DEVELOPMENT -- ASSESSMENT.**~~

~~**01. Assessment Process.** The service coordination assessment must be completed by a service~~

coordinator as part of the person-centered planning process. The focus of the assessment is to identify the participant's need for assistance in gaining and coordinating access to care and services. The participant must be included in the assessment process. The parent or legal guardian, when appropriate, and pertinent service providers as identified by the participant must also be included during the assessment process. The assessment component is used to determine the prioritized needs and services of the participant and must be documented in the plan. When the participant is a child, the assessment must include identification of the family's needs to ensure the child's needs are met. (7-1-21)T

02. Components of an Assessment. The components in the assessment of a participant's service coordination needs must document the following information; (7-1-21)T

a. Basic needs; (7-1-21)T

b. Medical needs; (7-1-21)T

c. Health and safety needs; (7-1-21)T

d. Therapy needs; (7-1-21)T

e. Educational needs; (7-1-21)T

f. Social and integration needs; (7-1-21)T

g. Personal needs; (7-1-21)T

h. Family needs and supports; (7-1-21)T

i. Long range planning; (7-1-21)T

j. Legal needs; and (7-1-21)T

k. Financial needs. (7-1-21)T

731. SERVICE COORDINATION: PLAN DEVELOPMENT -- WRITTEN PLAN.
The service coordination plan is developed using information collected through the assessment of the participant's service coordination needs. The plan must specify the goals and actions to address the service coordination needs of the participant identified in the assessment process. The plan must include goals developed using the person-centered planning process. (7-1-21)T

01. Plan Implementation. The plan must identify activities required to respond to the assessed needs of the participant. (7-1-21)T

02. Plan Content. Plans must include the following: (7-1-21)T

a. A list of problems and needs identified during the assessment; (7-1-21)T

b. Identification of each and any potential risk or substantiation that there are no potential risks. The plan must identify services and actions that will be implemented in case of a participant crisis situation. (7-1-21)T

c. Concrete, measurable goals and objectives to be achieved by the participant; (7-1-21)T

d. Reference to all services and contributions provided by the participant's supports including the actions, if any, taken by the service coordinator to develop the support system; (7-1-21)T

e. Documentation of who has been involved in the service planning, including the participant's involvement; (7-1-21)T

f. Schedules for service coordination monitoring, progress review, and reassessment; (7-1-21)T

g. Documentation of unmet needs and service gaps including goals to address these needs or gaps; (7-1-21)T

~~**h.** References to any formal services arranged including costs, specific providers, schedules of service initiation, frequency or anticipated dates of delivery; and (7-1-21)T~~

~~**i.** Time frames for achievement of the goals and objectives. (7-1-21)T~~

~~**03. Adult Developmental Disability Service Coordination Plan.** The plan for adults with developmental disabilities must comply with and be incorporated into the participant's developmental disability plan of service identified in Section 513 of these rules. (7-1-21)T~~

730. -- 735. (RESERVED)

736. SERVICE COORDINATION: PROVIDER REIMBURSEMENT.

01. Duplication. Participants are only eligible for one (1) type of service coordination. If they qualify for more than one (1) type, the participant must choose one (1). Service coordination payment must not duplicate payment made to public or private sector entities under other program authorities for this same purpose. (7-1-21)T

02. Payment for Service Coordination. Subject to the service limitations in Subsection 736.06 of this rule, only the following services are reimbursable: (7-1-21)T

a. Service coordination plan development defined in Section 721 of these rules. (7-1-21)T

b. Face-to-face contact required in Subsection ~~728.06~~ 513.04 of these rules. (XX-XX-XX)~~(7-1-21)T~~

c. Two-way communication between the service coordinator and the participant, participant's service providers, family members, primary care givers, legal guardian, or other interested persons. (7-1-21)T

d. Face-to-face contact between the service coordinator and the participant's family members, legal representative, primary caregivers, providers, or other interested persons. (7-1-21)T

e. Referral and related activities associated with obtaining needed services as identified in the service coordination plan. (7-1-21)T

03. Service Coordination During Institutionalization. Service coordination is reimbursable on the day a participant is admitted to a medical institution if the service is provided prior to admission. Service coordination is reimbursable on the day of discharge from a medical institution if the service is provided after discharge.(7-1-21)T

a. Service coordination for reintegration into the community, can only be provided by and reimbursed to a service coordination agency when the following applies: (7-1-21)T

i. During the last fourteen (14) days of an inpatient stay that is less than one hundred eighty (180) days in duration; or (7-1-21)T

ii. During the last sixty (60) days of an inpatient stay of one hundred eighty (180) days or more. (7-1-21)T

b. Service coordination providers may not file claims for reimbursement until the participant is discharged and using community services; (7-1-21)T

c. Service coordination must not duplicate activities provided as part of admission or discharge planning activities of the medical institution. (7-1-21)T

04. Incarceration. Service coordination is not reimbursable when the participant is incarcerated. (7-1-21)T

05. Services Delivered Prior to Assessment. Payment for on-going service coordination will not be made prior to the completion of the service coordination plan. (7-1-21)T

06. Payment Limitations. Reimbursement is not allowed for missed appointments, attempted contacts, travel to provide the service, leaving messages, scheduling appointments with the Medicaid service coordinator, transporting participants, or documenting services. (7-1-21)T

a. Service coordination providers are paid in unit increments of fifteen (15) minutes each. A service coordinator can only be reimbursed for the amount of time worked and must not bill for more than four (4) billing units per hour. The following table is an example of minutes to billing units. (7-1-21)T

Services Provided Are More Than Minutes	Services Provided Are Less Than Minutes	Billing Units
8	23	1
22	38	2
37	53	3
52	68	4
67	83	5
82	98	6
97	113	7

(7-1-21)T

b. Direct delivery of medical, educational, psychiatric, social, early intervention, or other service to which a participant has been referred is not reimbursable as service coordination. (7-1-21)T

c. Activities that are an integral component of another covered Medicaid service are not reimbursable as service coordination. (7-1-21)T

d. Activities that are integral to the administration of foster care programs are not reimbursable as service coordination. (7-1-21)T

e. Activities that are integral to the administration of another non-medical program are not reimbursable as service coordination. This exclusion does not apply to case management provided as part of the individualized education program or individualized family service plan required by the Individuals with Disabilities Education Act. (7-1-21)T

07. Group Service Coordination. Payment is not allowed for service coordination provided to a group of participants. (7-1-21)T

737. -- 779. (RESERVED)

[End of Draft Text for IDAPA 16.03.10]

[See Next Page for Draft Text for IDAPA 16.03.13]

16.03.13 – CONSUMER-DIRECTED SERVICES

[Sections Omitted]

135. SUPPORT BROKER REQUIREMENTS AND LIMITATIONS.

01. Initial Application to Become a Support Broker. Individuals interested in becoming a support broker must complete the Department-approved application to document that they: (3-30-07)

a. Is eighteen (18) years of age or older; (3-30-07)

b. Has skills and knowledge typically gained by completing college courses or community classes or workshops that count toward a degree in the human services field; and (3-30-07)

c. Has at least two (2) years verifiable experience with the target population and knowledge of services and resources in the developmental disabilities field. (3-30-07)

02. Application Exam. Applicants that meet the minimum requirements outlined in this section will receive training materials and resources to prepare for the application exam. Under Family-Directed Community Supports (FDCS), children's support brokers must attend the initial training. Applicants must earn a score of seventy percent (70%) or higher to pass. Applicants may take the exam up to three (3) times. After the third time, the applicant will not be allowed to retest for twelve (12) months from the date of the last exam. Applicants who pass the exam, and meet all other requirements outlined in these rules, will be eligible to enter into a provider agreement with the Department. (7-1-11)

03. Required Ongoing Training. All support brokers must document a minimum of twelve (12) hours per year of ongoing, relevant training in the provision of support broker services. Up to six (6) hours of the required twelve (12) hours may be obtained through independent self-study. The remaining hours must consist of classroom training. (3-30-07)

04. Termination. The Department may terminate the provider agreement when the support broker: (3-30-07)

a. Is no longer able to pass a criminal history background check as outlined in Section 009 of these rules. (3-30-07)

b. Puts the health or safety of the participant at risk by failing to perform job duties as outlined in the employment agreement. (3-30-07)

c. Does not receive and document the required ongoing training. (3-30-07)

05. Limitations. ~~The support broker must not:~~ (XX-XX-XX)~~(3-30-07)~~

a. The support broker must ~~Provide~~ not provide or be employed by an agency that provides paid community supports under Section 150 of these rules to the same participant; and (XX-XX-XX)~~(3-30-07)~~

b. For Self-Directed Community Supports (SDCS), ~~be the guardian, parent, spouse, payee, or conservator of the participant, or have direct control over the participant's choices.~~ the support broker must meet the conflict of interest standards described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 721. ~~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.~~ (XX-XX-XX)~~(3-30-07)~~

[Sections Omitted]

190. INDIVIDUALIZED BUDGET.

~~The Department sets an individualized budget for each participant according to an individualized measurement of the participant's functional abilities, behavioral limitations, medical needs, and other individual factors related to the participant's assessed needs. Using these specific participant factors, the budget-setting methodology will correlate a participant's characteristics with the participant's individualized budget amount, so participants with higher needs will be assigned a higher individualized budget amount. The participant must work within the identified budget and acknowledge that they understand the budget figure is a fixed amount.~~ The Department will assign budgets based on the criteria described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 510. (XX-XX-XX)~~(3-30-07)~~

01. Budget Amount Notification. The Department notifies each participant of their set budget amount as part of the eligibility determination or annual redetermination process. The notification will include how the participant may appeal the set budget amount. (3-29-12)

02. Annual Re-Evaluation of Adult ~~Individualized~~ Participant Budgets. ~~Individualized~~ Participant budgets will be re- evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when ~~there are documented changes in the participant's condition that results in a need for services that meet medical necessity criteria, and that is not reflected on the current inventory of individual needs~~ there is a change to the participant's budget assignment criteria as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 510. (XX-XX-XX)~~(3-29-12)~~

03. Annual Re-Evaluation of Children's Individualized Budgets. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes that may support placement in a different budget category as identified in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 527. (3-29-12)

[End of Draft Text for IDAPA 16.03.13]