THIS DOCUMENT CONTAINS THE FOLLOWING DOCUMENTS RELATED TO THE IMPLEMENTATION OF THE NEW RESOURCE ALLOCATION MODEL FOR THE ADULT DEVELOPMENTAL DISABILITIES PROGRAM:

1. Amended and Restated Notice of Intent to Submit Waiver Amendments and State Plan Amendments (**Comments must be submitted by December 31, 2021**);

2. Draft Amendment to 1915(c) Waiver for Adults with Developmental Disabilities;

3. Draft Amendment to 1915(i) State Plan Home and Community-Based Services Benefit for Adults with Developmental Disabilities; and

4. Draft Amendment to Enhanced Alternative Benefit Plan Service Definition for Targeted Service Coordination.

INSTRUCTIONS FOR READING THIS DOCUMENT

Additions are marked in red underlined font and deletions are marked in ~~red strikethrough font~~.

Sections that have not been modified have been omitted. Omitted sections are noted in the draft amendments as **[Sections Omitted]**.

AMENDED AND RESTATED NOTICE OF INTENT TO SUBMIT WAIVER AMENDMENT AND STATE PLAN AMENDMENTS SOLICITATION OF PUBLIC INPUT

Pursuant to 42 C.F.R. § 440.386, 42 C.F.R. § 441.304 and 42 C.F.R. § 447.205, the Idaho Department of Health and Welfare Division of Medicaid (Department) provides public notice of its intent to submit a 1915(c) waiver amendment, a 1915(i) state plan amendment, and an alternative benefit plan amendment to the Centers for Medicare and Medicaid Services (CMS) for Idaho's Adult Developmental Disabilities Program. The proposed changes will not impact recipients of Idaho's State Plan for the Children's Health Insurance Program.

This notice amends, restates and supersedes the initial "Notice of Intent to Submit Waiver Amendment and State Plan Amendments – Solicitation of Public Input" that was previously published in the following newspapers: (1) Coeur d'Alene Press, (2) Idaho Press Tribune, (3) Idaho State Journal, (4) Idaho Stateman, (5) The Post Register, and (6) The Times-News on or about November 16, 2021. In addition to certain technical changes, the Department is extending the deadline for submitting public comments on this matter to December 31, 2021.

Comments must be submitted to the Department as set forth below on or before Friday, December 31, 2021 at 11:59 p.m. (Mountain Time).

PROPOSED 1915(c) WAIVER CHANGES

The Department proposes and requests public input regarding the following changes:

- Establish new resource allocation model (Appendix C-4);
- Modify service level limitations (Appendix C-1/C-3);
- Modify the functional assessment tools utilized by the state to determine ICF/ID level of care and set budget amounts (Appendix B-6 and C-4);
- Remove non-medical transportation from waiver (to relocate to state's 1915(i) state plan HCBS benefit) (Appendix C-1/C-3);
- Add prevocational services and career planning services (Appendix C-1/C-3);
- Update plan developer conflict of interests provisions (Appendix D);
- Make corresponding changes to participant direction of services provisions (Appendix E);
- Modify the rate determination methods for existing services (Appendix I);
- Establish rate determination methods for new services; (Appendix I); and
- Make technical changes to revise or delete obsolete language/provisions/web references.

PROPOSED 1915(i) STATE PLAN HCBS BENEFIT CHANGES

The Department proposes and requests public input regarding the following changes:

- Add community habilitation service and non-Medical transportation service;
- Modify existing service level limitations;
- Modify the functional assessment tools utilized by the state;
- Update plan developer conflict of interests provisions;
- Establish rate determination methods for new services (Attachment 4.19-B); and
- Make technical changes to revise or delete obsolete language/provisions/web references.

PROPOSED ALTERNATIVE BENEFIT PLAN CHANGES

The Department proposes and requests public input regarding the modification of allowable plan development hours that may be provided by targeted service coordinators.

The Department assures these changes are in compliance with 42 CFR 440.386 and 42 CFR 440.345, and with the provisions of section 5006(e) of the ARRA of 2009.

PROPOSED CHANGES TO RATE DETERMINATION METHODS

1. Details Regarding Changes to Rate Determination Method for Supported Living – Residential Habilitation, Adult Day Health, Community Supported Employment, Prevocational Services, Career Planning Services, Community Habilitation, Developmental Therapy, and Community Crisis Support (provided by Residential Habilitation Agency, Supported Employment Agency, Certified Family Homes, and Behavior Consultation Providers).

- The rate model that will be used to develop the reimbursement rates is described in Idaho Administrative Code (IDAPA) 16.03.10.038. The Department will survey providers to identify the actual cost of providing the specified services (Cost Survey). Reimbursement rates will be based on surveyed data and derived using a combination of four cost components – direct care staff wages, employee-related expenses, program-related expenses, and general and administrative expenses.

- The individual components of the rate will be determined as follows:
  (a) Direct Care Staff Wages. The direct care staff wage component (Wage) used to establish the new reimbursement rate is set using the mean hourly wage of one (1) or more occupation profiles from the most current Bureau of Labor and Statistics (BLS) State Occupational Employment and Wage Estimates table for the state of Idaho found on the BLS website at www.bls.gov. The BLS occupation profile that most closely aligns with the duties, education level, and supervision requirements of the direct care staff providing the service is utilized. If more than one (1) occupation profile aligns with the duties, education level, and supervision requirements of the direct care staff providing the service, then a weighted average of the mean hourly wage of multiple BLS occupation profiles is utilized. When there is no comparable occupation profile or profiles for the direct care staff then the wage component used to establish the new reimbursement rate is set using the weighted average hourly rate (WAHR) of the surveyed wages included in the final cost survey results.
  (b) Employee-Related Expenses. The ERE component percentage (ERE%) used to establish the new reimbursement rate is set using the cumulative percentage of employer costs for employee compensation from the most current BLS Employer Costs for Employee Compensation table for the West Region in the Mountain Division and IRS Publication 15.
  (c) Program-Related Expenses. Utilizing data in the final cost survey results, each agency's PRE component percentage (PRE%) is calculated by dividing the agency's total PRE by the agency's total wages. Each agency's PRE% is ranked, and the PRE% used to calculate the new reimbursement rate is set at the mean of the agency PRE%.
  (d) General and Administrative Expenses. Utilizing data in the final cost survey results, each agency's G&A component percentage (G&A%) is calculated by dividing the agency's total G&A expenses by the sum of the agency's total wages, plus the total ERE, plus the total PRE, plus the total G&A expenses. Each agency's G&A% is ranked, and the G&A% used to calculate the new reimbursement rate is set at the mean of the agency G&A%. The G&A% used to calculate the new reimbursement rate will not exceed ten percent (10%) of the total reimbursement rate per staff hour.

- Total Reimbursement Rate Per Staff Hour of Service = ((Wage + (ERE% x Wage) + (PRE% x Wage)) /(1- (G&A%)).

- Reimbursement rates may be set at a percentage of the total reimbursement rate per staff hour. All reimbursement rate increases are subject to approval by the Idaho State Legislature.

- If approved by the Idaho State Legislature, the Department anticipates the rate changes will be effective on or after July 1, 2022.

- These changes are being made to be consistent with Idaho Administrative Code, and Medicaid Policy.

- Proposed supported living reimbursement rates and estimated annual aggregate expenditures are as follows:

- Supported Living Level 1 (1 Unit = 1 Day) / $229.46 per Unit;
- Supported Living Level 2 (1 Unit = 1 Day) / $295.02 per Unit;
- Supported Living Level 3 (1 Unit = 1 Day) / $377.58 per Unit;
- Supported Living Level M/B (1 Unit = 1 Day) / $613.52 per Unit;
- Supported Living Supplemental – Individual (1 Unit = 15 minutes) / $7.54 per Unit;
- Supported Living Supplemental – Group (1 Unit = 15 minutes) / $4.10 per Unit;
- Supported Living Supplemental 2:1 (1 Unit = 15 minutes) / $12.55 per Unit;
- Supported Living 2:1 (1 Unit = 1 Day) / $1,044.62.
- Estimated annual aggregate expenditures for state fiscal year 2023 = $70,393,100.

- Proposed adult day health reimbursement rates and estimated annual aggregate expenditures are as follows:
  - Adult Day Health (1 Unit = 15 minutes) / $2.79 per Unit.
  - Estimated annual aggregate expenditures for fiscal year 2023 = $8,761,447.

- There are no anticipated changes to the reimbursement rates for community supported employment services.

- Proposed prevocational and career planning reimbursement rates and estimated annual aggregate expenditures are as follows:
  - Note: Because these services are new services, no cost survey could be collected to establish the PRE% and the G&A% for these services. To establish the new reimbursement rates, the Department used the cost survey data collected from the most recent Employment Services cost survey to calculate the PRE component percentage and the G&A component percentage.
  - Prevocational Services – Individual (1 Unit = 15 minutes) / $14.80 per Unit.
  - Prevocational Services – Group (1 Unit = 15 minutes) / $4.93 per Unit.
  - Career Planning Services – Individual (1 Unit = 15 minutes) / $14.80 per Unit.
  - Estimated annual aggregate expenditures for fiscal year 2023 = $9,439,255.

- Proposed community habilitation reimbursement rates and estimated annual aggregate expenditures are as follows:
  - Note: Because these services are new services, no cost survey could be collected to establish the PRE% and the G&A% for these services. To establish the new reimbursement rates, the Department used the cost survey data collected from the most recent Adult Developmental Disability Agency cost survey to calculate the PRE component percentage and the G&A component percentage.
  - Community Habilitation Services – Individual (1 Unit = 15 minutes) / $10.84 per Unit.
  - Community Habilitation Services – Group 1:2 (1 Unit = 15 minutes) / $5.42 per Unit.
  - Community Habilitation Services – Group 1:3 (1 Unit = 15 minutes) / $3.61 per Unit.
  - Community Habilitation Services – Group 2:1 (1 Unit = 15 minutes) / $16.79 per Unit.
  - Estimated annual aggregate expenditures for fiscal year 2023 = $33,051,204.

- Proposed developmental therapy reimbursement rates and estimated annual aggregate expenditures are as follows:
  - Developmental Therapy Evaluation (1 Unit = 15 minutes) / $16.95 per Unit.
  - Center-Based Developmental Therapy – Individual and Group (1 Unit = 15 minutes) / $4.17.
  - Home and Community Developmental Therapy – Individual and Group (1 Unit = 15 minutes) /$6.25.
  - Estimated annual aggregate expenditures for fiscal year 2023 = $39,623,141.

- There are no anticipated changes to the reimbursement rates for community crisis support services.

2. Details Regarding Method to Establish Reimbursement Rates for Non-Medical Transportation Services.

- The reimbursement rate for non-medical transportation is set to align with the Internal Revenue Service (IRS) Notice 2021-02 standard mileage rate for the use of a car (also vans, pickups or panel trucks).

- Proposed non-medical transportation reimbursement rate and estimated annual aggregate expenditures are as follows:
    - Non-Medical Transportation (1 Unit = 1 mile) / $0.56 per Unit.
    - Estimated annual aggregate expenditures for fiscal year 2023 = $749,323.

PUBLIC REVIEW

Copies of the proposed amendments are available on the Department's website at: https://healthandwelfare.idaho.gov/about-dhw/public-meetings or https://healthandwelfare.idaho.gov/services-programs/whats-new.

Unless otherwise specified, copies of the amendments are also available for public review during regular business hours at any regional or field office of the Idaho Department of Health and Welfare and any regional or local public health district office. In Boise and Camas counties, copies of the amendments will be available at the county clerk's office in each of these counties. See below for detailed list of county locations.

LOCATIONS FOR PUBLIC REVIEW OF PROPOSED AMENDMENTS

Ada County
DHW Region 4, 1720 Westgate Drive, Boise, ID 83704
Central District Health Department, 707 North Armstrong Place, Boise, ID 83704

Adams County
Southwest District Health, 102 E. Exeter St., Council, ID 83612

Bannock County
DHW Region 6, 1070 Hiline, Pocatello, ID 83201
Southeastern Idaho Public Health, 1901 Alvin Ricken Drive, Pocatello, ID 83201

Bear Lake County
Southeastern Idaho Public Health, 2431 Clay St., Montpelier, ID 83254

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

Bingham County
DHW Region 6, 701 East Alice, Blackfoot, ID 83221
Southeastern Idaho Public Health, 145 W Idaho Street, Blackfoot, ID 83221

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

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

Bonner County
DHW Region 1, 207 Larkspur Street, Ponderay, ID 83852
Panhandle Health District, 2101 W. Pine Street, Sandpoint, ID 83864

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

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

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

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

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

Canyon County
DHW Region 3, 3402 Franklin Road, Caldwell, ID 83605
Southwest District Health, 13307 Miami Lane, Caldwell, ID 83607

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

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

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

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

Custer County
Eastern Idaho Public Health, 610 Clinic Road, Suite A, Challis, ID 83226

Elmore County
DHW Region 4, 520 E. 8th Street N., Mountain Home, ID 83647
Central District Health Department, 520 E. 8th Street N, Mountain Home, ID 83647

Franklin County
Southeastern Idaho Public Health, 42 West 1 St. South, Preston, ID 83263

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

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

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

Idaho County
DHW Region 2, Camas Resource Center, 216 South C Street, Grangeville, ID 83530
North Central Health District, 903 W Main, Grangeville, ID 83530

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

Jerome County

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

Kootenai County
DHW Region 1, 1120 Ironwood Drive, Coeur d'Alene, ID 83814
Panhandle Health District, 8500 N. Atlas Road, Hayden, ID 83835

Latah County
DHW Region 2, 1350 Troy Highway, Moscow, ID 83843
North Central Health District, 333 E Palouse River Drive, Moscow, ID 83843

Lemhi County
DHW Region 7, 111 Lillian Street, Suite 104, Salmon, ID 83467
Eastern Idaho Public Health, 801 Monroe, Salmon, ID 83467

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

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

Madison County
DHW Region 7, 333 Walker Drive, Rexburg, ID 83440
Eastern Idaho Public Health, 314 North 3rd East, Rexburg, ID 83440

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

Nez Perce County
DHW Region 2, 1118 F Street, Lewiston, ID 83501
North Central Health District, 215 10th Street, Lewiston, ID 83501

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

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

Payette County
DHW Region 3, 515 N. 16th Street, Payette, ID 83661
Southwest District Health, 1155 Third Avenue North, Payette, ID 83661

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

Shoshone County
DHW Region 1, 35 Wildcat Way, Suite B, Kellogg, ID 83837
Panhandle Health District, 35 Wildcat Way, Kellogg, ID 83837

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

Twin Falls County
DHW Region 5, 601 Pole Line Road, Twin Falls, ID 83301
South Central Public Health, 1020 Washington Street North, Twin Falls, ID 83301

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

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

PUBLIC COMMENT
The Department is accepting written and recorded comments regarding the proposed amendments for a period of at least 30 calendar days.

Comments must be received by the Department on or before Friday, December 31, 2021 at 11:59 p.m. (Mountain Time) and must be sent using one of the following methods:

- *Send Email Comments To:* HCBSWaivers@dhw.idaho.gov
- *Call Toll Free Voicemail and Leave Recorded Comments At:* 1-855-249-5024
- *Send Fax Comments To:* 1-208-332-7286
- *Comment at Public Hearing:* Times and Locations for Public Hearings Scheduled Below
- *Mail Comments To:* Medicaid Central Office, Idaho Department of Health and Welfare,
  PO Box 83720, Boise, ID 83720-0036
  Attn: Karen Westbrook
- *Hand Deliver Comments During Regular Business Hours (M-F from 8AM to 5PM, except holidays) To:*
  Medicaid Central Office, Idaho Department of Health and Welfare,
  3232 Elder Street, Boise, ID 83705
  Attn: Karen Westbrook

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

PUBLIC HEARING – VIA WEBEX/TELECONFERENCE
The Department will hold a public hearing concerning these amendments on **Friday, December 10, 2021 at 10:00 a.m. (Mountain Time)**.

Link to Screen: https://idhw.webex.com/idhw/onstage/g.php?MTID=e7116d86811947039178b1c89420cfd58
Join by Phone: US Toll +1 (415) 655-0003
Event Number/Access Code: 2469 342 2940
Event Password: 1234

The hearing site will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address above.

QUESTIONS
If you have questions regarding the proposed changes, you may contact Karen Westbrook at HCBSWaivers@dhw.idaho.gov.

Draft Amendment to 1915(c) Waiver for Adults with Developmental Disabilities

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

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

C. Waiver Number: ID.0076
Original Base Waiver Number: ID.0076.90.R3B

D. Amendment Number: [TBD]

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

05/01/22

Approved Effective Date: [TBD]
Approved Effective Date of Waiver being Amended: 10/01/17

2. Purpose(s) of Amendment

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

Character Count: 1344 out of 12000

The purpose of this amendment is to revise the waiver provisions to reflect changes to the state's resource allocation model for home and community-based services available to adults with developmental disabilities that will set participant's budgets based on level of support needs, and allow for greater participant choice about the types of services they receive. Specifically, this amendment will make the following changes:

- Modifies the additional limits on amount of waiver services from Prospective Individual Budget Amount to Budget Limits by Level of Support (Appendix C-4);
- Removes certain service level utilization restrictions regarding the receipt of combinations of certain services to increase participant choice within budgets set by levels of support (Appendix C-1/C-3);
- Modifies the functional assessment tools utilized by the state to determine level of care and set budget amounts by level of support (Appendix B-6 and C-4);

- Removes non-medical transportation from waiver (to relocate to state's 1915(i) state plan HCBS benefit for adults with developmental disabilities) (Appendix C-1/C-3);
- Adds prevocational services and career planning services (Appendix C-1/C-3);
- Modifies plan developer conflict of interests provisions (Appendix D);
- Make corresponding changes to participant direction of services provisions (Appendix E);
- Modify the rate determination methods (Appendix I); and
- Make technical changes to revise or delete obsolete language/provisions/web references.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☒ **Waiver Application**	2, 6-I, and 7
☐ **Appendix A – Waiver Administration and Operation**	
☒~~☐~~ **Appendix B – Participant Access and Eligibility**	B-6-b, B-6-d, B-6-f, B-6-j, B-7-a, B-7-b, and B-8
☒~~☐~~ **Appendix C – Participant Services**	C-1-a, C-1/C-3, C-1-c, and C-4a
☒~~☐~~ **Appendix D – Participant Centered Service Planning and Delivery**	D-1-a, D-1-c, and D-1-d
☒~~☐~~ **Appendix E – Participant Direction of Services**	E-1-a, E-1-e, and E-2-b-ii
☐ **Appendix F – Participant Rights**	
☐ **Appendix G – Participant Safeguards**	
☐ **Appendix H**	
☒~~☐~~ **Appendix I – Financial Accountability**	I-1, and I-2-a
☐ **Appendix J – Cost-Neutrality Demonstration**	

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

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

Specify:

Character Count: ~~0~~ 304 out of 6000

- Modify Additional Limits on Amount of Waiver Services;
- Modify Evaluation/Reevaluation of Level of Care;
- Modify plan developer conflict of interests provisions;
- Revise Participant Direction of Services provisions;
- Revise Rate Determination Methods; and
- Make technical changes to revise or delete obsolete language/provisions/web references.

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

1. Request Information (1 of 3)

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

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

Idaho Adult Developmental Disabilities Waiver ~~(renewal)~~

C. Type of Request: amendment

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

☐ **3 years** ☒ **5 years**

Original Base Waiver Number: ID.0076

Waiver Number: ID. 0076.R06.03

Draft ID:

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

Regular Waiver

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

[Sections Omitted]

2. Brief Waiver Description

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

Character Count: 5032 out of 6000

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

The key objectives of this waiver are:
• To allow eligible participants, who meet the level of care required to receive services in an intermediate care facility for individuals with intellectual disabilities, to choose between living in their home or other community-based setting, or living in an institution;
• To require the use of a person-centered planning process to develop service plans and ensure that each participant's goals, needs and preferences are reflected in their respective plan;
• To assure that home and community-based services are provided by qualified and trained providers;
• To allow for participant-direction of home and community-based services;
• To safeguard and protect the health and welfare of participants receiving home and community-based services under this waiver.

The waiver serves adults, age 18 or older, who are determined to have a developmental disability in accordance with Idaho Code § 66-402, and who are capable of living safely in a non-institutional setting and, but for the provision of

waiver services, would require institutionalization in an intermediate care facility for individuals with intellectual disabilities.

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

Participants who select traditional waiver services must use a plan developer to develop a plan of service. The costs for all paid supports identified on the participant's plan of service must not exceed the ~~individualized~~ personal supports budget assigned to them (except as modified by the Department for health, safety or employment needs) for the upcoming plan year. In developing the plan of service, the person must identify paid and unpaid services and supports ~~available outside of Medicaid-funded services~~ that can help them meet their desired goals. The plan of service must identify: (1) type of paid and unpaid services to be delivered; ~~(2) goals to be addressed within the plan year;~~ (~~3~~2) frequency of ~~supports and~~ services; ~~and~~ (~~4~~3) service providers; (4) service delivery preferences; (5) participant's HCBS setting preferences; (6) participant's strengths and preferences; (7) individually identified goals and desired outcomes; (8) risk factors and measures to minimize them; and (9) plan monitor. In addition, the plan of service must include activities to promote progress, maintain functional skills, delay or prevent regression, and allow for health and safety.

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

Participants, who select consumer-directed services, must use a support broker (paid or unpaid) to assist the participant to make informed choices, participate in a person-centered planning process, and become skilled at managing his own supports. The costs for all paid supports identified on the participant's plan of service must not exceed the ~~individualized~~ personal supports budget assigned (except as modified by the Department for health, safety or employment needs) ~~to them~~ for the upcoming plan year. ~~The plan of service must identify: (1) the participant's preferences and interests by identifying all the supports and services, both paid and non-paid, the participant wants and needs to live successfully in his community; (2) response to emergencies including access to emergency assistance and care; (3) risks or safety concerns in relation to the identified support needs on the participant's plan and the supports or services needed to address each identified risk; and (4) sources of payment for the listed supports and services, including the frequency, duration, and main task of the listed supports and services.~~ The plan of service must identify: (1) type of paid and unpaid services to be delivered; (2) frequency of services; (3) service providers; (4) service delivery preferences; (5) participant's HCBS setting preferences; (6) participant's strengths and preferences; (7) individually identified goals and desired outcomes; (8) risk factors and measures to minimize them; and (9) plan monitor. In addition, the plan of service must include activities to promote progress, maintain functional skills, delay or prevent regression, and allow for health and safety. Participants, who select consumer-directed services, must use a

fiscal employer agent Medicaid provider to provide Financial Management Services (FMS) for payroll and reporting functions.

Review and approval of proposed plans of care, ~~exception review~~ budget modification review regarding community supported employment or health and safety concerns, and hearings to appeal a Department decision regarding DD eligibility, ICF/ID LOC eligibility or service plan denial are handled by the Department.

[Sections Omitted]

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

Character Count: ~~0~~ 2344 out of 12000

1. Eliminating a Service. The Department is eliminating non-medical transportation a service available under this waiver. The Department intends to provide non-medical transportation under its 1915(i) state plan HCBS benefit for adults with developmental disabilities. Because individuals who qualify for this waiver also qualify for the 1915(i) state plan HCBS benefit for adults with developmental disabilities, all waiver participants currently receiving non-medical transportation as a waiver service will have the option to receive non-medical transportation as a 1915(i) state plan HCBS benefit.

2. Adding or Decreasing Limits to a Service. The Department is decreasing limits regarding the receipt of combinations of certain services to increase participant choice within budgets set by levels of support. Participants will have to opportunity to select previously restricted combinations of services during the person-centered planning process to develop their next annual plan of service.

3. Making Any Changes That Could Result in Reduced Services to Participants. Moving from the current resource allocation methodology of assigning Prospective Individual Budget Amounts to a new resource allocation methodology of assigning budgets by support level could reduce budget amounts available to participants thereby reducing their services. This change in resource allocation methodology is pursuant to the KW vs. Armstrong settlement agreement (which was approved by the United States District Court for the District of Idaho) and program participants have received regular updates regarding this planned transition since 2016.
Participants will have the opportunity to obtain services beyond what their budget assigned by support level would allow for when one (1) of the following conditions are met:

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;

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

c. Community supported employment services as defined in IDAPA Section 16.03.10.703 are needed for the participant to obtain or maintain employment and the services are requested on the plan of service or addendum.

The Department is in the process of developing numerous educational materials and guidance to participants, service coordinators, support brokers, and plan developers to explain in detail how the resource allocation model works and how participants can obtain needed services beyond what the budget assigned by support level may allow.

[Sections Omitted]

Appendix A: Waiver Administration and Operation (3 of 7)

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

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

   Character Count: 445 out of 6000

   The Department contracts with an Independent Assessment Provider (IAP) to complete level of care determinations and assign ~~individualized~~ personal supports budgets.

   The Department contracts with a Program Coordination Provider who provides administrative services on behalf of the Department for the oversight, quality assurance and improvement, and program coordination of the residential habilitation programming provided by the Certified Family Home provider.

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

[Sections Omitted]

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

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

1

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

☒ **The provision of waiver services at least monthly**

☐ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**
If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

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

☐ **Directly by the Medicaid agency**

☐ **By the operating agency specified in Appendix A**

☐~~☒~~ **By an government agency under contract with the Medicaid agency.**
Specify the entity:

Character Count: 0 out of 4000

~~Independent Assessment Contractor~~

☒~~☐~~ **Other**
Specify:

Character Count: 33 out of 4000

Independent Assessment Provider

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

Character Count: 242 out of 6000

Independent Assessment Providers who perform the initial evaluation of level of care must be a Qualified Intellectual Disability Professional who meets the qualifications specified in the Code of Federal Regulations, Title 42 section 483.430.

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

Character Count: ~~3142~~ 3213 out of 12000

Participants must meet ICF/ID level of care as defined in IDAPA 16.03.10.584. ICF/ID level of care criteria for this waiver are described below.

1. 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 16.13.10; and persons must qualify based on functional assessment, maladaptive behavior, a combination of both, or medical condition.

2. Active Treatment. Persons living in an ICF/ID, must require and receive intensive inpatient active treatment as defined in IDAPA Section 16.03.10.010~~ of these rules~~, to advance or maintain his functional level.

3. Must 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.

In addition to the above criteria, an individual must demonstrate one of the following:

A. Functional Limitations. Persons may qualify based on their functional skills. Persons with an ~~age equivalency composite score of eight (8) years and zero (0) months or less on a full scale functional assessment (Woodcock Johnson Scales of Independent Behavior, or SIB-R, or subsequent revisions)~~ 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.

B. Maladaptive Behavior

• ~~A Minus Twenty-Two (-22) or Below Score~~ 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 on the Woodcock Johnson Scales of Independent Behavior (SIB-R) or subsequent revision is minus twenty-two (-22) or less~~ internalizing or externalizing maladaptive behavior v-scale score on the Vineland Adaptive Behavior Scales (Third Edition) assessment tool is twenty-one (21) or greater; or

• ~~Above a Minus Twenty-Two (-22) Score~~ 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 (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; ~~they~~ (ii) 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 (iii) the person requires active treatment to control or decrease the behavior.

C. Combination Functional and Maladaptive Behaviors.

• Persons may qualify for ICF/ID level of care if they display a combination of criteria 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:

• Persons with an ~~overall age equivalency up to eight and one-half (8-1/2) years is significant in the area of functionality when combined with a General Maladaptive Index on the Woodcock Johnson SIB-R up to minus seventeen (-17), minus twenty-two (-22) inclusive~~ adaptive behavior composite standard score between sixty (60) and sixty-three (63) inclusive is significant in the area of functionality when combined with 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.

D. 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.

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

☒ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**

☐ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

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

Character Count: ~~8348~~ 5769 out of 12000

The initial Eligibility Application for Adults with Developmental Disabilities is submitted to the Bureau of Developmental Disability Services (BDDS) in the region in which the participant seeking services resides.

Within three (3) days of receiving the application for services, BDDS verifies if the participant is financially eligible for Medicaid. After verifying a participant's financial eligibility, the Application is forwarded to the Department's Independent Assessment ~~contractor~~ Provider, to determine if the participant meets ICF/ID Level of Care (LOC) criteria.

The independent assessment ~~contractor~~ provider is responsible for completing the ICF/ID LOC eligibility determination process within thirty (30) days of receiving an application. This process includes the following:

a. The independent assessment ~~contractor~~ provider requests a current physician's health and physical report/medical care form (completed within the prior ~~six (6) months~~ one (1) year) from the participant's primary care physician.

b. The independent assessment ~~contractor~~ provider contacts the participant or their decision-making authority (if applicable) to identify who will serve as a respondent for the initial eligibility assessments to be completed by the independent assessment ~~contractor~~ provider. The participant or their decision-making authority (if applicable) is responsible for identifying a respondent who has knowledge about the participant~~;~~'s current level of functioning. The participant is required to be present with the respondent for a face-to-face meeting with the independent assessment ~~contractor~~ provider to complete the initial eligibility assessment process.

c. During the face-to-face meeting with the independent assessment ~~contractor~~ provider, the respondent for the participant will ~~participant~~ participate in completing ~~the following assessments: 1) Scales of Independent Behavior-Revised (SIB-R)~~ a Department-approved functional assessment tool(s) and Medical, Social, Developmental Assessment Summary. These assessments, in addition to other required documentation, are used to verify ICF/ID LOC criteria as follows:

i. Developmental Disability diagnosis. The independent assessment ~~contractor~~ provider obtains evaluations and other information needed to verify the participant has a primary diagnosis of being intellectually disabled. A developmental disability means a chronic disability of a person which appears before the age of 22 (twenty-two) years and is attributable to an impairment such as intellectual disability, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one of these impairments and requires treatment or services. Participants must provide the Independent Assessment ~~contractor~~ Provider with 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.

ii. Functional, Maladaptive or Medical Limitations. The independent assessment ~~contractor~~ provider administers a ~~SIB-R~~Department-approved functional assessment tool to verify the participant's developmental disability results in substantial functional impairment in three or more of seven areas of major life activity and meets ICF/ID LOC criteria based on level of functioning, maladaptive behavior, ~~or~~ a combination of functioning and maladaptive behavior, or a medical condition. (IDAPA 16.03.10.584.05-~~07~~08). ~~For individuals who meet ICF/ID LOC based on medical criteria (IDAPA 16.03.10.584.08) the Department's contractor will coordinate with a Nurse Reviewer within the Bureau of Long-term Care, Division of Medicaid, to complete a Supplemental Medical Assessment for ICF/ID Level of Care Determinations, in addition to completing the SIB-R. The Supplemental Medical Assessment is completed to determine whether or not a~~

~~medical condition has/will significantly affect the functional level/capabilities of a developmentally disabled individual who otherwise may not meet ICF/ID LOC. The independent assessment contractor must maintain supportive documentation with the Supplemental Medicaid Assessment.~~ A medical condition~~, for the purposes of the Supplemental Medicaid Assessment,~~ refers to any chronic or recurrent medical condition, which requires continued medical treatment or follow-up and has a significant impact on the individual's functioning.

iii. Must Require Certain Level of Care. The independent assessment ~~contractor~~ provider completes a Medical, Social, Developmental Assessment Summary to validate the participant requires 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.

d. At the time of the face-to-face meeting, the independent assessment ~~contractor~~ provider completes ~~an Inventory of Individual Needs~~ a Department-approved functional assessment tool with the respondent(s)~~. This assessment is used to calculate an annual budget according to the participant's functional abilities, behavioral limitations, medical needs and other individual factors related to the person's disability~~ to assign a support level based on the participants general support needs. Participants who are identified as potentially meeting the criteria for a support level based on their extraordinary medical or behavioral support needs are directed to a secondary process known as verification to determine if they meet those criteria. A participant's budget is then assigned based on their support level, the type of in-home habilitation services they have selected, and their chosen service delivery method.

e. The independent assessment ~~contractor~~ provider communicates eligibility determinations and ~~calculated~~ assigned budgets to the participant/decision-making authority through a written Notice of Decision. Participants/decision-making authority who do not agree with a decision regarding eligibility or the ~~calculated~~ assigned budget may request an administrative hearing.

f. The independent assessment ~~contractor~~ provider maintains all documentation associated with the initial eligibility assessment process in an electronic file in the Independent Assessment ~~contractor~~ Provider database. ~~Additionally, the independent assessment contractor uploads the Eligibility Application, Eligibility Notices and documentation used to support approval of eligibility into the Member's case file in the Department's MMIS system.~~

PROCESS FOR ANNUAL LEVEL OF CARE EVALUATION/REEVALUATION

Except for the following differences, the annual eligibility re-determination process is the same:

A new Eligibility Application for Adults with Developmental Disabilities does not have to be submitted by participant on an annual basis.

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

The independent assessment ~~contractor~~ provider is only required to complete ~~a~~ new ~~SIB-R assessment~~ Department-approved functional assessment tool(s) when it is determined the existing ~~SIB-R~~ Department-approved functional assessment tool(s) does not accurately describe the current status of the participant. ~~the Independent Assessment~~ The Independent Assessment Provider will make a clinical decision about the need for completing ~~a new SIB-R~~ Department-approved functional assessment tool(s) through a review of participant documentation and information provided by respondent during the annual face-to-face eligibility re-determination meeting. ~~However, if a participant's SIB-R scores in the prior year were considered to be 'borderline', the independent assessment contractor must complete a new SIB-R as part of the annual eligibility determination process. 'Borderline' criteria is as follows:~~

~~i. If the person met ICF/ID LOC based on functional criteria, a new SIB-R will be done if the participant's age equivalency is between ages 6.5 and 8 years; OR~~
~~ii. If the person met ICF/ID LOC eligibility based on Maladaptive Behavior Criteria, a new SIB-R will be done if the participant's General Maladaptive Index score falls between -22 and -25. OR~~
~~iii. If the person met eligibility based on a combination of age equivalency and maladaptive score, a new SIB-R must be completed annually.~~

The independent assessment ~~contractor~~ provider is only required to update those sections of the Medical, Social, Developmental Assessment Summary when the respondent indicates a change has occurred.

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

- ☐ **Every three months**
- ☐ **Every six months**
- ☒ **Every twelve months**
- ☐ **Other schedule**

Specify the other schedule:

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

- ☒ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ☐ **The qualifications are different.**

Specify the qualifications:

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

Character Count: 290 out of 6000

The independent assessment provider (IAP) utilizes an electronic database to track annual redetermination dates and ensures timely reevaluations. The Department ensures the IAP continues to meet contract requirements through monitoring of quarterly IAP reports and annual statewide reviews.

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

Character Count: ~~125~~ 127 out of 6000

The ~~contractor~~ independent assessment provider is required to maintain all participant records for five years after the participant's most recent assessment.

[Sections Omitted]

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

i. informed of any feasible alternatives under the waiver; and

ii. given the choice of either institutional or home and community-based services.

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

Character Count: 3310 out of 12000

Individuals who inquire about adult DD services are sent an application packet by the Bureau of Developmental Disability Services (BDDS). Each adult Developmental Disability (DD) Services application packet includes a hand-out that identifies all adult DD services available. This handout specifies which services are available to persons who are determined DD eligible and which services are available to persons who meet ICF/ID Level of Care (placement in ICF/ID or HCBS DD waiver services). The Eligibility Application for Adults with Developmental Disabilities included in the application packet also allows a person to choose which services they are seeking from a list. This list includes: DD Waiver Services (traditional or self-directed community supports), Developmental Disability Agency services, ICF/ID, Family Support, Service Coordination, or Other. In addition, information on all adult DD services is included on the public Health and Welfare website~~, Adult Developmental Disabilities Care Management webpage, Medicaid Services and Supports for Adults with a Developmental Disability~~.

In addition, participants who choose to access traditional DD and/or HCBS waiver services in lieu of placement in an ICF/ID must develop an individual service plan that identifies the DD services they wish to receive. The signature page of the individual service plan includes a statement for the participant and their legal guardian (as applicable) to initial to indicate they understand the participant has a choice between DD services and placement in an ICF/ID. This statement reads as follows: I have been informed of and understand my choice of waiver services. I choose to receive waiver services rather than placement in an ICF/ID. I understand that I may, at any time, choose facility admission. A plan cannot be reviewed and approved unless the participant/guardian has initialed this statement.

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

For participants accessing traditional services, the service coordinator is responsible for answering questions or assisting individuals with information about alternatives and services. Support brokers are responsible for assisting participants with information about alternatives and services for participants accessing consumer-directed services. Department Care Managers are also available to assist participants with questions related to alternatives and services.

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

Character Count: 1731 out of 4000

Per 45 CFR §92.42, copies of individual service plans and support and spending plans indicating the participant's freedom of choice are maintained and electronically retrievable for a minimum of three (3) years through a Department database ~~(MMIS), as well as a separate database~~ maintained by the Department's independent assessment ~~contractor~~ provider.

Additionally, a copy of the individual service plan must be retained by the service provider responsible for its development. The requirement for record retention and the length of time these records must be retained is specified in the following rules:
• IDAPA 16.03.10.040.05. Records must be retained by the provider for a period of five (5) years from the date of the final payment under the provider agreement. Failure to retain records for the required period can void the Department's obligation to make payment for the goods or services.
• IDAPA 16.03.10.704.04. ~~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.

Also, for participants accessing traditional waiver services, IDAPA 16.03.10.728.~~03~~02.m. requires the plan developer/service coordination agency to maintain records that document the participant has been informed of the purposes of service coordination, his rights to refuse service coordination, and his right to choose his service coordinator and other service providers'. Per IDAPA 16.03.10.040.05 and IDAPA 16.03.10.704.04, this informed consent documentation would need to be maintained for a minimum of five (5) years.

[Sections Omitted]

Appendix C: Participant Services

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

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

Service Type	Service
Statutory Service	**Residential Habilitation**
Statutory Service	**Respite**
Statutory Service	**Supported Employment**
Supports for Participant Direction	**Financial Management Services**
Supports for Participant Direction	**Support Broker Services**
Other Service	**Adult Day Health**
Other Service	**Behavioral Consultation/Crisis Management**
Other Service	**Chore Services**
Other Service	**Community Support Services (Participant Direction)**
Other Service	**Environmental Accessibility Adaptations**
Other Service	**Home Delivered Meals**
~~**Other Service**~~	~~**Non-Medical Transportation**~~
Other Service	**Personal Emergency Response System**
Other Service	**Skilled Nursing**
Other Service	**Specialized Medical Equipment and Supplies**

Other Service	Transition Services
Other Service	Prevocational Service
Other Service	Career Planning Service

Appendix C: Participant Services

C-1/C-3: Service Specification for Residential Habilitation (1 of 3)

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

Service Definition (Scope):

Character Count: 3,077 out of 12000

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

a. Habilitation services aimed at assisting the individual to acquire, retain, or improve his 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:

i. Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities;

ii. Money management including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations;

iii. Daily living skills including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency procedures;

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

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;

vi. Behavior shaping and management includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services, which consist of reinforcing physical, occupational, speech and other therapeutic programs.

b. Personal Assistance Services necessary to assist the individual 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 his own behalf.

c. Skills training to teach waiver participants, family members, alternative family caregiver(s), or a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self direction, money management, socialization, mobility and other therapeutic programs.

d. Transportation integral to meeting the participant's goals, desired outcomes, and needs specified in the provider implementation plan (required by IDAPA Section 16.03.10.513).

~~Participants authorized to receive intense supported living services or high supported living services will not be authorized to receive developmental therapy services, adult day health services, or non-medical transportation services because these services are included in the intense support daily rate and high supports daily rate.~~

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

Character Count: 542 out of 6000

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

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).

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

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

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

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

Provider Specifications:

Provider Category	Provider Type
Individual	**Certified Family Home Provider**
Agency	**Residential Habilitation Agency**

Appendix C: Participant Services

C-1/C-3: Provider Specification for Residential Habilitation (2 of 3)

Provider Category:

Individual

Provider Type:

Certified Family Home Provider

Provider Qualifications:

License *(specify)*:

Character Count 0 out of 4000

Certificate *(specify)*:

Character Count 87 out of 6000

Certified Family Home certificate as described in Idaho Administrative Code at 16.03.19

Other Standard *(specify)*:

Character Count 3257 out of 12000

a. An individual who provides direct residential habilitation services in his own home must be certified by the Department to operate a certified family home under IDAPA 16.03.19, Rules Governing Certified Family Homes, and must receive residential habilitation program coordination services provided through the Department, or its contractor, for the residential habilitation services he provides.

b. CFH providers providing residential habilitation services as a DD Waiver provider must meet the following minimum qualifications:

i. Be at least eighteen (18) years of age;

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

iii. Have current CPR and First Aid certifications;

iv. Be free from communicable diseases;

v. If transporting participants, have a current and valid driver's license and vehicle insurance;

vi. Each CFH provider of residential habilitation services assisting with participant medications must successfully complete and follow the Assistance with Medications course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing, or other Department-approved training.

vii. CFH providers of residential habilitation services who provide direct care and services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, Criminal History and Background Checks; and

viii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure.

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.

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:

i. Purpose and philosophy of services;

ii. Service rules;

iii. Policies and procedures;

iv. Proper conduct in relating to waiver participants;

v. Handling of confidential and emergency situation that involve the waiver participant;

vi. Participant rights;

vii. Methods of supervising participants;

viii. Working with individuals with developmental disabilities; and

ix. Training specific to the needs of the participant.

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:

i. Instructional Techniques: Methodologies for training in a systematic and effective manner;

ii. Managing behaviors: techniques and strategies for teaching adaptive behaviors;

iii. Feeding;

iv. Communication;

v. Mobility;

vi. Activities of daily living;

vii. Body mechanics and lifting techniques;

viii. Housekeeping techniques; and

ix. Maintenance of a clean, safe, and healthy environment.

f. The 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Character Count 32 out of 4000

Department of Health and Welfare

Frequency of Verification:

Character Count 159 out of 6000

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

C-1/C-3: Provider Specification for Residential Habilitation (3 of 3)

Provider Category:

Agency

Provider Type:

Residential Habilitation Agency

Provider Qualifications:

License *(specify)*:

Character Count 0 out of 4000

Certificate *(specify)*:

Character Count 44 out of 6000

As described in IDAPA 16.04.17 and 16.03.705

Other Standard *(specify)*:

Character Count 3002 out of 12000

When residential habilitation services are provided by an agency, the agency must be certified by the Department as a Residential Habilitation Agency under IDAPA 16.04.17, Rules Governing Residential Habilitation Agencies, and must be capable of supervising the direct services provided. Individuals who provide residential habilitation services in the home of the participant (supported living) must be employed by a Residential Habilitation Agency. Providers of residential habilitation services must meet the following requirements:

a. Direct service staff must meet the following minimum qualifications:

i. Be at least eighteen (18) years of age;

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

iii. Have current CPR and First Aid certifications;

iv. Be free from communicable diseases;

v. If transporting participants, have a current and valid driver's license and vehicle insurance;

vi. Each staff person assisting with participant medications must successfully complete and follow the Assistance with Medications course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training.

vii. Residential habilitation service providers who provide direct care or services must satisfactorily complete a criminal background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks.

viii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure.

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.

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:

i. Purpose and philosophy of services;

ii. Service rules;
iii. Policies and procedures;
iv. Proper conduct in relating to waiver participants;
v. Handling of confidential and emergency situations that involve the waiver participant;
vi. Participant rights;
vii. Methods of supervising participants;
viii. Working with individuals with developmental disabilities; and
ix. Training specific to the needs of the participant.

d. Additional training requirements must be completed within six (6) months of employment with the residential habilitation agency and include at a minimum:
i. Instructional techniques: Methodologies for training in a systematic and effective manner;
ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors;
iii. Feeding;
iv. Communication;
v. Mobility;
vi. Activities of daily living;
vii. Body mechanics and lifting techniques;
viii. Housekeeping techniques; and
ix. Maintenance of a clean, safe, and healthy environment.

e. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed.

Verification of Provider Qualifications

Entity Responsible for Verification:

Character Count 32 out of 4000

Department of Health and Welfare

Frequency of Verification:

Character Count 190 out of 6000

Residential habilitation providers are surveyed when they seek renewal of their certificate. The Department issues certificates that are in effect for a period of no longer than three years

[Sections Omitted]

Appendix C: Participant Services

C-1/C-3: Service Specification for Supported Employment (1 of 2)

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

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

Service Definition (Scope):

Character Count: 1417 out of 12000

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

a. Supported employment services rendered under 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.

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.

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

Character Count: 685 out of 6000

Supported employment includes activities needed to sustain paid work at or above the minimum wage by participants, including oversight and training. Service payment is made only for the adaptations, oversight and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Idaho's Division of Vocational Rehabilitation assists participants to locate a job or develop a job on behalf of the participant.

~~The combination of developmental therapy, adult day health and community supported employment must not exceed forty (40) hours per week.~~

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

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

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

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

Provider Specifications:

Provider Category	Provider Type
Agency	**Supported Employment Agencies**

Appendix C: Participant Services

C-1/C-3: Provider Specification for Supported Employment (2 of 2)

Provider Category:

Agency

Provider Type:

Supported Employment Agencies

Provider Qualifications:

License *(specify)*:

Character Count: 0 out of 4000

Certificate *(specify)*:

Character Count: 0 out of 6000

Other Standard *(specify)*:

Character Count: 496 out of 12000

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Character Count: 32 out of 4000

Department of Health and Welfare

Frequency of Verification:

Character Count: 25 out of 6000

At least every two years.

[Sections Omitted]

Appendix C: Participant Services

C-1/C-3: Service Specification for Support Broker Services (1 of 2)

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

Service Type:

Supports for Participant Direction

Service:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Support Broker Services

HCBS Taxonomy:

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

The waiver provides for participant direction of services as specified in Appendix E. *(check each that applies)*:

- ☒ **The waiver includes Information and Assistance in Support of Participant Direction, Financial Management Services or other supports for participant direction as waiver services.**
- ☐ **Some or all of the supports for participant direction are provided as administrative activities and are described in Appendix E.**

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

- ☐ ~~☒~~ **Service is included in approved waiver. There is no change in service specifications.**
- ☒ ~~☐~~ **Service is included in approved waiver. The service specifications have been modified.**

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

Service Definition (Scope):

Character Count: 3066 out of 12000

Support brokers provide counseling and assistance for participants with arranging, directing, and managing goods and services. They serve as the agent or representative of the participant to assist in identifying immediate and long-term needs, developing options to meet those needs, and accessing identified supports and services. This includes providing participants with any assistance they need for gathering and reviewing their budget and financial data and reports prepared and issued to them by the FEA. Practical skills training is offered to enable participants to remain independent. Examples of skills training include helping participants understand the responsibilities involved with directing services, providing information on recruiting and hiring community support workers, managing workers and providing information on effective communication and problem-solving. The extent of support broker services furnished to the participant must be specified on the support and spending plan.

Support broker services may include only a few required tasks or may be provided as a comprehensive service package depending on the participant's needs and preferences. At a minimum, the support broker must:

Participate in the person centered planning process;

Develop a written support and spending plan with the participant that includes the supports the participant needs and wants, related risks identified with the participant's wants and preference, and a comprehensive risk plan for each potential risk that includes at least three back up plans should a support fall out; Assist the participant to monitor and review his budget through data and financial information provided by the FEA; Submit documentation regarding the participant's satisfaction with identified supports as requested by the Department; Participate with Department quality assurance measures, as requested. Assist the participant with scheduling required assessments to complete the Department's annual determination process as needed, including assisting the participant or his representative to update the support and spending plan and submit it to the Department for authorization.

In addition to the required minimum support broker duties, the support broker must be able to provide the following services when requested by the participant:

Assist the participant to develop and maintain a circle of support; help the participant learn and implement the skills needed to recruit, hire and monitor community supports; assist the participant to negotiate rates for paid community support workers; maintain documentation of supports provided by each community support worker and participant's satisfaction with these supports; assist the participant to monitor community supports; assist the participant to resolve employment-related problems; assist the participant to identify and develop community resources to meet specific needs.

Support brokers qualifications, requirements and responsibilities as well as allowable activities are described in Idaho Administrative Rule.

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

Character Count: 293 out of 6000

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

Support brokers may not act as fiscal employer agents, instead support brokers work together with the participant to review their financial information that is produced and maintained by the fiscal employer agent.

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

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

☐ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type
Individual	**Support Broker**

Appendix C: Participant Services

C-1/C-3: Provider Specification for Support Broker Services (2 of 2)

Provider Category:

Individual

Provider Type:

Support Broker

Provider Qualifications:

License *(specify)*:

Character Count: 0 out of 4000

Certificate *(specify)*:

Character Count: 0 out of 6000

Other Standard *(specify)*:

Character Count: 1242 out of 12000

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

All support brokers must document a minimum of twelve (12) hours per year of ongoing, relevant training in the provision of support broker services.

The support broker must not: Provide or be employed by an agency that provides paid community supports to the same participant; and ~~must not be in a position to both influence a participant's decision making and receive undue~~

~~financial benefit from the participant's decisions~~ must meet the conflict of interest standards described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 721.

Verification of Provider Qualifications

Entity Responsible for Verification:

Character Count: 44 out of 4000

Department of Health and Welfare

Participant

Frequency of Verification:

Character Count: 135 out of 6000

At the time of application, annual review of ongoing education requirement, and by participant when entering into employment agreement.

Appendix C: Participant Services

C-1/C-3: Service Specification for Adult Day Health (1 of 3)

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

Service Type:

Other Service

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

Service Title:

Adult Day Health

HCBS Taxonomy:

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

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

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

Service Definition (Scope):

Character Count: 738 out of 12000

Adult day health is a supervised, structured service generally furnished four or more hours per day on a regularly scheduled basis, for one or more days per week. It is provided in a non-institutional, community-based setting and it encompasses health services, social services, recreation, supervision for safety, and assistance with activities of daily living needed to ensure the optimal functioning of the participant. Adult day health services provided under this waiver will not include room and board payments. Transportation between participant's place of residence and adult day health service site is not included in the adult day health rate, but may be provided as non-medical transportation (a separately billable service).

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

Character Count: 141 out of 6000

~~Adult Day Health cannot exceed thirty (30) hours per week either alone or in combination with developmental therapy and occupational therapy.~~

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

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

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

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

Provider Specifications:

Provider Category	Provider Type
Agency	**Adult Day Health**
Individual	**Adult Day Health**

Appendix C: Participant Services

C-1/C-3: Provider Specification for Adult Day Health (2 of 3)

Provider Category:

Agency

Provider Type:

Adult Day Health

Provider Qualifications:

License *(specify)*:

Character Count: 0 out of 4000

Certificate *(specify)*:

Character Count: 0 out of 6000

Other Standard *(specify)*:

Character Count: 1399 out of 12000

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

Providers of adult day health must meet the following:

a. Services provided in a facility must meet the building and health standards identified in IDAPA 16.03.21, Developmental Disabilities Agencies (DDA).

b. Services provided in a home must meet the standards of home certification identified in IDAPA 16.03.19, Rules Governing Certified Family Home.

c. Adult day health providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, Criminal History and Background Checks;

d. Providers of adult day health services 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 be capable of supervising direct services, provide services as identified on the plan of service, provide care and supervision identified on the participant's residential habilitation plan

e. Be free from communicable disease

Verification of Provider Qualifications

Entity Responsible for Verification:

Character Count: 32 out of 4000

Department of Health and Welfare

Frequency of Verification:

Character Count: 25 out of 6000

At least every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specification for Adult Day Health (3 of 3)

Provider Category:

Individual

Provider Type:

Adult Day Health

Provider Qualifications:

License *(specify)*:

Character Count: 0 out of 4000

Certificate *(specify)*:

Character Count: 0 out of 6000

Other Standard *(specify)*:

Character Count: 1395 out of 12000

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

Providers of adult day health must meet the following:

a. Services provided in a facility must meet the building and health standards identified in IDAPA 16.03.21, Developmental Disabilities Agencies (DDA).

b. Services provided in a home must meet the standards of home certification identified in IDAPA 16.03.19, Rules Governing Certified Family Home.

c. Adult day health providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, Criminal History and Background Checks;

d. Providers of adult day health services 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 be capable of supervising direct services, provide services as identified on the plan of service, provide care and supervision identified on the participant's residential habilitation plan

e. Be free from communicable disease

Verification of Provider Qualifications

Entity Responsible for Verification:

Character Count: 32 out of 4000

Department of Health and Welfare

Frequency of Verification:

Character Count: 25 out of 6000

At least every two years.

[Sections Omitted]

Appendix C: Participant Services

C-1/C-3: Non-Medical Transportation Service Specification (1 of 2)

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

Service Type:

~~Other Service~~

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

Service Title:

~~Non-Medical Transportation~~

HCBS Taxonomy:

Category 1:	Sub-Category 1:
~~15 Non-Medical transportation~~	~~15010 non-medical transportation~~
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition (Scope):

Character Count: ~~452~~ 0 out of 12000

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

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

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

~~Payment for non-medical transportation services is limited to costs of non-medical transportation needed to access a waiver service or other activities and resources identified in a participant's service plan.~~

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

Character Count: 0 out of 6000

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

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

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

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

Provider Specifications:

Provider Category	Provider Type
~~**Agency**~~	~~**Non-Medical Transportation**~~

Appendix C: Participant Services

C-1/C-3: Provider Specification for Non-Medical Transportation (2 of 2)

Provider Category:

~~Agency~~

Provider Type:

~~Non-Medical Transportation~~

Provider Qualifications:

License *(specify)*:

Character Count: ~~16~~ 0 out of 4000

~~Driver's License~~

Certificate *(specify)*:

Character Count: 0 out of 6000

Other Standard *(specify)*:

Character Count: ~~168~~ 0 out of 12000

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

~~a. Possess a valid driver's license; and~~

~~b. Possess valid vehicle insurance~~

Verification of Provider Qualifications

Entity Responsible for Verification:

Character Count: ~~32~~ 0 out of 4000

~~Department of Health and Welfare~~

Frequency of Verification:

Character Count: ~~8~~ 0 out of 6000

~~Annually~~

[Sections Omitted]

Appendix C: Participant Services

C-1/C-3: Skilled Nurse Service Specification (1 of 3)

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

Service Type:

Other Service

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

Service Title:

Skilled Nursing

HCBS Taxonomy:

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

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

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

Service Definition (Scope):

Character Count: 787 out of 12000

Intermittent or continuous oversight, training, or skilled care which is within the scope of the Nurse Practice Act and as such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. Nursing Services must be referred by a physician or other practitioner of the healing arts. Nursing services may include but are not limited to:

a. The insertion and maintenance of nasogastric tubes and the monitoring or installation of feeding material;

b. The maintenance of volume ventilators including associated tracheotomy care, tracheotomy, and oral pharyngeal suctioning.

c. Maintenance and monitoring of IV fluids or nutritional supplements which are to be administered on a continuous or daily basis;

d. Injections;

e. Blood glucose monitoring; and

f. Blood pressure monitoring.

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

Character Count: 0 out of 6000

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

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

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

- ☐ **Legally Responsible Person**

☒ **Relative**
☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type
Individual	**Skilled Nurse**
Agency	**Skilled Nurse**

Appendix C: Participant Services

C-1/C-3: Provider Specification for Skilled Nurse (2 of 3)

Provider Category:

Individual

Provider Type:

Skilled Nurse

Provider Qualifications:

License *(specify)*:

Character Count: 171 out of 4000

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

Certificate *(specify)*:

Character Count: 0 out of 6000

Other Standard *(specify)*:

Character Count: 89 out of 12000

Nursing service providers must adhere to requirements specified in IDAPA 23.01.01.400-401

Verification of Provider Qualifications

Entity Responsible for Verification:

Character Count: 32 out of 4000

Department of Health and Welfare

Frequency of Verification:

Character Count: 25 out of 6000

At least every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specification for Skilled Nurse (3 of 3)

Provider Category:

Agency

Provider Type:

Skilled Nurse

Provider Qualifications:

License *(specify)*:

Character Count: 171 out of 4000

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

Certificate *(specify)*:

Character Count: 0 out of 6000

Other Standard *(specify)*:

Character Count: 89 out of 12000

Nursing service providers must adhere to requirements specified in IDAPA 23.01.01.400-401

Verification of Provider Qualifications

Entity Responsible for Verification:

Character Count: 32 out of 4000

Department of Health and Welfare

Frequency of Verification:

Character Count: 25 out of 6000

At least every two years.

Appendix C: Participant Services

C-1/C-3: Specialized Medical Equipment and Supplies Service Specification (1 of 2)

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

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

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

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

Service Definition (Scope):

Character Count: 704 out of 12000

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

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

The services under specialized medical equipment are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

Character Count: 0 out of 6000

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

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

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

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

Provider Specifications:

Provider Category	Provider Type
Agency	**Specialized Medical Equipment and Supplies**

Appendix C: Participant Services

C-1/C-3: Provider Specification for Specialized Medical Equipment and Supplies (2 of 2)

Provider Category:

Agency

Provider Type:

Specialized Medical Equipment and Supplies

Provider Qualifications:

License *(specify)*:

Character Count: 0 out of 4000

Certificate *(specify)*:

Character Count: 0 out of 6000

Other Standard *(specify)*:

Character Count: 369 out of 12000

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Character Count: 32 out of 4000

Department of Health and Welfare

Frequency of Verification:

Character Count: 25 out of 6000

At least every two years.

[Sections Omitted]

Appendix C: Participant Services

C-1/C-3: Service Specification (1 of 2)

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

Service Type:

Other Services

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

Service Title:

Prevocational Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04010 prevocational
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

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

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

Service Definition (Scope):

Character Count: 1884 out of 12000

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.

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.

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.

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.

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.

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

Character Count: 361 out of 6000

The duration of this service shall not exceed one year.

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.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type
Agency	Supported Employment Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specification for Service (2 of 2)

Provider Category:

Agency

Provider Type:

Supported Employment Agencies

Provider Qualifications:

License *(specify)*:

Character Count: 0 out of 4000

Certificate *(specify)*:

Character Count: 0 out of 6000

Other Standard *(specify)*:

Character Count: 436 out of 12000

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 IDAPA Section 16.03.10.009 and IDAPA 16.05.06, "Criminal History and Background Checks."

Verification of Provider Qualifications

Entity Responsible for Verification:

Character Count: 32 out of 4000

Department of Health and Welfare

Frequency of Verification:

Character Count: 25 out of 6000

At least every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification (1 of 2)

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

Service Type:

Other Service

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

Service Title:

Career Planning Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
03 Supported Employment	03030 career planning
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

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

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

Service Definition (Scope):

Character Count: 1639 out of 12000

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.

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.

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.

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.

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

Character Count: 89 out of 6000

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

This service may be offered only on an individual basis.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type
Agency	Supported Employment Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specification for Service (2 of 2)

Provider Category:

Agency

Provider Type:

Supported Employment Agencies

Provider Qualifications:

License *(specify)*:

Character Count: 0 out of 4000

Certificate *(specify)*:

Character Count: 0 out of 6000

Other Standard *(specify)*:

Character Count: 438 out of 12000

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 IDAPA Section 16.03.10.009 and IDAPA 16.05.06, "Criminal History and Background Checks."

Verification of Provider Qualifications

Entity Responsible for Verification:

Character Count: 32 out of 4000

Department of Health and Welfare

Frequency of Verification:

Character Count: 25 out of 6000

At least every two years.

Appendix C: Participant Services

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

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

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

☒ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☒ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

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

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

Character Count: ~~3671~~ 3324 out of 4000

Participants who select traditional waiver services receive case management through Service Coordination as described in IDAPA 16.03.10.720 through 779. Service Coordination is a case management activity which

assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of the individual. Service coordination includes plan assessment and periodic re-assessment, development of a plan, referral activities, monitoring activities that ensure the participant's plan is implemented and adequately addresses the participant's needs, and crisis assistance. In order to ensure there is no conflict of interest, Service Coordinators ~~may not provide both service coordination and direct services to the same participant~~ must ensure its employees and contractors meet the conflict of interest standards described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 721.

Participants who select Consumer Directed Services receive case management through a Support Broker as described in IDAPA 16.03.13.135 through 136. Within these rules a Support Broker is defined as an individual who advocates on behalf of the participant and who is hired by the participant to assist with planning, negotiating and budgeting. Support broker services may include only a few required tasks or may be provided as a comprehensive service package depending on the participant's needs and preferences. At a minimum the Support Broker must:

a. Participate in the person-centered planning process;

b. Develop a written support and spending plan with the participant that includes the paid and unpaid supports that the participant needs and wants, related risks identified with the participant's wants and preferences, and a comprehensive risk plan for each potential risk that includes at least three (3) backup plans should a support fail. This plan must be authorized by the Department;

c. Assist the participant to monitor and review his budget;

d. Submit documentation regarding the participant's satisfaction with identified supports as requested by the Department;

e. Participate with Department quality assurance measures, as requested;

f. Assist the participant to complete the annual re-determination process as needed, including updating the support and spending plan and submitting it to the Department for authorization;

g. Assist the participant, as needed, to meet the participant responsibilities and assist the participant, as needed, to protect his own health and safety; ~~and~~

h. Complete the Department-approved criminal history check waiver form when a participant chooses to waive the criminal history check requirement for a community support worker; and

i. Meet the conflict of interest standards described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 721.

In addition to the required support broker duties, each support broker must be able to provide the following services when requested by the participant:

a. Assist the participant to develop and maintain a circle of support;

b. Help the participant learn and implement the skills needed to recruit, hire, and monitor community supports; Assist the participant to negotiate rates for paid community support workers;

c. Maintain documentation of supports provided by each community support worker and participant's satisfaction with these supports;

d. Assist the participant to monitor community supports;

e. Assist the participant to resolve employment-related problems; and Assist the participant to identify and develop community resources to meet specific needs.

Case managers in both the traditional and consumer directed option must ensure that participants or their decision-making authority direct the development of their service plan through a person-centered planning process. The case manager must provide information and support to the HCBS participant to maximize their ability to make informed choices and decisions.

[Sections Omitted]

C-4: Additional Limits on Amount of Waiver Services

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

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

☒ **Applicable** - The State imposes additional limits on the amount of waiver services.

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

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

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

Character Count: ~~5354~~ 0 out of 24000

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

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

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

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

~~2) 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. When the Department determines there has been a documented change in condition not reflected on the current inventory, a new inventory is completed and budget calculated for the participant. The participant has the right to appeal this new budget.~~

~~3) A participant may submit a service plan requesting a combination of DD services that exceed their annual calculated budget if the participant is eligible for, and intends to receive, High or Intense~~

~~Residential Habilitation Supported Living services, and the combination of services on the plan is necessary to ensure the health and safety of the participant.~~

~~4) A participant may submit a service plan requesting a combination of services that exceeds their annual calculated budget when the request for additional budget dollars is associated with services to obtain or maintain employment and meets criteria defined in Department rule. The participant, person centered planning team and plan developer will identify what employment services are needed to meet the participant's goals at the time of annual plan development or when a service plan is adjusted during the year. If, through these processes, it is identified that a participant may require a budget modification in order to maintain or obtain employment, the plan developer will assist the participant in requesting an Exception Review.~~

~~For participants requesting an exception review, plan developers will submit a Department approved Exception Review form and supporting documentation along with the annual plan of service or addendum. Exception review requests will be reviewed and approved by Department Case Managers based on the following:~~

~~1. A Supported Employment service recommendation including the recommended amount of service, level of support needed, employment goals and a transition plan designed to facilitate the participant's independence in their work environment which includes criteria on how the participant will transition to less dependence on paid supports. The Supported Employment recommendation shall accompany the Exception Review Request and must be completed by the Idaho Division of Vocational Rehabilitation (IDVR) when the participant is transitioning from IDVR services or by the Supported Employment Agency identified on the plan of service or addendum~~

~~2. The participant's plan of service has been developed by the participant and their person centered planning team to support employment as a priority. Exception reviews submitted with an addendum should include service modifications to accommodate the addition or increase of Supported Employment services. If no service modifications are made to accommodate the addition or increase of Supported Employment services, the person centered planning team will identify the reasons for the ongoing need for the requested mix of services.~~

~~3. Acknowledgement that additional budget dollars approved to purchase Supported Employment services may not be reallocated to purchase any other Medicaid service signed by the participant and legal guardian if one exists.~~

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

☒ ~~☐~~ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

Budget Assignments.

Each participant will be assigned an annual budget based on the following criteria established by the Department and more particularly described in Department guidance materials:

a. General support needs determined by a Department-approved functional assessment tool or verified extraordinary support needs;

b. Type of in-home habilitation services selected by the participant; and

c. Service delivery approach (waiver traditional, or waiver self-directed).

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 Department program manuals.

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:

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;

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

c. Community supported employment services as defined in IDAPA Section 16.03.10.703 are needed for the participant to obtain or maintain employment and the services are requested on the plan of service or addendum.

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.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

[Sections Omitted]

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individual Support Plan or Support and Spending Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies)*:

- ☐ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:
- ☐ **Social worker.**
  Specify qualifications:

☒ **Other.**

Specify the individuals and their qualifications:

Character Count: 3152 out of 6000

In Idaho, adult participants age eighteen (18) or older who meet DD eligibility criteria are provided the option to select either a paid or unpaid plan developer to develop their initial/annual plan.

For individuals who select traditional waiver services, paid plan developers must meet service coordination qualifications as defined in IDAPA 16.03.10.729. Neither a provider of direct service to the participant nor the assessor may be chosen to be the paid plan developer. ~~Family members and all others who wish to be paid for plan development must be employed as a service coordinator.~~

A service coordinator providing services to a participant accessing traditional DD Waiver services must meet the following qualifications:

• Service coordinators must be employees or contractors of an agency that has a valid provider agreement with the Department; and

• Minimum of a Bachelor's degree in human services field from a nationally accredited university or college and have twelve (12) months supervised work experience with the population being served; or be a licensed professional nurse (RN); and have twelve (12) months' work experience with the population being served. When an individual meets the education or licensing requirements but does not have the required supervised work experience, the individual must be supervised by a qualified service coordinator while gaining the required work experience; and

• Service coordination agencies must verify that each service coordinator and paraprofessional they employ or with whom they contract has complied with IDAPA 16.05.06, Criminal History and Background Checks.; and

• Service coordination agencies must ensure its employees and contractors meet the conflict of interest standards described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 721; and

• The total caseload of a service coordinator must assure quality service delivery and participant satisfaction.

For individuals who select consumer directed services, plan development is completed by the support broker. Support brokers must meet qualifications as defined in IDAPA 16.03.13.135.

A Support Broker providing services to a participant accessing Consumer Directed Services must meet the following qualifications:

• Be eighteen (18) years of age or older;

• Have skills and knowledge typically gained by completing college courses or community classes or workshops that count toward a degree in the human services field;

• Have at least two (2) years verifiable experience with the target population and knowledge of services and resources in the developmental disabilities field ;

• Successfully pass a Department-administered application exam containing proctored exam questions on the state's developmental disability programs and a case study for each population for which the support broker intends to provide services;

• Complete a criminal history check, including clearance in accordance with IDAPA 16.05.06, Criminal History and Background Checks; and

• Complete an employment agreement with the participant that identifies the specific tasks and services that are required of the support broker.

All support brokers must document a minimum of twelve (12) hours per year of ongoing, relevant training in the provision of support broker services.

The support broker must not: Provide or be employed by an agency that provides paid community supports to the same participant; and must ~~not be in a position to both influence a participant's decision making and receive undue financial benefit from the participant's decisions~~ meet the conflict of interest standards described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 721.

[Sections Omitted]

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

b. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Character Count: 2617 out of 12000

During the assessment process, participants are provided with a list, organized by geographic area, of plan developers in the State of Idaho. The list also includes website links that provide helpful resources for participants, guardians, family members and person centered team members. Additional information is provided to participants on the traditional service and consumer directed service options. For families interested in consumer directed services, the Department offers an orientation and a "My Voice My Choice" training.

For participants who select traditional waiver services, the participant or their decision-making authority must direct the development of their service plan through a person-centered planning process. The plan developer must provide information and support to the HCBS participant to maximize their ability to make informed choices and decisions. Individuals invited to participate in the person-centered planning process should be identified by the participant or the participant's decision-making authority.

Participants who select consumer directed services must choose a qualified support broker to assist with writing the Support and Spending Plan. As outlined in IDAPA 16.03.13, "Consumer-Directed Services," the participant decides who will participate in the planning sessions in order to ensure the participant's choices are honored and promoted. The participant must direct the development of their service plan. The participant may choose to facilitate their person-centered planning meetings, or have the meetings facilitated by the chosen support broker. In addition, the participant selects a circle of support. Members of the circle of support commit to work within the group to: help promote and improve the life of the participant in accordance with the participant's choices and preferences; and meet on a regular basis to assist the participant to accomplish his/her expressed goals.

~~With respect to the waiver amendment addressing Community Supported Employment, the Division of Medicaid, in coordination with the Council on Developmental Disabilities, Division of Vocational Rehabilitation, Disabilities Rights of Idaho and Vocational Services of Idaho, will communicate to participants, plan developers and Community Supported Employment providers that the exception review process has been expanded to include budget modifications when the additional funds are needed to obtain or maintain employment. Communication outreach will include updates to the Department's website, memos to Targeted Service Coordinators and a MedicAide newsletter article~~

D-1: Service Plan Development (4 of 8)

c. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Character Count: 12980 out of 24000

After the Department notifies each participant of their set budget amount as part of the eligibility determination process or annual determination process, the participant determines if they want to select traditional waiver or consumer directed services.

For participants who select traditional waiver services, the participant or their decision-making authority must direct the development of their service plan through a person-centered planning process with a plan developer (service coordinator). For participants who select consumer directed services, the participant or their decision-making authority must direct the development of their service plan through a person-centered planning process with a plan developer (support broker) and the circle of support.

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

For participants selecting traditional waiver services, each Individual Service Plan (ISP) must be submitted to the Department at least 45 days prior to the expiration of the current ISP in accordance with IDAPA 16.03.10. The Department has thirty (30) days to review the plan, discuss any issues with the plan developer (service coordinator), and request changes as needed. The plan developer (service coordinator) has the responsibility to discuss identified plan review issues with the participant and their decision-making authority (if applicable). The Department has an additional fifteen (15) days to enter the authorizations for approved services into the MMIS system.

Participants who select consumer directed services submit their Support and Spending Plan (SSP) directly to the Department for review and authorization. The Department has ten (10) days to review the plan, discuss any issues with the plan developer (support broker), and request changes as needed. The plan developer (support broker) has the responsibility to discuss identified plan review issues with the participant and their decision making authority (if applicable). The Department has an additional five (5) days to enter the authorizations for the approved services into the MMIS system.

Written notification of plan approval or denial is sent to the participant. As part of this notification, participants receive information on how to appeal the Department's decision.

The independent assessment provider conducts and collects a variety of assessments and determines the participant's ~~individualized~~ personal supports budget at the time of initial application and on an annual basis. These assessments are used to secure information and support the service plan development process.

At the time of initial application for adult DD services, the independent assessment provider conducts and/or obtains the following assessments:

• Physician's health and physical from the participant's Primary Care Physician;

• Medical, social and developmental assessment summary; and

• Department-approved ~~Functional~~ functional assessment tool(s); ~~Scales of Independent Behavior-Revised (SIB-R)~~

At the time of the annual re-determination, the IAP reviews and/or updates the following:

• A health and physical. This information is required and provided to the IAP on an annual basis.

• The medical, social and developmental assessment summary

• ~~Scales of Independent Behavior-Revised (SIB-R) – SIB-R~~ Department-approved functional assessment tool(s) results are reviewed and another assessment is conducted if ~~reassessment criteria is met:~~ the current assessment does not accurately describe the functional status of the participant.

The following assessments may be obtained as needed to determine initial DD and/or ICF/ID level of care eligibility and to calculate an individual budget:

• Psychological evaluations

• Supplemental Medical Assessment

• Risk Assessment

Participants, guardians, and other members of the support team can receive information regarding the waiver services through several methods:

• The Department of Health and Welfare web site for Adult DD Care Management has a page giving a detailed explanation for each service provided under the Waiver.

• The Independent Assessor has a list of all waiver services with a description of what each service entails. During the eligibility process the assessor can provide this information to the family and may explain options to initial applicants.

• During the eligibility process, the independent assessor provides each new applicant with a Consumer Tool Kit which includes a listing of agencies in the local area that provide services, including plan development, service coordination, residential habilitation, and developmental disabilities agency services.

• For participants selecting traditional waiver services, the plan developer and service coordinator is charged with verbally explaining the various programs and options to the participant during the person-centered planning process, under the traditional option.

• For participants selecting consumer directed services, the support broker is charged with assisting the participant to assess what services meet their needs.

Idaho requires that a person centered-planning process be utilized in development of the plan to ensure that participant goals, needs and preferences are reflected on the ISP or on the Support and Spending Plan. An ISP manual was developed by the Department and is used by plan developers statewide. The manual provides details on addressing participant goals, needs, and preferences.

Participants who select consumer directed services must attend a "My Choice My Voice" training prior to submitting their first Support and Spending Plan. Completion of this training is documented in the Department's quality assurance database. The training covers participant responsibilities and the process of developing a Support and Spending Plan. The consumer directed option utilizes the My Voice My Choice Workbook and a support broker to ensure that the participant's individual goals, needs and preferences are thoroughly explored and prioritized during the plan development process.

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

For participants who select traditional waiver services, the plan developer and Department staff that authorize the plan are responsible to ensure that services are coordinated.

• The plan developer is responsible to work with the members of the person-centered planning team and providers to ensure that the service needs of the participant are reflected on the ISP.

• The plan developer is responsible to ensure that services are not duplicative.

• Department staff are responsible to review each ISP submitted by the plan developer to ensure that the participant's needs are addressed by the plan and services are not duplicative.

For participants who select consumer directed services, the participant and the circle of supports use the My Voice My Choice Workbook and the person-centered planning process to identify participant needs and develop a Support and Spending Plan that meets the participant's needs.

• The support broker writes the Support and Spending Plan to reflect the needs and wants of the participant.

• Department staff reviews the plan to ensure that all health and safety requirements are met.

• The Fiscal Employer Agent (FEA) ensures that duplication of payment does not occur.

Participants selecting traditional waiver services must choose a plan monitor as outlined in IDAPA 16.03.10. The person-centered planning team identifies the frequency of monitoring but at a minimum it must occur at least every ninety (90) days. In addition, the plan must be monitored for continuing quality. Plan monitoring ensures that the ISP addresses the participant's goals, needs and preferences by requiring:

• Face to face contact with the participant at least every ninety (90) days to identify the current status of the program and changes if needed.

• Contact with service providers to identify barriers to service provision.

• Discuss satisfaction regarding quality and quantity of services with the participant.

• Review of provider status reports for annual plan development.

• Report any suspicion or allegation of abuse, neglect or exploitation to the appropriate authorities including the Department.

Participants who select consumer directed services may choose to assume the responsibility of plan monitoring themselves, utilize members of the circle of supports, or require the support broker to perform these duties. Plan monitoring is assigned during the person-centered planning process and is reflected in the My Voice My Choice Workbook.

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

• Participate in the annual person-centered planning meeting;

• Assist the participant to complete the annual re-determination process as needed, including updating the support and spending plan and submitting it to the Department for authorization.

Any other face-to-face contact outside of the support broker duties required by rule would be at the discretion of the participant.

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

The 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.

Requests for ~~an exception review~~ a budget modification with an annual plan should be submitted with the plan at least forty-five (45) days prior to the expiration of the existing plan.

Adjustments to the plan of service can be made anytime throughout the year through an addendum to the Plan of Service. Addendums accompanied by a request for ~~an exception review~~ a budget modification should be submitted 15 days prior to the anticipated start date of the modified service.

For both traditional services and consumer directed services, the person-centered planning process must:

• Be conducted timely and occur at convenient times and locations to the participant and the participant's decision-making authority

• Reflect cultural considerations of the participant.

• Be conducted by providing information in plain language and in a manner that is accessible to participants with disabilities and persons who are limited English proficient as defined in 42 CFR 435.905(b).

Plan developers and support brokers must, if needed, utilize strategies for solving conflict or disagreement within the process, and follow clear conflict-of-interest guidelines for all planning participants.

All person-centered service plans must include:

• Clinical services and supports that are important for the participant's behavioral, functional, and medical needs as identified through an assessment.

• Indication of what is important to the participant with regard to the service provider and preferences for the delivery of such services and supports.

• Documentation of the HCBS setting selected by the participant or the participant's decision-making authority and indication the setting was chosen from among a variety of setting options. 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.

• Participant strengths and preferences.

• Individually identified goals and desired outcomes.

• 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.

• 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.

• The name of the individual or entity responsible for monitoring the plan.

• Documentation that the plan is finalized and agreed to, by the participant, or the participant's decision-making authority, in writing, indicating informed consent. The plan must also be signed by all individuals and providers responsible for its implementation indicating they will deliver services according to the authorized plan of service and consistent with home and community based requirements.

All person centered service plans must be understandable to the participant receiving services and supports, and the individuals important in supporting him or her. 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). The plans are distributed to the participant and the participant's decision-making authority, if applicable, and other people involved in the implementation of the plan.

[Sections Omitted]

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Character Count: 8376 out of 12000

Idaho's consumer directed services option provides a more flexible system, enabling participants to exercise more choice and control over the services they receive which helps participants live more productive and participatory lives within their home and communities. This option is provided within the existing system so that it is sustainable and reflects the value of this option for all waiver participants who choose to direct their own services and supports. The process supports participants' preferences and honors their desire to self-direct their own services; how and when supports and services are provided; and who will assist them in developing and monitoring a realistic support and spending plan that accurately reflects their individual wants and needs.

~~Once participants are determined eligible for the DD waiver, an individualized budget is developed for each participant that incorporates a budget methodology which is calculated consistently. The budget model provides participants with an individual budget and a maximum level of funding that varies according to individual needs. This allows for spending flexibility within the set budgeted dollars according to participants needs and preferences. The support need is determined from an evaluation completed using a uniform assessment tool. Upon completion of an individual participant's individual assessment, the individualized budget methodology which the Department uses to determine an individual's budget is reviewed with the participant either by an IAP representative or a DHW staff.~~ Once participants are determined eligible for the DD waiver, they are assigned a budget based on the criteria outlined in Appendix C-4-a. The budget model provides participants with an assigned budget that varies according to assessed support needs which can be flexibility used according to participants' needs and preferences. Participants in Idaho's self-direction program may also receive services which total in excess of the assigned budget if they meet any of the budget modification criteria outlined in Appendix C-4-a.

~~Participants then have the option to select consumer directed services. This option is offered statewide.~~ All Adult DD waiver participants have the option to self-direct their services. Consumer directed services allows eligible participants to choose the type and frequency of supports they want, to negotiate the rate of payment, and to hire the person or agency they prefer to provide those supports. Through consumer directed services, participants select and hire a trained support broker to help plan, access, negotiate, and monitor their chosen services to their satisfaction. The support broker provides information and support to assist the participant in:

- making informed choices
- directing the person-centered planning process, and
- becoming skilled at managing their own supports.

The support broker possesses skills and knowledge that go beyond typical service coordination. Support broker services are included as part of the community support services that participants may purchase out of their allotted budget dollars. The support broker assists participants to convene a circle of supports team and engages in a person-centered planning process. The circle of supports team assists a participant to plan for and access needed services and supports based on their wants and needs within their established budget.

Participants have the freedom to make choices and plan their own lives, authority to control the resources allocated to them to acquire needed supports, the opportunity to choose their own supports and the responsibility to make choices and take responsibility for those choices. With the assistance of the support broker and legal representative, if one exists, participants are responsible for the following:

- Accepting and honoring the guiding principles of self-direction to the best of their ability.
- Directing the person-centered planning process in order to identify and document support and service needs, wants, and preferences.
- Negotiating payment rates for all paid community supports they want to purchase.
- Developing and implementing employment/service agreements.

Participants, with the help of their support broker, must develop a comprehensive support and spending plan based on the information gathered during the person centered planning. The support and spending plan is reviewed and authorized by the Department and includes participant's preferences and interests by identifying all the supports and services, both paid and non-paid, and the participant's wants and needs to live successfully in their community.

Self-directed community supports focuses on participants wants, needs, and goals in the following areas: (1) personal health and safety including quality of life preferences, (2) securing and maintaining employment, (3) establishing and maintaining relationships with family, friends and others to build the participant's natural support community, (4) learning and practicing ways to recognize and minimize interfering behaviors, and (5) learning new skills or improving existing ones to accomplish set goals.

They also identify support needs in the areas of: (1) medical care and medicine, (2) skilled care including therapies or nursing needs, (3) community involvement, (4) preferred living arrangements including possible roommate(s), and (5) response to emergencies including access to emergency assistance and care.

Participants choose support services, categorized as "consumer directed community supports," that will provide greater flexibility to meet the participant's needs in the following areas:

My Job Needs– focuses on assisting an individual in securing and maintaining employment or job advancement, alternate specialized funding and budgeting skills. (Under the traditional model, these needs are met by: community supported employment, transportation, environmental accessibility adaptations, personal assistance, and behavioral consultation/crisis management).

My Personal Needs - focuses on identifying supports and services needed to assure the person's health, safety, and basic quality of life. (Under the traditional model, these needs are met by: personal care services, residential habilitation, chore services, skilled nursing, home delivered meals, developmental therapy, specialized medical equipment and supplies, and personal emergency response systems).

My Relationship Needs – identifies strategies in assisting an individual to establish and maintain relationships with immediate family members, friends, spouse, or other persons and build their natural support network. (Under the traditional model, these needs are met by: residential habilitation, environmental accessibility adaptations, respite care, chore services, adult day care, and transportation).

My Emotional Needs – addresses strategies in assisting an individual to learn and increasingly practice behaviors consistent with the person's identified goals and wishes while minimizing interfering behaviors. (Under the traditional model, these needs are met by: residential habilitation, personal emergency response systems, and behavior consultation/crisis management).

My Learning Needs - identifies activities that support an individual in acquiring new skills or improving established skills that relate to a goal that the person has identified. (Under the traditional model, these needs are met by: residential habilitation, environmental accessibility adaptations, transportation, chore services, personal emergency response systems, home delivered meals, and adult day care).

With the assistance of their Support Broker, participants hire community support workers or enter into vendor agreements to access needed services and supports from these areas, as identified in their support and spending plan.

Participants selecting consumer directed services will be required to choose a qualified financial management services provider, to provide Financial Management Services for them and to process and make payments to community support workers for the community supports and services contained in their support and spending plan. Financial management service providers have primary responsibility for monitoring the dollars spent in accordance with the itemized spending plan and for ensuring payment itemization and accuracy. Financial management service providers also manage payroll expenses including required tax withholding, unemployment/ workers compensation insurance; ensuring completion of criminal history checks or waivers and providing access to spending reports to the participant and the support broker. Financial management service providers offer services on behalf of the participant in accordance with Section 3504 of the IRS code and the IRS Revenue Procedure 70-6, which outlines requirements of financial management service providers who are fiscal employer agents.

[Sections Omitted]

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

b. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Character Count: 1049 out of 12000

The Department holds regular informational meetings where participants can learn about self-direction. Participants are also provided with informational materials during their initial and annual eligibility determinations by the Department's contractor. These materials include a self-assessment tool and information about selecting either the traditional waiver services or consumer directed services. ~~Eligibility notices also include information on traditional waiver and consumer directed services.~~

The self-assessment tool provided during the eligibility process helps participants assess potential benefits, risks and responsibilities with selecting consumer directed services. Participants who express interest in consumer directed services are required to attend a "Guide to a Self Directed Life" with Department staff. At this meeting, participants receive a consumer toolkit that guides them through the self-direction process of selecting a support broker, hiring community support workers, and utilizing Financial Management Services.

[Sections Omitted]

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (3 of 6)

b. Participant - Budget Authority

i. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Character Count: 2283 out of 12000

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

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

~~To ensure a participant's budget is adequate to meet their individual needs, Idaho provides the following safeguards: 1) When the participant is noticed regarding their budget amount they have the opportunity to appeal that budget within 28 days of the date on the eligibility notice. When the appeal is received it is reviewed by the Department to ensure all the participant's needs were accurately captured through responses on the inventory of individual needs and the participant does not have~~

~~needs outside of what is captured by the inventory that meet medical necessity criteria. If there are medically necessary services that are needed to ensure a participant's health and safety, but the need for such services is not addressed by the inventory, dollars to meet those needs are added to the budget. Individualized budgets will be re-evaluated annually. 2) 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 are necessary to ensure a participant's health and safety, and this is not reflected on the current inventory of individual needs. When the Department determines there has been a documented change in condition not reflected on the current inventory, a new inventory is completed and budget calculated for the participant. The participant has the right to appeal this new budget.~~

~~The budget setting methodology is identified in IDAPA 16.03.10.514.10 and is also available to anyone submitting a Public Record Request.~~

Budget Assignments.

Each participant will be assigned an annual budget based on the following criteria established by the Department and more particularly described in Department program manuals:

a. General support needs determined by a Department-approved functional assessment tool or verified extraordinary support needs;

b. Type of in-home habilitation services selected by the participant; and

c. Service delivery approach (waiver traditional, or waiver self-directed).

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 Department guidance materials.

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:

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;

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

c. Community supported employment services as defined in IDAPA Section 16.03.10.703 are needed for the participant to obtain or maintain employment and the services are requested on the plan of service or addendum.

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.

[Sections Omitted]

Appendix F: Participant Rights

F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Character Count: 3071 out of 12000

Participants are given the opportunity to appeal any Department decision related to waiver eligibility or waiver services. Appeal rights are on all notices including notices for:

- Participants who do not meet ICF/ID Level of Care criteria
- Participants who are not provided the choice of HCBS as an alternative to institutional care;
- Participants whose services on their Individual Support Plan or Support and Spending Plan have been denied, reduced, terminated or suspended;
- Participants who are denied the provider of their choice;
- Eligibility approval notices which include the participant's ~~individualized~~ personal supports budgets.

Department notices are provided to the participant and guardian in writing and contain information on appealing Department decisions that negatively affect eligibility or services. Copies of these notices are maintained in the participant file. In order to appeal a decision, a participant must request a Department administrative (fair) hearing within 28 days from the date the notice was mailed.

When a participant requests a Department administrative hearing, the services under appeal are extended until a settlement between the Department and the participant is reached or the participant's administrative appeal rights have been fully exhausted. An internal review of the participant's file will take place. If through this review additional information is provided, or it is determined that a specific need was inaccurately assessed or missed, Medicaid staff will work with the participant to resolve the appeal prior to hearing. If a settlement is not jointly agreed upon, by the participant and the Department, a hearing will be scheduled.

Participants and the public may learn more about the Department's administrative (fair) hearing processes and policies by accessing the Department of Health & Welfare's website at www.healthandwelfare.idaho.gov, and clicking on the Idaho CareLine 2-1-1 link. The Idaho CareLine website is widely publicized in Idaho and can be accessed directly at www.idahocareline.org. The CareLine provides a detailed description of the Department's administrative hearing process as well as contact information for additional questions.

In addition, participants may receive information on administrative hearings by navigating to the Adult Developmental Disabilities Care Management page. The Adult DD Care Management page provides a list of answers to frequently asked questions including, "What if someone does not like the outcome of the assessment process?" Also, the Consumer Toolkit, distributed by the IAP, describes the participant's right to appeal any Department decision that negatively affects their eligibility or services.

In the hearing process, a hearing officer acts as an impartial third party in reviewing Department actions. The Department and the participant each have the opportunity to present his/her case before the hearing officer. The hearing officer considers testimony and evidence presented during hearing along with the pertinent state rules and federal regulations in making a decision.

A written decision is issued by the hearing officer and is sent to the Department and participant. When all administrative remedies are exhausted, the participant may appeal the final decision by requesting a judicial review by the District Court.

[Sections Omitted]

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Character Count: 2748 out of 12000

The Department must authorize all reimbursable services under the HCBS Waiver Program before the services are rendered.

Prior authorizations for approved services are entered into the Medicaid Management Information System (MMIS) by Medicaid. The prior authorization number must appear on the claim or it will be denied. Approved prior authorizations are valid for one (1) year from the date of prior authorization by Medicaid unless otherwise indicated. Claims are adjudicated by the MMIS in accordance with federal guidelines and Idaho policies. This includes extensive claim edit and audit processing, claim pricing, and claim suspense resolution processing.

The Medical Program Integrity Unit processes support the post-payment analysis of expenditures to identify potential misuse, abuse, quality of care, and treatment outcomes in Medicaid. Functions specifically supported by these processes include the traditional surveillance and utilization review features of the MMIS, retrospective drug utilization review, and outcome-oriented analysis regarding quality of care assessments.

The Department conducts performance monitoring of the MMIS contract to ensure that claims are adjudicated by the MMIS in accordance with federal guidelines and Idaho policies. In addition, Idaho is participating in the Payment Error Rate Measurement (PERM) Program beginning FY 2006.

All records are maintained by the MMIS and are available for review during post-payment audits. These records include: all claims submitted either electronically or on paper, all remittance and status reports which accompany provider payments; and all adjustment request forms.

The State requires the MMIS contractor to contract with, and pay for, an independent certified public accounting firm to perform an annual audit of the contractor's services to the State in compliance with AICPA Statement on Auditing Standards number 70 (Reports on the Processing of Transactions by Service Organizations).

~~With respect to the waiver amendment addressing Community Supported Employment, exception review requests related to employment will be reviewed and approved based on a Community Supported Employment recommendation which includes the recommended amount of service, level of support needed, employment goals and a transition plan. When supported by documentation and the recommendation, the requested amount of services will be authorized. Additional budget dollars will be determined by multiplying the number of approved services hours by the reimbursement rate established on the posted fee schedule. As described in IDAPA, the combination of developmental therapy, adult day health and community supported employment must not exceed forty (40) hours per week.~~

[Sections Omitted]

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Character Count: 5804 out of 12000

The Department provides public notice of significant reimbursement changes in accordance with 42 CFR § 447.205 (made applicable to waivers through 42 CFR § 441.304(e)). The Department publishes public notice of proposed reimbursement changes in multiple newspapers throughout the State and on the Department's website at www.healthandwelfare.idaho.gov. Copies of public notices and text of proposed significant reimbursement changes are made available for public review on Department's website and during regular business hours at agency locations in each Idaho county as identified in each public notice. Additionally, payment rates are published on our website at www.healthandwelfare.idaho.gov for the public to access.

The Department provides opportunity for meaningful public input related to proposed reimbursement changes in accordance with 42 CFR § 441.304(f). The Department solicits comments from the public (including beneficiaries, providers and other stakeholders) through its public notice process and through public hearings related to the proposed reimbursement changes. The public is given the opportunity to comment on the proposed reimbursement changes for at least 30 days prior to the submission of a waiver amendment to CMS. Additionally, when administrative rules are promulgated in connection with reimbursement changes, the proposed rules are published in the Idaho Administrative Bulletin and the public is given the opportunity to comment.

Waiver service providers will be paid on a fee for service basis as established by the Department depending on the type of service provided. The Bureau of Financial Operations is responsible for rate determinations.

Please see below for services and Reimbursement Methodology information:

Adult Day Health / Residential Habilitation / Community Supported Employment Services:
~~The rate was derived by using Bureau of Labor Statistics mean wage for the direct care staff providing the service adjusted for employment related expenditures and indirect general and administrative costs which includes program related costs and are based on surveyed data. The rate for this service is set at a~~

~~percentage of the statewide target reimbursement rate.~~ The rate model used to develop the reimbursement rates is described in Idaho Administrative Code (IDAPA) 16.03.10.038. The Department will survey providers to identify the actual cost of providing the specified services (Cost Survey). Reimbursement rates will be based on surveyed data and derived using a combination of four cost components – direct care staff wages, employee-related expenses, program-related expenses, and general and administrative expenses.

The individual components of the rate will be determined as follows:

(1) Direct Care Staff Wages. The direct care staff wage component (Wage) used to establish the new reimbursement rate is set using the mean hourly wage of one (1) or more occupation profiles from the most current Bureau of Labor and Statistics (BLS) State Occupational Employment and Wage Estimates table for the state of Idaho found on the BLS website at www.bls.gov. The BLS occupation profile that most closely aligns with the duties, education level, and supervision requirements of the direct care staff providing the service is utilized. If more than one (1) occupation profile aligns with the duties, education level, and supervision requirements of the direct care staff providing the service, then a weighted average of the mean hourly wage of multiple BLS occupation profiles is utilized. When there is no comparable occupation profile or profiles for the direct care staff then the wage component used to establish the new reimbursement rate is set using the weighted average hourly rate (WAHR) of the surveyed wages included in the final cost survey results.

(2) Employee-Related Expenses. The ERE component percentage (ERE%) used to establish the new reimbursement rate is set using the cumulative percentage of employer costs for employee compensation from the most current BLS Employer Costs for Employee Compensation table for the West Region in the Mountain Division and IRS Publication 15.

(3) Program-Related Expenses. Utilizing data in the final cost survey results, each agency's PRE component percentage (PRE%) is calculated by dividing the agency's total PRE by the agency's total wages. Each agency's PRE% is ranked, and the PRE% used to calculate the new reimbursement rate is set at the mean of the agency PRE%.

(4) General and Administrative Expenses. Utilizing data in the final cost survey results, each agency's G&A component percentage (G&A%) is calculated by dividing the agency's total G&A expenses by the sum of the agency's total wages, plus the total ERE, plus the total PRE, plus the total G&A expenses. Each agency's G&A% is ranked, and the G&A% used to calculate the new reimbursement rate is set at the mean of the agency G&A%. The G&A% used to calculate the new reimbursement rate will not exceed ten percent (10%) of the total reimbursement rate per staff hour.

Total Reimbursement Rate Per Staff Hour of Service = ((Wage + (ERE% x Wage) + (PRE% x Wage)) /(1-(G&A%)).

Reimbursement rates may be set at a percentage of the total reimbursement rate per staff hour. All reimbursement rate increases are subject to approval by the Idaho State Legislature.

Prevocational and Career Planning Services.
The rates were derived using the rate methodology specified for Community Supported Employment Services (above). However, because these services are new services, no cost survey could be collected to establish the PRE% and the G&A% for these services. To establish the new reimbursement rates, the Department used the cost survey data collected from the most recent Employment Services Cost Survey to calculate the PRE component percentage and the G&A component percentage.

Reimbursement rates may be set at a percentage of the total reimbursement rate per staff hour. All reimbursement rate increases are subject to approval by the Idaho State Legislature.

Behavioral Consultation/Crisis Management:

The rate was derived by using Bureau of Labor Statistics mean wage for the direct care staff providing the service adjusted for employment related expenditures and indirect general and administrative costs which includes program related costs and are based on surveyed data. The rate for this service is set at a percentage of the statewide target reimbursement rate.

Chore Services:
These items are manually priced based on the submitted invoice price which cannot exceed $8.00 an hour.

Environmental Accessibility Adaptations:
For adaptations over $500, three bids are required if it is possible to obtain three bids. The lowest bid which meets the participant's needs is selected.

Home Delivered Meals:
The rate is set based on Personal Care Service rates and then increased or decreased based on the qualifications to provide the waiver service, what sort of supervision was required, and agency costs associated with delivering the services.

~~Non-Medical Transportation~~
~~A study is conducted that evaluates the actual costs of fuel reasonably incurred by the typical non-commercial transportation provider whose personal vehicle averages fifteen (15) miles per gallon.~~

Personal Emergency Response System:
The rate is developed by surveying Personal Emergency Response System vendors in all seven regions of the State to calculate a state-wide average. The state-wide average is the rate paid for this service.

~~Residential Habilitation:~~
~~The rate model used to develop Residential Habilitation rates is described in Idaho Administrative Code (IDAPA) 16.03.10.037.04. The Department will survey current residential habilitation providers to identify the actual cost of providing residential habilitation services (Cost Survey). Reimbursement rates will be based on surveyed data and derived using a combination of four cost components – direct care staff wages, employer related expenditures, program related costs, and indirect general and administrative costs.~~
~~The individual components of the rate will be determined as follows: (1) the direct care staff wage component will be determined using either the wage for a comparable Bureau of Labor Statistics (BLS) occupation title, or the weighted average hourly rate from surveyed data if there is no comparable BLS occupation title; (2) the employer related expenditure component will be determined by multiplying the direct care staff wage by the cumulative percentage of employer costs for employee compensation identified by BLS for the West Region, Mountain Division and the internal revenue service employer cost for social security benefit and Medicare benefit; (3) the program related cost component will be determined by identifying the 75th percentile of the ranked program related costs from the surveyed data; and (4) the indirect general and administrative cost component will be determined by identifying the 75th percentile of the ranked general and administrative costs from the surveyed data.~~

Respite:
The rate is set based on Personal Care Service rates and then increased or decreased based on the qualifications to provide the waiver service, what sort of supervision was required, and agency costs associated with delivering the services.

Skilled Nursing:
These services are paid on a uniform reimbursement rate based on an annual survey conducted by the Department.

Specialized Medical Equipment and Supplies:
For equipment and supplies that are manually priced, including miscellaneous codes, a copy of the manufacturer's suggested retail pricing (MSRP) or an invoice or quote from the manufacturer is required. Reimbursement will be seventy-five percent (75%) of MSRP. If pricing documentation is the invoice,

reimbursement will be at cost plus ten percent (10%), plus shipping (if that documentation is provided). For equipment and supplies that are not manually priced, the rate is based on the Medicaid fee schedule price.

Transition Services:
The benefit limit of $2,000 was recommended by Federal partners and validated by an informal cost analysis conducted in 2013. Additionally, the State opted to align with other states with approved Transition Services in their waivers. These states include Colorado, Georgia, Ohio, and Tennessee. The analysis included sample shopping at multiple retailers to procure essential household furnishings, appliances and supplies. Additionally, the State regularly reaches out to existing providers and agencies to raise interest and participation in Transition Management training to increase the provider pool.

~~Supported Employment:~~
~~The rate was derived by using Bureau of Labor Statistics mean wage for the direct care staff providing the service adjusted for employment related expenditures and indirect general and administrative costs which includes program related costs and are based on surveyed data. The rate for this service is set at a percentage of the statewide target reimbursement rate.~~

Self-Directed Services (Support Broker Services and Community Support Services):
Rates are set by the participant based on the specific needs of the participant through negotiation with the worker. The identified rates may not exceed prevailing market rates. The Department provides training and resource materials to assist the participant, support broker, and circle of supports to make this determination. The participant and the support broker monitor this requirement each time the participant enters into an employment agreement. The Department ensures that the proposed plan of service does not exceed the overall budget at the time of plan review and approval. The Department also reviews a statistically valid sample of participant employment agreements during the annual retrospective quality assurance reviews.

Financial Management Services:
Reimbursement methodology for FMS is based on a market study of other state Medicaid program rates for FMS to gather a range which allows the Department to accept a Per Member Per Month (PMPM) rate within the range determined from the market study. The established PMPM payment rates for each Department approved qualified FMS provider will be published on a fee schedule by the Department. This fee schedule will be updated at least yearly, and when new providers are approved. This information will be published for consumer convenience to the IDHW Medicaid website, and by request.

[Sections Omitted]

[END OF PROPOSED 1915(c) WAIVER AMENDMENT]

Draft Amendment to 1915(i) State Plan Home and Community-Based Services Benefit for Adults with Developmental Disabilities

1915(i) State plan Home and Community-Based Services Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. Services. *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

Adult – Developmental Therapy
Adult – Community Crisis Supports
Adult – Community Habilitation
Adult – Non-Medical Transportation

[Sections Omitted]

4. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed *(check each that applies):*

(Check all agencies and/or entities that perform each function):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☐	☐
2 Eligibility evaluation	☑	☐	☑	☐
3 Review of participant service plans	☑	☐	☐	☐
4 Prior authorization of State plan HCBS	☑	☐	☐	☐
5 Utilization management	☑	☐	☐	☐
6 Qualified provider enrollment	☑	☐	☐	☐
7 Execution of Medicaid provider agreement	☑	☐	☐	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐

9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
10 Quality assurance and quality improvement activities	☑	☐	☐	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Eligibility Evaluation: The Department contracts with an Independent Assessment Provider (IAP) to complete level of care determinations and assign ~~individualized~~ personal supports budgets. The IAP is not a provider of 1915(i) state plan home and community-based services (HCBS), nor does the IAP serve under the authority of a provider of 1915(i) state plan HCBS.

[Sections Omitted]

Evaluation/Reevaluation of Eligibility

[Sections Omitted]

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Adults applying for 1915(i) State Plan HCBS Benefit services will submit an Eligibility Application for Adults with Developmental Disabilities to the Bureau of Developmental Disability Services (BDDS) in the region in which they live. Eligibility applications for adults with developmental disabilities are completed in paper format and may be submitted to the State by hand delivery, U.S. mail, fax, or email.

Within three (3) days of receiving the application for services, BDDS verifies if the participant is financially eligible for Medicaid. After verifying a participant's financial eligibility, the application is forwarded to the Department's Independent Assessment Provider (IAP) to determine if the participant meets Needs-based HCBS Eligibility Criteria for this HCBS benefit.

The IAP is responsible for completing the eligibility determination process within thirty (30) days of receiving an application. This process includes the following:

a. The IAP requests a current physician's health and physical report (completed within the prior ~~six (6) months~~one (1) year) ~~and Nursing Service and Medication Administration form~~ from the participant's primary care physician.

b. The IAP contacts the participant or their decision-making authority (if applicable) to identify who will serve as a respondent for the initial eligibility assessments to be completed by the IAP. The participant or their decision-making authority (if applicable) is responsible for identifying a respondent who has knowledge about the participant's current level of functioning. The participant is required to be present with the respondent for a face-to-face meeting with the IAP to complete the initial eligibility assessment process.

c. During the face-to-face meeting with the IAP, the respondent for the participant will participate in completing the Department-approved functional assessment tool(s), and Medical, Social, Developmental Assessment Summary. These assessments, in addition to other required documentation, are used to verify the participant meets the Needs-based HCBS Eligibility Criteria for this HCBS benefit.

d. ~~At the time of the face-to-face meeting, the IAP completes an Inventory of Individual Needs with the respondent. This inventory is used to calculate an initial budget according to the participant's functional abilities, behavioral limitations, medical needs and other individual factors related to the participant's disability.~~At the time of the face-to-face meeting, the IAP completes Department-approved functional assessment tool(s) with the respondent(s) to assign a support level based on the participant's general support needs. Participants who are identified as potentially meeting the criteria for a support level based on their extraordinary medical or behavioral support needs are directed to a secondary process known as verification to determine if they meet those criteria. A participant's budget is then assigned based on their support level.

e. The IAP communicates eligibility determinations and ~~calculated~~ assigned budgets to the participant and their decision-making authority (if applicable) through a written Notice of Decision. Participants or their decision-making authority (if applicable) who do not agree with a decision regarding eligibility or the ~~calculated~~ assigned budget may request an administrative hearing.

f. The IAP maintains all documentation associated with the initial eligibility assessment process in an electronic file in the IAP database. ~~Additionally, the IAP uploads the Eligibility Application, Eligibility Assessments, Eligibility Notices and any other documentation used to support approval of eligibility into the participant's case file in the Department's MMIS system.~~

PROCESS FOR ANNUAL REEVALUATION

The annual reevaluation process is the same as the initial evaluation process, except for the following differences:

a. A new Eligibility Application for Adults with Developmental Disabilities does not have to be submitted by the participant on an annual basis.

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

c. The IAP is only required to complete ~~a~~ new Department-approved functional assessment tool(s) ~~or update the Medical, Social, Developmental Assessment Summary~~ when it is determined that the existing ~~documentation~~ Department-approved functional assessment tool(s) does not accurately describe the current status of the participant. The IAP will make a clinical determination regarding the need for ~~a new/updated assessment~~ completing new Department-approved functional assessment tool(s) based on information provided by the respondent during the annual face-to-face eligibility re-determination meeting. This respondent is someone the participant and their decision making authority (if applicable) have identified as the person who is most qualified to provide current information regarding the participant's medical, functional, and behavioral needs. The IAP is only required to update sections of the Medical, Social, Developmental Assessment Summary when the respondent indicates a change has occurred.

d. Unless contra-indicated, the participant is required to attend the annual re- determination meeting. Any comments or questions voiced by the participant during this meeting will be addressed and considered by the IAP completing the annual eligibility assessment.

~~e. Information from the Inventory of Individual Needs that is completed with the respondent is included with the Notice of Decision sent to the participant regarding their annual eligibility determination.~~

[Sections Omitted]

6. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
The individual requires assistance due to substantial limitations in three 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	Idaho has developed a Uniform Assessment Instrument (UAI) as the basis of the nursing facility level of care instrument. The UAI measures deficits in ADLs, IADLs, Behavioral and Cognitive Functioning. A score of 12 points is needed to demonstrate NF LOC. Idaho Administrative Procedure defines this in IDAPA 16.03.10.322.04-.08, "Medicaid Enhanced Plan Benefit."	In addition to being part of the Target Group described in this SPA and having substantial limitations outlined in the HCBS Needs-Based Criteria, the individual must be determined to need consistent, intense and frequent services by meeting the following criteria: The individual must require a certain level of care. Persons living in the community must require the	The State uses criteria defined in 42 CFR 440.10 for inpatient hospital services. (end)

The individual has a need for combination and sequence of special interdisciplinary or generic care, treatment or other services which are of life-long or extended duration and individually planned and coordinated due to a delay in developing age appropriate skills occurring before the age of 22. (end)	In determining need for nursing facility care an adult must require the level of assistance according to the following formula: **Critical Indicator - 12 Points Each.** a. Total assistance with preparing or eating meals. b. Total or extensive assistance in toileting. c. Total or extensive assistance with medications which require decision making prior to taking, or assessment of efficacy after taking. (con't)	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 institutionalized, other than services in an institution for mental disease, in the near future; and Persons may qualify based on their functional skills. Persons with an ~~age equivalency composite score of eight (8) years and zero (0) months or less on the Department approved assessment tool~~ 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 Persons may qualify based on their Maladaptive Behaviors: a. ~~A minus twenty-two (-22) or below score.~~Twenty-One (21) or Greater Score. Adults will be eligible if their ~~general Maladaptive index on the Department approved assessment tool is minus twenty-two (-22) or less~~ internalizing or externalizing maladaptive behavior v-scale score on the Vineland Adaptive Behavior Scales (Third Edition) assessment tool is twenty-one (21) or greater; or (con't)	

*Long Term Care/Chronic Care Hospital
**LOC= level of care

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
	High Indicator - 6 Points Each a. Extensive assistance with preparing or eating meals. b. Total or extensive assistance with routine medications. c. Total, extensive or moderate assistance with transferring. d. Total or extensive assistance with mobility. e. Total or extensive assistance with personal hygiene. f. Total assistance with supervision from Section II of the Uniform Assessment Instrument (UAI).	b. ~~Above a Minus twenty-two (-22) score.~~ A Below Twenty-One (21) Score. Individuals ~~who score above minus twenty-two (-22) may qualify for ICF/ID level of care if~~ 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 (i) the individual scores a two for at least one internalizing or externalizing maladaptive	

	Medium Indicator - 3 Points Each. a. Moderate assistance with personal hygiene. b. Moderate assistance with preparing or eating meals. c. Moderate assistance with mobility. d. Moderate assistance with medications. e. Moderate assistance with toileting. f. Total, extensive, or moderate assistance with dressing. g. Total, extensive or moderate assistance with bathing. h. Extensive or moderate assistance with supervision from Section II No. 18 of the UAI. (end)	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; (ii) ~~they~~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 (iii) the person requires active treatment to control or decrease the behavior; or Persons may qualify based on a combination of functional and maladaptive behaviors. Persons may qualify for ICF/ID level of care if they display a combination of criteria at a level that is significant. An ~~overall age equivalency up to eight and one-half (8.5) years is significant in the area of functionality when combined with a general maladaptive index on the SIB-R Department approved assessment tool from minus seventeen (-17), up to minus twenty-two (-22) inclusive;~~ adaptive behavior composite standard score between sixty (60) and sixty-three (63) inclusive is significant in the area of functionality when combined with 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 Persons may qualify based on their Medical Condition. Individuals may meet ICF/ID level of care based on their medical conditions if the medical condition significantly affects their functional level/capabilities and if it can be determined that they are in need of the level of services provided in	

		an ICF/ID, including active treatment services. (end)	

*Long Term Care/Chronic Care Hospital
**LOC= level of care

[Sections Omitted]

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☑ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution.
(Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441. 710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

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

[Sections Omitted]

Person-Centered Planning & Service Delivery

[Sections Omitted]

5. **Responsibility for Development of Person-Centered Service Plan.** There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications)*:

At a minimum, a paid plan developer developing a plan of care must meet service coordination qualifications outlined in IDAPA 16.03.10.729.

a. 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 be paid for plan development must be employed as a service coordinator.~~ To be paid for plan development, an individual must be employed as a service coordinator as defined in IDAPA Section 16.03.10.729.

b. Service coordinators must be employees or contractors of an agency that has a valid provider agreement with the Department.

c. Service coordinators must have a minimum of a Bachelor'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 be a licensed professional nurse (RN); and have twelve (12) months' work experience with the population being served. When an individual meets the education or licensing requirements but does not have the required supervised work experience, the individual must be supervised by a qualified service coordinator while gaining the required work experience.

d. Service coordination agencies must verify that each service coordinator and paraprofessional they employ or with whom they contract has complied with IDAPA 16.05.06, Criminal History and Background Checks.

e. The total caseload of a service coordinator must assure quality service delivery and participant satisfaction.

6. **Supporting the Participant in Development of Person-Centered Service Plan.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process)*:

During the assessment process, participants are provided with a list, organized by geographic area, of plan developers in the State of Idaho. The list also includes website links that provide helpful resources for participants, their decision-making authority, family members and person-centered team members.

The plan of service is developed by the participant and their person-centered planning team. This group includes, at a minimum, the participant, their decision-making authority (if applicable) and the service coordinator or plan developer chosen by the participant. With the participant's consent, the person-centered planning team may include family members, or individuals who are significant to the participant. A plan developer's responsibility for developing a service plan using a person-centered planning process is supported by IDAPA 16.03.10.~~730.731~~513.

If limits for targeted service coordination are reached, additional hours for person-centered planning and needed addendums can be authorized by the Department in those situations where the participant demonstrates a health and safety need.

[Sections Omitted]

Services

1. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Adult - Developmental Therapy
Service Definition (Scope):	
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 services must be delivered by Developmental Specialists or paraprofessionals based on a comprehensive developmental assessment completed prior to the delivery of services. • Areas of service. These services must be directed toward the rehabilitation or habilitation of physical or mental disabilities in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. • Age-appropriate. Developmental therapy includes instruction in daily living skills the participant has not gained at the normal developmental stages in his life, or is not likely to develop without training or therapy. Developmental therapy must be age-appropriate. • 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. • Settings for developmental therapy. 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. • Staff-to-participant ratio. Unless otherwise approved by the Department, ~~When~~ 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. Additional staff must be added, as necessary, to meet the needs of each individual served. • Community-based services must occur in integrated, inclusive settings and, unless otherwise approved by the Department, with no more than three (3) participants per qualified staff at each session. The services under the 1915(i) State Plan Option HCBS Benefit for Adults with Developmental Disabilities are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.	
Additional needs-based criteria for receiving the service, if applicable *(specify)*:	
N/A	

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*

☑ Categorically needy *(specify limits)*:

~~Developmental therapy benefits limitation is 22 hours per week. The Department ensures that the individual's needs can be met within the service limit by requiring that each service plan be prior authorized by the Department. The prior authorization process ensures that the provision of services promote participant rights, self-determination and independence. All participants may request an exception review of plans and addendums requesting adult developmental therapy services that exceed established limits. These requests will be authorized when the requested services are necessary for the individual to live and receive services in their home and community.~~

~~Developmental therapy is not authorized for participants receiving high or intense residential habilitation – supported living services (1915(c) HCBS). Home-based developmental therapy is not authorized for participants receiving residential habilitation in a certified family home.~~

Legally responsible individuals (e.g., a parent of minor child or a spouse) and relatives may not be paid for the provision of Developmental Therapy services.

A DDA may not hire the parent or legal guardian of a participant to provide services to the parent's or legal guardian's child.

☐ Medically needy *(specify limits)*:

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify):*	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Developmental Disabilities Agency		Developmental Disabilities Agency (DDA) certificate as described in IDAPA 16.03.21	Agencies providing Developmental therapy must meet the staffing requirements and provider qualifications defined in IDAPA rule 16.03.21.400-499

Verification of Provider Qualifications *(For each provider type listed above. Copy rows as needed):*		
Provider Type *(Specify):*	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Developmental Disabilities Agencies	Department of Health and Welfare	• At initial provider agreement or renewal • At least every three years, and as needed based on service monitoring concerns

Service Delivery Method. *(Check each that applies):*			
☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Adult - Community Crisis Support

Service Definition (Scope):

Community crisis supports are interventions used to assist participants to access community resources to resolve a crisis. A crisis is an unanticipated event, circumstance or life situation that places a participant at risk of at least one (1) of the following: ~~for adult participants who are at risk of~~ hospitalization; ~~losing~~loss of housing, loss of employment or major source of income, ~~or are at risk of~~ incarceration, or physical harm to self or others, including family altercation or other emergencies. 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.~~If a participant experiences a crisis, community crisis supports can be offered to assist the participant out of the crisis and develop a plan that mitigates risks for future instances.~~ 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.

These individualized interventions are to ensure the health and safety of the participant and may include referral of the participant to community resources to resolve the crisis, direct consultation and clinical evaluation of the participant, training and staff development related to the needs of a participant, emergency back-up involving the direct support of the participant in crisis, and/or other assistance that is appropriate to resolve the crisis and does not duplicate another service that is the same in nature and scope regardless of source, including Federal, state, local and private entities. Payments may not be made for room and board, items of comfort or convenience, or items that are for purely diversional/recreational purposes. Any housing support activities that are directly performed by the provider on behalf of the participant, community transition services, and home adaptations are excluded. Any other services and supports that are not permissible for federal financial participation are excluded.

Community crisis supports are a benefit authorized to support a participant when the normal support structure fails. During times of crisis, service hours can be authorized when existing prior authorized services have been exhausted or are not appropriate for addressing the crisis. Crisis supports are only approved when support is not available to stabilize the participant through other sources.

Community crisis supports are based on a crisis plan that outlines interventions used to resolve the crisis. After community crisis supports are provided, the crisis provider must supply the Department with documentation of the crisis outcome, identification of factors contributing to the crisis and a proactive

strategy that will address the factors that resulted in a crisis in order to minimize the opportunity for future occurrences.	
Additional needs-based criteria for receiving the service, if applicable *(specify)*:	
~~Participant is at risk of losing housing, employment or income, or who are at risk of incarceration, physical harm, family altercations or other emergencies.~~	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☑	Categorically needy *(specify limits)*:
	Community crisis support is limited to a maximum of 20 hours during any consecutive five-day period. In order to initiate a request for community crisis supports, the targeted service coordinator, in coordination with the person-centered planning team, submits a request for community crisis supports to the Department. The Department case manager will review the request to ensure that the supports requested are not duplicative of other services being delivered to the participant. Community crisis supports will only be approved if all service hours previously prior authorized that may be appropriate to address the crisis have already been exhausted. When Community Crisis Supports has been accessed, the proactive strategy used to address the factors that resulted in a crisis should be incorporated as goals into the participant's person-centered plan of service. ~~Community crisis support may be retroactively authorized within seventy-two hours of providing the service 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.~~ 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. Participants who are not currently receiving developmental disability services may receive community crisis supports after completing an abbreviated person-centered planning process. In these cases, after eligibility for the service is determined, the participant and their planning team will develop a crisis plan to address the immediate crisis. This crisis plan will subsequently be incorporated into the overall person-centered planning process and development of the initial DD plan of service. Legally responsible individuals (e.g., a parent of minor child or a spouse) and relatives may not be paid for the provision of Community Crisis services.
☐	Medically needy *(specify limits)*:

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify):*	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
~~Service Coordination Agency~~			~~Service Coordination Agency providers must meet provider qualifications as outlined in IDAPA 16.03.10.721 and 729.~~
Behavioral Consultation			Behavioral Consultation Providers must meet provider qualifications as outlined in IDAPA 16.03.10.705.12
Supported Employment Services			Supported Employment Providers must meet provider qualifications as outlined in 16.03.10.705.05
Residential Habilitation Agency		Certificate as described in IDAPA 16.04.17 and 16.03.705	
Certified Family Home		Certified Family Home certificate as described in IDAPA at 16.03.19	

Verification of Provider Qualifications *(For each provider type listed above. Copy rows as needed):*

Provider Type *(Specify):*	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
~~Service Coordination Agency~~	~~Department of Health and Welfare~~	~~At least every two years~~
Behavioral Consultation	Department of Health and Welfare	At least every two years
Supported Employment Services	Department of Health and Welfare	At least every two years
Residential Habilitation Agency	Department of Health and Welfare	Residential habilitation providers are surveyed when they seek renewal of their certificate. The Department issues certificates that are in effect for a period of no longer than three years
Certified Family Home	Department of Health and Welfare	Certification for Certified Family Homes is required the year after the initial home certification study

		and at least every twenty-four (24) months thereafter.

Service Delivery Method. *(Check each that applies):*

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Community Habilitation

Service Definition (Scope):

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.

a. Community habilitation may include:
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;
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;
iii. Participating in social events/clubs, and/or recreational activities;
iv. Volunteering; and
v. Participating in organized worship, or spiritual activities.

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.

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.

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.

e. Transportation integral to meeting the participant's goals, desired outcomes, and needs specified in the provider implementation plan (required by IDAPA Section 16.03.10.513).

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*

☑ Categorically needy *(specify limits)*:

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.

This service may be delivered during the day, the evening, and/or the weekends.

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.

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).

Legally responsible individuals (e.g., a parent of minor child or a spouse) and relatives may not be paid for the provision of Community Habilitation services.

☐ Medically needy *(specify limits)*:

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify):*	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Developmental Disabilities Agency		Developmental Disabilities Agency (DDA) certificate as described in IDAPA 16.03.21	Agencies providing Community Habilitation must meet the staffing requirements and provider qualifications defined in IDAPA rule 16.03.21.400-499 and IDAPA 16.03.10.650.03.
Residential Habilitation Agency		Certificate as described in IDAPA 16.04.17 and 16.03.705	Agencies providing Community Habilitation must meet the staffing requirements IDAPA 16.03.10.650.03.

Verification of Provider Qualifications *(For each provider type listed above. Copy rows as needed):*

Provider Type *(Specify):*	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Developmental Disabilities Agencies	Department of Health and Welfare	• At initial provider agreement or renewal • At least every three years, and as needed based on service monitoring concerns

Residential Habilitation Agency	Department of Health and Welfare	Residential habilitation providers are surveyed when they seek renewal of their certificate. The Department issues certificates that are in effect for a period of no longer than three years.

Service Delivery Method. *(Check each that applies):*

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Non-Medical Transportation Services

Service Definition (Scope):

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.

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

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

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*

☑ Categorically needy *(specify limits)*:

Legally responsible individuals (e.g., a parent of minor child or a spouse) and relatives may not be paid for the provision of Non-medical transportation services.

☐ Medically needy *(specify limits)*:

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify):*	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Non-Medical Transportation Providers			Non-Medical Transportation Providers must meet provider

			qualifications as outlined in 16.03.10.650.04.

Verification of Provider Qualifications *(For each provider type listed above. Copy rows as needed):*		
Provider Type *(Specify):*	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Non-Medical Transportation Providers	Department of Health and Welfare	At least every two years

Service Delivery Method. *(Check each that applies):*			
☐	Participant-directed	☑	Provider managed

2. ☑ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Idaho does not allow payment for Adult Developmental Therapy, ~~or~~ Community Crisis Supports, Community Habilitation, or Non-Medical Transportation provided by persons who are relatives of the participant nor by persons who are legally responsible individuals for the participant.

Legal guardians may be paid providers of Community Crisis Supports, but not Adult Developmental Therapy, Community Habilitation, nor Non-Medical Transportation. Community crisis support is only authorized if there is a documented need for immediate intervention related to an unanticipated event, circumstance or life situation that places a participant at risk of at least one of the following: loss of housing, loss of employment or income, incarceration, physical harm, family altercation, or other emergencies. In order to closely monitor this service, authorization is limited to a maximum of twenty hours during any consecutive five-day period. Payment is authorized based on a crisis support plan and assessment. During the authorization process, Department Care Managers review the plan to ensure that services authorized do not duplicate any other paid Medicaid services. If applicable, guardian papers are available to the Department Care Manager at the time the plan is review and approved to ensure services are not prior authorized if they duplicate services the legal guardian is required to provide. After community crisis support has been provided, the provider must complete a crisis resolution plan and submit it to the Department within three business days. The crisis resolution plan shall identify the factors contributing to the crisis and must include a proactive strategy to address these factors in order to minimize future occurrences.

[Sections Omitted]

Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates):*

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☑	HCBS Habilitation
	Developmental Therapy / Community Crisis Support The rate model used to develop the reimbursement rates is described in Idaho Administrative Code (IDAPA) 16.03.10.038. The Department will survey providers to identify the actual cost of providing the specified services (Cost Survey). Reimbursement rates will be based on surveyed data and derived using a combination of four cost components – direct care staff wages, employee-related expenses, program-related expenses, and general and administrative expenses. The individual components of the rate will be determined as follows: (1) Direct Care Staff Wages. The direct care staff wage component (Wage) used to establish the new reimbursement rate is set using the mean hourly wage of one (1) or more occupation profiles from the most current Bureau of Labor and Statistics (BLS) State Occupational Employment and Wage Estimates table for the state of Idaho found on the BLS website at www.bls.gov. The BLS occupation profile that most closely aligns with the duties, education level, and supervision requirements of the direct care staff providing the service is utilized. If more than one (1) occupation profile aligns with the duties, education level, and supervision requirements of the direct care staff providing the service, then a weighted average of the mean hourly wage of multiple BLS occupation profiles is utilized. When there is no comparable occupation profile or profiles for the direct care staff then the wage component used to establish the new reimbursement rate is set using the weighted average hourly rate (WAHR) of the surveyed wages included in the final cost survey results. (2) Employee-Related Expenses. The ERE component percentage (ERE%) used to establish the new reimbursement rate is set using the cumulative percentage of employer costs for employee compensation from the most current BLS Employer Costs for Employee Compensation table for the West Region in the Mountain Division and IRS Publication 15.

	(3) Program-Related Expenses. Utilizing data in the final cost survey results, each agency's PRE component percentage (PRE%) is calculated by dividing the agency's total PRE by the agency's total wages. Each agency's PRE% is ranked, and the PRE% used to calculate the new reimbursement rate is set at the mean of the agency PRE%. (4) General and Administrative Expenses. Utilizing data in the final cost survey results, each agency's G&A component percentage (G&A%) is calculated by dividing the agency's total G&A expenses by the sum of the agency's total wages, plus the total ERE, plus the total PRE, plus the total G&A expenses. Each agency's G&A% is ranked, and the G&A% used to calculate the new reimbursement rate is set at the mean of the agency G&A%. The G&A% used to calculate the new reimbursement rate will not exceed ten percent (10%) of the total reimbursement rate per staff hour. Total Reimbursement Rate Per Staff Hour of Service = ((Wage + (ERE% x Wage) + (PRE% x Wage)) /(1- (G&A%)). Reimbursement rates may be set at a percentage of the total reimbursement rate per staff hour. All reimbursement rate increases are subject to approval by the Idaho State Legislature. Community Habilitation The rates were derived using the rate methodology specified for Developmental Therapy Services (above). However, because these services are new services, no cost survey could be collected to establish the PRE% and the G&A% for these services. To establish the new reimbursement rates, the Department used the cost survey data collected from the most recent Adult Developmental Disability Agency cost survey to calculate the PRE component percentage and the G&A component percentage. Reimbursement rates may be set at a percentage of the total reimbursement rate per staff hour. All reimbursement rate increases are subject to approval by the Idaho State Legislature.
☐	HCBS Respite Care
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
Other Services (specify below)	
☑	Non-Medical Transportation The reimbursement rate for non-medical transportation is set to align with the Internal Revenue Service (IRS) Notice 2021-02 standard mileage rate for the use of a car (also vans, pickups or panel trucks).
☐	

Draft Amendment to Enhanced Alternative Benefit Plan Service Definition for Targeted Service Coordination

Alternative Benefit Plan

Other 1937 Benefit Provided:

Targeted Service Coordination: DD Adults

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Program Description: Targeted Case Management Services; 1905(a)(19) of the Act.

Other services covered by the Department, but not covered by the Base Benchmark: Targeted Service Coordination for Adults with Developmental Disabilities.

Target Group (42 CFR 441.18(a)(8)(i) and 441.18(a)(9):

Adults age 18 and older, who have a developmental disability diagnosis, and who require and choose assistance to access services and supports necessary to maintain independence in the community.

For targeted service coordination provided to individuals in medical institutions: [Olmstead letter #3] Target group is comprised of individuals transitioning to a community setting and targeted service coordination services will be made available for up to the last 60 consecutive days of the covered stay in the medical institution.

Areas of State in which services will be provided: Entire State.

Services are not comparable in amount duration and scope - 1915(g)(1).

Definition of services: [42 CFR 440.169]

Targeted service coordination is a service furnished to assist participants, eligible under the State plan, in gaining access to needed medical, social, educational and other services.

Targeted service coordination includes the following assistance:

• Comprehensive assessment and annual reassessment of a participant to determine the need for any medical, educational, social or other services and to update the plan. These assessment activities include up to ~~six~~ twelve (12) hours of:

- Taking client history;

- Identifying the participant's needs and completing related documentation;

- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the participant.

Additional hours may be prior authorized if medically necessary.

• Development (and periodic revision) of a specific care plan that:

- Is based on the information collected through the assessment;

- Specifies the goals and actions to address the medical, social, educational, and other services needed by the participant;

- Includes activities such as ensuring the active participation of the participant, and working with the participant (or the participant's authorized health care decision-maker) and others to develop those goals; and

- Identifies a course of action to respond to the assessed needs of the participant.

• Referral and related activities:

- To help a participant obtain needed services including activities that help link the participant with: Medical, social, educational providers; or other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the participant.

• Monitoring and follow-up activities:

- Activities, and contacts, necessary to ensure the care plan is implemented and adequately addresses the individual's needs. These activities, and contacts, may be with the participant, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary, including at least one annual monitoring to assure following conditions are met:

Services are being furnished in accordance with the participant's care plan;

Services in the care plan are adequate; and

If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and service arrangements with providers.

Targeted service coordination may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the participant to access services.

Qualifications of providers:

• Targeted service coordination must only be provided by a service coordination agency enrolled as a Medicaid provider. 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.

• Agencies must provide supervision to all service coordinators and paraprofessionals.

• Any willing, qualified public or private service coordination agency may be enrolled.

Agency Supervisor: Education and Experience

• Master's Degree in a human services field from a nationally accredited university or college and twelve (12) months of experience with adults with developmental disabilities; or

• Bachelor's degree in a human services field from a nationally accredited university or college, or being a licensed professional nurse (RN) with twenty-four (24) months of experience with adults with developmental disabilities.

Service Coordinator: Education and Experience

• Minimum of a Bachelor's Degree in a human services field from a nationally accredited university or college and twelve (12) months of experience working with adults with developmental disabilities, or being a licensed professional nurse (RN) with twelve (12) months of experience working with adults with developmental disabilities. Individuals who meet the education or licensing requirements, but do not have the required work experience, may work as a service coordinator under the supervision of a qualified service coordinator while they gain this experience.

Paraprofessional: Education and Experience

• Be at least eighteen (18) years of age, have a minimum of a high school diploma (or equivalency), be able to read and write at a level commensurate with the paperwork and forms involved in the provision of the service, and have twelve (12) months of experience with adults with developmental disabilities. Under the supervision of a qualified service coordinator, a paraprofessional may be used to assist in the implementation of the service plan.

Freedom of choice: The State assures that the provision of targeted service coordination will not restrict a participant's free choice of providers in violation of section 1902(a)(23) of the Act. Any willing, qualified private agency may be enrolled as a service coordination agency.

• Participants will have free choice of the providers of targeted service coordination within the specified geographic area identified in this plan.

• Participants will have free choice of the providers of other medical care under the plan. Access to Services: The State assures that:

• Targeted service coordination will be provided in a manner consistent with the best interests of recipients and will not be used to restrict a participant's access to other services under the plan; [section 1902 (a)(19)]

• Participants will not be compelled to receive targeted service coordination, condition receipt of targeted service coordination on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of targeted service coordination; [section 1902 (a)(19)]

• Providers of targeted service coordination do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):

Payment for targeted service coordination under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records: The State assures that providers maintain case records that document the following for all participants receiving targeted service coordination [42 CFR 441.18(a)(7)]:

• The name of the participant.

• The dates of the targeted service coordination services.

• The name of the provider agency and the person providing the targeted service coordination.

• The nature, content, and units of the targeted service coordination services received, and whether goals specified in the care plan have been achieved.

• Whether the participant has declined services in the care plan.

• The need for, and occurrences of, coordination with other service coordinators.

• A timeline for obtaining needed services.

• A timeline for reevaluation of the plan.

Limitations:

Targeted service coordination does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the targeted service coordination activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) §4302). Targeted service coordination does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the targeted service coordination activities constitute the direct delivery of underlying medical, educational, social, or other services to which a participant has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; and making placement arrangements. (42 CFR 441.18(c))

FFP is only available for targeted service coordination if there are no other third parties liable to pay for such services, including reimbursement under a medical, social, educational, or other program except for targeted service coordination that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

Additional limitations:

• Reimbursement for ongoing service coordination is not allowed prior to the completion of the assessment and service plan.

• In order to assure that no conflict of interest exists, providers of targeted service coordination may not provide both service coordination and direct services to the same Medicaid participant.

• Reimbursement is not allowed for missed appointments, attempted contacts, leaving messages, travel to provide the service, documenting services, or transporting the participant.