



BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

# IDAHO DEPARTMENT OF HEALTH & WELFARE

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

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Amanda Hill  
Center for Medicaid and CHIP Services (CMCS)  
[Amanda.Hill@cms.hhs.gov](mailto:Amanda.Hill@cms.hhs.gov)

Dear Ms. Hill:

Below please find the state's update for CMS on the Home and Community Based Settings Rule.

Description of how the state's oversight systems (licensure and certification standards, provider manuals, person-centered plan monitoring by case managers, etc.) have been modified to embed the regulatory criteria into ongoing operations;

Idaho has implemented the HCBS Settings Final Rule standards pertaining to setting qualities and person-centered planning into our oversight systems in various ways.

### **Idaho Administrative Code (IDAPA) Rule Promulgation**

Idaho codified HCBS setting qualities and person-centered service plan and planning requirements into administrative code under [16.03.10, "Medicaid Enhanced Plan Benefits," subsections 310-318](#). Administrative rules were promulgated over the course of 2015 with stakeholder engagement sessions, including negotiated rulemaking and public hearings. Rules were presented to the 2016 Idaho legislature and implemented effective July 1, 2017.

### **Person-Centered Service Plan Templates**

Additional fields have been added to several documents produced by the state, including service plan templates, to ensure that new required elements are not overlooked. This includes areas to document risks and interventions, participant strengths and preferences, and individually identified goals and desired outcomes. Other required service plan elements were already in place prior to the implementation of the HCBS Settings Final Rule.

### **Provider Training Materials**

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

### **Internal Policies and Procedures**

State documents have been updated to include new regulatory criteria:

- Process manuals for conducting provider audits and supplemental tools have been modified to include a review of setting qualities and person-centered service planning compliance (as applicable to the provider type/service type).
- Complaint and critical incident management systems have been modified to include a category specific to HCBS setting qualities and service plan-related issues. Regular trend monitoring activities have been updated to include oversight of these regulatory criteria.
- Onboarding processes and training materials for new state staff have been updated to include orientation to the HCBS regulatory requirements and associated job-specific tasks.

**Description of how the state assesses providers for initial compliance and conducts ongoing monitoring for continued compliance; and**

Below is an excerpt from Idaho's approved Statewide Transition Plan describing our processes for determining initial compliance for new Medicaid HCBS providers and monitoring continued compliance by established providers.

To ensure providers' continued compliance with the state's rules and federal regulations, Idaho has implemented robust ongoing monitoring activities for all HCBS settings. The ongoing monitoring activities are outlined by bureau below. Monitoring is in place to ensure HCBS settings are following state rules and allow for integration and choice in the setting where individuals access HCBS. Person-Centered Planning processes have been strengthened to ensure that participants and their decision-making authority have a choice of when and where their services are received.

State rules address the number of provider locations for services, participant complaints and critical incidents, and program quality to monitor emerging patterns. Further, the state has updated review templates and provider enrollment processes to include HCBS rules. This assures that each new HCBS provider is aware of the rules and expectations with regard to the HCBS services they provide. Quality Assurance Specialists have been trained to offer collaboration to non-compliant providers, in the form of technical assistance, onsite meetings, or other methods as defined by the Department. Collaboration is used to provide insight and training to providers.

During the intake and eligibility process for HCBS waiver programs in Idaho, participants are given a provider list that includes all regional providers that render the service type(s) they are seeking. This affords each participant the opportunity to evaluate all service provider options, not just providers that tailor to a specific disability or population.

Implementation of ongoing quality assurance activities began in January 2017. Those activities include:

- Existing participant feedback mechanisms have been modified to include targeted questions about HCBS compliance in the participant's service setting. There are three tools used at Medicaid:

- The Children’s Service Outcome Review (CSOR) which is used to assess services provided to Children’s DD waiver and Act Early waiver participants.
- The Adult Service Outcome Review (ASOR) which is used to assess services provided to Adult DD waiver participants.
- The Quality Survey, which is used to assess services provided to A&D waiver and State Plan Personal Care Services participants.
- Existing Provider Quality Review processes have been modified to include components specific to HCBS compliance.
- Existing complaint and critical incident tracking and resolution processes have been modified to include an HCBS setting quality category.
- Licensing and Certification staff will assess compliance with all HCBS requirements when completing their routine surveys of Certified Family Homes (CFHs), Developmental Disability Agencies (DDAs), Residential Assisted Living Facilities (RALFs), and private homes. They will continue to cite on requirements that are included in their rules. If the Division of Licensing and Certification does not have rule support to remediate a potential violation, they will identify the potential violation through their assessment activity and notify the appropriate Medicaid Bureau's Quality Assurance Manager. That Bureau's Quality Assurance Manager will assign a Quality Assurance Specialist to review, investigate, and document the potential violation in the same manner as a complaint.
- Ongoing monitoring activities will occur in all settings where HCBS services occur, including individual’s private homes where HCBS services are delivered. Monitoring activities in private homes include: outcome reviews, agency reviews, and follow up with complaint and critical incident reporting.

Ongoing issues or trends are captured and reported in regular program performance reporting.

The table below provides an overview of ongoing monitoring activities implemented by the state. Immediately following is a summary of how each responsible entity uses each data source to monitor HCBS compliance.

<b>Responsible Entity</b>			
<b>Data Source</b>	<b>Bureau of Developmental Disability Services</b>	<b>Bureau of Long Term Care</b>	<b>Division of Family and Community Services</b>
Licensing and Certification	X	X	*
Participant Feedback Mechanisms	X	X	X
Provider Reviews	X	X	X
Complaints and Critical Incidents	X	X	X
Provider Enrollment	X	X	X
Service Plan Review	X	X	*
Other		X	

\*The Division of Family and Community Services receives information from these sources via the Complaint and Critical Incident process

## **Bureau of Developmental Disability Services (BDDS)**

### **Licensing and Certification**

- Licensing and Certification surveys DDAs, CFHs and Supported Living agencies.
- Licensing and Certification reviews the following HCBS regulations: integration and access, selection of setting, participant rights, autonomy and independence, choice, written agreement, privacy, schedules and activities, access to food, visitors, and physical accessibility.
- Surveys are completed every six months to three years, depending on provider type and status.

### **Participant Feedback Mechanisms**

- BDDS QA/QI staff conduct an Adult Services Outcome Review (ASOR) yearly with a sample of program participants to assess the delivery of adult developmental disabilities services. To conduct an ASOR, QA/QI staff complete a file record review and interview the participant and their decision-making authority. Interviews may also be completed with plan developers and other paid or non-paid supports.
- If compliance issues are identified, BDDS QA/QI staff proceed with: education, technical assistance, or issue a Request for Corrective Action.
- The ASOR Templates and Instruction Manual were revised in 2018 to incorporate HCBS requirements.

### **Provider Reviews**

- BDDS completes provider agency reviews on the following provider types: Adult Day Health, DDAs, Chore services, Home Delivered Meals, Durable Medical Equipment providers, Supported Living, Respite Care, Non-Medical Transportation, Supported Employment, Nursing Services, Behavioral Consultation/Crisis Management, and Financial Management Services.
- Provider reviews are completed every six months to three years, depending on provider type and status.
- Provider review and instruction templates have been revised to incorporate HCBS requirements. Provider reviews may include a review of:
  - Policies and procedures.
  - Service delivery documentation, such as progress notes, service plans, and implementation plans.
  - Staff records, such as training records, criminal history background checks, and performance reviews.

### **Complaints and Critical Incidents**

- Complaints and critical incidents are received from a variety of sources including: participant/ guardian/ service provider input, Licensing and Certification referrals, external stakeholder referrals, health and safety reports, program integrity, or law enforcement.

- The complaint and critical incident database includes an indicator for potential violations of HCBS setting quality requirements.
- BDDS will follow established internal review and remediation processes regarding HCBS violations.

### **Provider Enrollment**

- Prior to approval of new enrollment applications, BDDS evaluates HCBS compliance for the following provider types: Adult Day Health, CFHs, DDAs, Supported Living, Supported Employment, Nursing Services, Respite Services, and Behavioral Consultation/Crisis Management.
- Documents reviewed prior to approval as a Medicaid HCBS provider include:
  - Provider application
  - Template notices, including privacy, confidentiality, termination, etc.
  - Template intake packets
  - Policies and procedures

### **Service Plan Review**

- BDDS Care Managers review all service plans prior to authorization and annually thereafter to ensure that **only** HCBS-compliant settings are selected for identified services.
- The person-centered service plan template has been modified to include all HCBS person-centered planning requirements. BDDS Care Managers ensure that all components are completed accurately.
- BDDS Care Managers ensure all services and settings are chosen by the participant or their decision-making authority as evidenced by their signature on the person-centered service plan. Service providers also sign the plan acknowledging they will deliver services according to the authorized plan of service and consistent with HCBS requirements.
- BDDS has an established process for reviewing requests for exceptions to provider owned or controlled residential setting qualities.

### **Bureau of Long Term Care (BLTC)**

#### **Licensing and Certification**

- Licensing and Certification surveys CFHs, RALFs, and Supported Living Agencies.
- Licensing and Certification reviews the following HCBS regulations: integration and access, selection of setting, participant rights, autonomy and independence, choice, written agreement, privacy, schedules and activities, access to food, visitors, and physical accessibility.
- Surveys are completed every six months to three years, depending on provider type and status.

#### **Participant Feedback Mechanisms**

- A Quality Survey is conducted as part of the initial and annual redetermination assessment process for all participants served under BLTC Programs. The Quality Survey includes questions specific to HCBS setting qualities and service delivery. Questions are asked of the participant or his or her decision-making authority.

- If compliance issues are identified, BLTC QA/QI are notified via an automated system and proceed with: education, technical assistance, or issue a Request for Corrective Action.

### **Provider Reviews**

- The BLTC completes provider agency reviews on the following provider types: Adult Day Health, Home-Delivered Meals, Personal Emergency Response Systems, and Personal Assistance Agencies.
- BLTC provider reviews are completed every six months to two years, depending on provider type and status.
- The BLTC Provider Review SharePoint has been revised to incorporate HCBS requirements. Provider reviews may include a review of:
  - Policies and procedures.
  - Service delivery documentation, such as progress notes, service plans, and implementation plans.
  - Staff records, such as training records, criminal history background checks, and performance reviews.

### **Complaints and Critical Incidents**

- Complaints and critical incidents are received from a variety of sources including: participant/ guardian/ service provider input, Licensing and Certification referrals, external stakeholder referrals, health and safety reports, program integrity, or law enforcement.
- The complaint and critical incident database includes an indicator for potential violations of HCBS setting quality requirements.
- BLTC will follow established internal review and remediation processes regarding HCBS violations.

### **Provider Enrollment**

- Prior to approval of new enrollment applications, BLTC evaluates HCBS compliance for the following provider types: Adult Day Health, Personal Assistance Agencies, and RALFs.
- Documents reviewed prior to approval as a Medicaid HCBS provider include:
  - Provider application
  - Template notices, including privacy, confidentiality, termination, etc.
  - Template intake packets
  - Policies and procedures

### **Service Plan Review**

- The BLTC support staff validate provider compliance status prior to keying authorizations for services identified on the service plan.
- The Assessment and Certification Tool, which generates the initial participant service plan, has been modified to include all HCBS person-centered planning requirements. BLTC Nurse Managers ensure that all components are completed accurately.
- The BLTC Nurse Reviewers ensure all services and settings are chosen by the participant or their decision-making authority as evidenced by their signature on the Service and Provider Choice Form and individual service plan. Service providers also

sign the plan acknowledging they will deliver services according to the authorized plan of service and consistent with HCBS requirements.

- The BLTC has an established process for reviewing requests for exceptions to provider owned or controlled residential setting qualities.

#### **Other**

- The BLTC Nurse Reviewers conduct annual redetermination assessments face-to-face with A&D waiver and PCS participants. Staff have been trained to identify potential violations of HCBS setting quality requirements while in the participant's residence and document via the Assessment and Certification Tool. Reports of potential violations are routed to BLTC QA/QI staff for investigation and follow-up.

### **Division of Family and Community Services (FACS)**

#### **Licensing and Certification**

- Licensing and Certification surveys DDAs.
- Licensing and Certification reviews the following HCBS regulations: integration and access, selection of setting, participant rights, autonomy and independence and choice.
- Surveys are completed every six months to three years, depending on provider type and status.

#### **Participant Feedback Mechanisms**

- The Division of Family and Community Services QA/QI staff conduct Children's Services Outcome Reviews (CSOR) yearly with a sample of program participants to assess the delivery of children's developmental disabilities services. To conduct a CSOR, QA/QI staff complete a file record review, interview the parent/guardian/decision-making authority and participant (if possible), and complete an observation of the child while they are receiving services.
- If compliance issues are identified, FACS QA/QI staff proceed with: education, technical assistance, or issue a Request for Corrective Action.
- The CSOR templates have been revised to incorporate HCBS requirements.

#### **Provider Reviews**

- The Division of Family and Community Services completes HCBS provider agency reviews for DDAs that exclusively serve children.
- Home and Community-Based provider reviews are completed every six months to three years, depending on provider type and status.
- Provider review and instruction templates have been revised to incorporate HCBS requirements. HCBS provider reviews may include a review of:
  - Policies and procedures.
  - Service delivery documentation, such as progress notes, service plans, and implementation plans.

#### **Complaints and Critical Incidents**

- Complaints and critical incidents are received from a variety of sources including: participant/ guardian/ service provider input, Licensing and Certification referrals,

external stakeholder referrals, health and safety reports, program integrity, or law enforcement.

- The complaint and critical incident database includes an indicator for potential violations of HCBS setting quality requirements.
- The Division of Family and Community Services will follow established internal review and remediation processes regarding HCBS violations.

### **Provider Enrollment**

- Prior to approval of new enrollment applications, FACS will evaluate HCBS compliance for the following provider types: DDAs providing services to children, and Independent Therapeutic Consultation and Respite.
- Documents reviewed prior to approval as a Medicaid HCBS provider include:
  - Provider application
  - Policies and procedures
  - Acknowledgement of HCBS requirements

### **Service Plan Review**

- The FACS Case Managers develop all service plans and ensure that **only** HCBS-compliant settings are selected for identified services.
- The person-centered service plan template has been modified to include all HCBS person-centered planning requirements. The FACS Case Managers ensure that all components are completed accurately.
- The FACS Case Managers ensure all services and settings are chosen by the participant or their decision-making authority as evidenced by their signature on the person-centered service plan. Service providers also sign the plan acknowledging they will deliver services according to the authorized plan of service and consistent with HCBS requirements.
- The FACS Case Managers have been trained on all HCBS requirements. If a potential HCBS violation is identified they will refer the provider to the Complaint and Critical Incident process. QA/QI staff will follow up on any referrals as needed.

### **Description of a beneficiary's recourse to notify the state of provider non-compliance (grievance process, notification of case manager, etc.) and how the state will address beneficiary feedback.**

All Idaho HCBS programs, regardless of the administering business unit, operate a complaint and critical incident management system. Participants may notify the state of provider non-compliance in several ways, including:

- Contacting their targeted service coordinator or care coordinator
- Calling or emailing state staff directly
- Reporting a problem during a participant experience survey
- Reporting a problem during a redetermination assessment
- Submitting a complaint or critical incident directly to the state via each program's general complaint intake or via the web-based portal at <http://medicaidcomplaints.dhw.idaho.gov>



The state also launched an outreach effort to ensure participants were not only aware of their rights under the HCBS Settings Final Rule, but also understood how to report possible issues. This outreach effort included a one-page "These are My Rights" flyer, updated program brochures, and a magnet with state contact information (a toll-free telephone number and a website URL) and our "Report it, Don't Ignore it!" slogan developed to encourage participants and guardians/advocates to report potential concerns to the state.

When a potential compliance issue is reported to the state, the respective QA/QI staff research the referral by gathering additional information from the participant if needed and then contacting the provider to request information related to the complaint. Information requested may include, but is not limited to: agency policies and procedures, progress note documentation, admission agreement documents, HCBS setting exception documentation (when applicable), photographs of settings, or other information. The state reserves the right to conduct unannounced site visits when egregious or repeated compliance issues are reported and may conduct a visit prior to requesting additional information pertaining to the complaint.

In instances where the complaint is substantiated and the provider determined to be out of compliance, QA/QI staff will require remediation. This may include a full targeted provider audit, informal remediation of an isolated incident, or a formal Request for Corrective Action. If a provider fails to come into compliance, the state will take progressive enforcement actions against the provider's Medicaid Provider Agreement. Enforcement actions available to the state are:

- Limiting the provider from serving new participants until the provider is in compliance.
- Suspending Medicaid payments until the provider is in compliance.
- Terminating the provider's Medicaid agreement.

Idaho has established processes for supporting participants in transitioning to new HCBS providers when a provider agreement is terminated. This includes outreach to affected participants and support via a targeted service coordinator, support broker, or care coordinator to identify and transition to a compliant provider.

Idaho appreciates your review of this. Please direct any questions to Angie Holick at [Angie.Holick@dhw.idaho.gov](mailto:Angie.Holick@dhw.idaho.gov).



JULIET CHARRON  
Administrator

JC/db

cc: Courtenay Savage, Amanda Hill