Table of Contents

State/Territory Name: Idaho

State Plan Amendment (SPA) #: 12-014

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
2201 6th Avenue, Mailstop RX-43
Seattle, Washington 98121

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Division of Medicaid & Children's Health Operations

SEP 18 2013

Richard Armstrong, Director
Department of Health and Welfare
Towers Building – Tenth Floor
Post Office Box 83720
Boise, Idaho 83720-0036

RE: Idaho State Plan Amendment (SPA) 12-014

Dear Mr. Armstrong:

The Centers for Medicare & Medicaid Services (CMS) Seattle Regional Office has completed its review of SPA Transmittal Number 12-014. This SPA amends Idaho's current 1915(i) State plan benefit by adding clarifying language regarding the specific services available to eligible participants. In addition, this SPA adds language to indicate that as of June 30, 2013, Adult Developmental Therapy (DT), and Adult Community Crisis Support Services have sunset in Idaho's Basic and Enhanced Benchmark Benefit plans. This state action finalizes the last piece of Idaho's intent to rescind its OBRA '89 status which allowed the state to provide "habilitative" services under the Section 1905(a) rehabilitation benefit.

This SPA is approved with an effective date of July 1, 2013.

Since the state has elected to target the population who can receive Section 1915(i) State plan HCBS, CMS approves this SPA for a five-year period, in accordance with Section 1915(i) (7) of the Act. Idaho will be able to renew this SPA for an additional five-year period if CMS determines, prior to the beginning of the renewal period, that the state met federal and state requirements and that the state's monitoring is in accordance with the quality improvement strategy specified in Idaho's approved SPA.

Upon publication of the final regulations for Section 1915(i) State plan HCBS, Idaho will need to evaluate their 1915(i) state plan section and revise it as necessary to comply with any requirements imposed by the final regulations not already met by the state.

The CMS appreciates the efforts and cooperation of state staff throughout the review process. If you have any additional questions or require further assistance, please contact me, or have your staff contact Jessica Terry at (206) 615-2358 or mailto:jessica.terry@cms.hhs.gov.

Sincerely,

[redacted]

Carol J.C. Peverly
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc:
Paul Leary, Medicaid Administrator, Division of Medicaid
David Simnitt, Deputy Administrator, Division of Medicaid

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **12-014**

2. STATE: IDAHO

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2013

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN **X** AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 6086 of the Deficit Reduction Act of 2005, and Section 2402(b) through 2402(f) of the Affordable Care Act

7. FEDERAL BUDGET IMPACT:
FFY 2013 $0 (zero dollars)
FFY 2014 $0 (zero dollars)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A Supplement 2, pages ~~1-27 (new)~~ 1-29 New
Attachment 2.2-A, page 23f New ((P&I)
Attachment 4.19-B, Page 43a new

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
None – new pages

10. SUBJECT OF AMENDMENT:
Add 1915(i) State Plan HCBS benefit for adults with developmental disabilities

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

[redacted]

13. TYPED NAME:
PAUL J. LEARY

14. TITLE:
Administrator

15. DATE SUBMITTED: 12-26-12

16. RETURN TO:

Paul J. Leary, Administrator
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 83720
Boise ID 83720-0009

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 26, 2012

18. DATE APPROVED:
September 18, 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2013

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Carol J.C. Peverly

22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health

23. REMARKS:

07/03/2013 State authorizes P&I change to box 8
07/26/2013 State authorizes P&I change to box 8

FORM HCFA-179 (07-92)

Groups Covered
Optional Groups other than the Medically Needy

☒ In addition to providing HCBS State plan services to individuals described in 1915(i)(l), the State is **also** covering the optional categorically needy eligibility group of individuals under 1902(a)(10)(A)(ii)(XXII) who are eligible for home and community-based services under the needs based criteria established under 1915(i)(l)(A) and have income that does not exceed 150% of the FPL or who are eligible for home and community based services under a waiver approved for the State under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate (select at least one).

☐ The State covers all of the individuals described in item l(a) and (b) as described below (Complete l(a) and l(b)).

☒ The State covers only the following group individuals described below (complete l(a) or l(b)):

1.(a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services.

Income Standard Methodology used (Select one)

☐ 150% FPL

☐ SSI

☐ OTHER (describe):

NA

For States that have elected the SSI methodology, the State uses the following less restrictive 1902(r)(2) income disregards for this group. There is no resource test for this group. (specify):

NA

l.(b) ☒ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate. For individuals eligible for 1915(c), (d) or (e) waiver services, this amount must be the same amount as the income standard specified under your State plan for the special income level group. For individuals eligible for 1915(c) like services under an approved 1115, this amount must be the same as the amount of the income standard used for individuals using institutional rules. (Select one):

☒ 300% of the SSI/FBR

☐ (Specify)____% Less than 300% of the SSI/FBR

The state uses the same eligibility criteria that it uses for the special income level group.

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 Habilitation

For health professionals authorized to administer developmental disability services, the statewide reimbursement rate for developmental disability services was derived by using Bureau of Labor Statistics mean wage for the direct care staff. This rate was then adjusted for employment related expenditures and indirect general and administrative costs (which includes program related costs and are based on surveyed data).

Reimbursement rates for these services are set at a percentage of the statewide target reimbursement rate described above.

The following CPT codes represent the service codes paid for Developmental Therapy and Community Crisis Supports.

Code	Description	Rate of Reimbursement
97537	Development Therapy in Home or Community (per 15 min.)	$ 3.34
H2032	Development Therapy in Center (per 15 min.)	$ 3.02
H2011	Community Crisis Support (per 15 minute)	$11.35

Supplement 2 to Attachment 3.1-A, Program Description

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 to add as set forth below:

1. **Services.** *(Specify service title(s) for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Adult -Developmental Therapy Adult – Community Crisis Supports

2. **State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit.** *(Select one)*:

○	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	☒	The Medical Assistance Unit *(name of unit)*:	Bureau of Developmental Disability Services
	○	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	
○	The State plan HCBS benefit is operated by *(name of agency)*		
	A separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

Supplement 2 to Attachment 3.1-A, Program Description

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):

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

Supplement 2 to Attachment 3.1-A, Program Description

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

5. ☒ **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
   - related by blood or marriage to the individual, or any paid caregiver of the individual
   - financially responsible for the individual
   - empowered to make financial or health-related decisions on behalf of the individual
   - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

N/A

6. ☒ **Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☒ **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☒ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
   (Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	July 1, 2013	June 30, 2014	2732
Year 2	July 1, 2014	June 30, 2015	2841
Year 3	July 1, 2015	June 30, 2016	2884
Year 4	July 1, 2016	June 30, 2017	2929
Year 5	July 1, 2017	June 30, 2018	2973

2. ☒ **Annual Reporting.** *(By checking this box the State agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☒ **Medicaid Eligible.** *(By checking this box the State assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Level (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(l0)(A)(ii)(XXII) of the Social Security Act.)

2. Income Limits.

☒ In addition to providing HCBS State plan services to individuals described in item 1 above the State is **also** covering the optional categorically needy eligibility group of individuals under 1902(a)(l0)(A)(ii)(XXII) who are eligible for home and community-based services under the needs based criteria established under 1915(i)(l)(A) and have income that does not exceed 150% of the federal poverty level or who are eligible for home and community based services under a waiver approved for the State under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate (as described in Attachment 2.2A, pages 23(f) of the state plan.).

☐ The State covers all individuals described in items 2(a) and 2(b) as described in Attachment 2.2-A, of the state plan

☒ The State covers only the following group individuals described below (complete 2(a) or 2(b)): As specified in Attachment 2.2-A of the state plan.

2.(a) ☐ Individuals not otherwise eligible for Medicaid who meets the needs based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services.

2(b) ☒ Individuals who would meet the criteria for a 1915(c) or 1115 waiver. The State covers all of the individuals described in item 1(b) as specified in Attachment 2.2A of the state plan.

☒ Specify the 1915(c) Waiver/Waivers CMS Base Control Number/Numbers for which the individual would be eligible:

Idaho Developmental Disabilities Waiver. Waiver Number ID.0076

Specify the name(s) or number(s) of the 1115 waiver(s) for which the individual would be eligible:

NA

3. Medically Needy. *(Select one):*

☒	The State does not provide State plan HCBS to the medically needy.	
○	The State provides State plan HCBS to the medically needy *(select one):*	
	○	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
	○	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

1. Responsibility for Performing Evaluations / Reevaluations. Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*select one*):

○	Directly by the Medicaid agency
☒	By Other (*specify State agency or entity with contract with the State Medicaid agency*):
	The Department's contracted Independent Assessment Provider, Idaho Center for Disabilities Evaluation (ICDE)

2. Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

Independent Assessment Providers who provide level of care determinations must be a Qualified Intellectual Disability Professionals (QIDP) who meets qualifications specified in the Code of Federal Regulations, Title 42 section 483.430.

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) 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.

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 contractor, Idaho Center for Disabilities Evaluation (ICDE), to determine if the participant meets Needs-based HCBS Eligibility Criteria.

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

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

b. ICDE contacts the participant's person-centered planning (PCP) team to identify who will serve as a respondent for the initial eligibility assessments to be completed by ICDE. The PCP team is responsible for identifying a respondent who has knowledge about the participant's current level of functioning. The participant is required to accompany the respondent to a face-to-face meeting with ICDE to complete the initial eligibility assessment process.

c. During the face-to-face meeting with ICDE, the respondent for the participant will participate in completing the Scales of Independent Behavior Revised (SIB-R) and Medical, Social, Developmental Assessment Summary. These assessments, in addition to other required documentation, are used to verify Needs-based HCBS Eligibility Criteria:

d. At the time of the face-to-face meeting, ICDE 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 person's disability.

e. ICDE communicates eligibility determinations and calculated budgets to the participant/guardian through a written Notice of Decision. Participants/guardians who do not agree with a decision regarding eligibility or the calculated budget may request an administrative hearing.

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

Supplement 2 to Attachment 3.1-A, Program Description

PROCESS FOR ANNUAL REEVALUATION

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

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

- If a change in the participant's income results in the termination of Medicaid financial eligibility, claims submitted for reimbursement by providers after the date of ineligibility will not be paid. Medicaid providers are required to verify participant eligibility prior to providing services as approved on the annual Individual Service Plan (ISP).

- ICDE is only required to complete a new SIB-R assessment or update the Medical, Social, Developmental Assessment Summary when it is determined that the existing documentation does not accurately describe the current status of the participant. ICDE will make a clinical determination regarding the need for a new/updated assessment based on information provided at the annual eligibility determination by a respondent selected by the participant's person-centered planning (PCP) team. This respondent is someone the participant and their person-centered planning team have identified as the person who is most qualified to provide current information regarding the participant's medical, functional, and behavioral needs.

- 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 Independent Assessment Provider (IAP) completing the annual eligibility assessment.

- 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. If the participant and their PCP team disagree with any of the responses contained on the Inventory, the participant is afforded the opportunity to appeal the responses through an administrative hearing process.

Supplement 2 to Attachment 3.1-A, Program Description

4. ☒ **Needs-based HCBS Eligibility Criteria.** (By checking this box the State assures that): Needs-based criteria are used to evaluate and reevaluate whether an adult individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

- 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;
- 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.

5. ☒ **Target Group(s).** Under the waiver of Section 1902 (a) (10)(B) of the Act, the State limits this section of 1915(i) state plan options services to a group or subgroups of individuals:

Adult participants age 18 or older diagnosed with Developmental Disabilities as defined in Idaho Code Section 66-402.

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 participant 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/ID (&ICF/ID LOC Waivers)	Applicable Hospital* LOC (& 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 State uses criteria defined in 42 CFR 440.10 for inpatient hospital services.

Supplement 2 to Attachment 3.1-A, Program Description

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.	In determining need for nursing facility care an adult must require the level of assistance according to the following formula: **Critical Indicator - 12 Points Each.** a. Total assistance with preparing or eating meals. b. Total or extensive assistance in toileting. c. Total or extensive assistance with medications which require decision making prior to taking, or assessment of efficacy after taking. **High Indicator - 6 Points Each.** a. Extensive assistance with preparing or eating meals. b. Total or extensive assistance with routine medications. c. Total, extensive or moderate assistance with transferring. d. Total or extensive assistance with mobility. e. Total or extensive assistance with personal hygiene. f. Total assistance with supervision from Section II of the Uniform Assessment Instrument (UAI). **Medium Indicator - 3 Points Each**. a. Moderate assistance with personal hygiene. b. Moderate assistance with preparing or eating meals. c. Moderate assistance with mobility. d. Moderate assistance with medications. e. Moderate assistance with toileting. f. Total, extensive, or moderate assistance with dressing. g. Total, extensive or moderate assistance with bathing. h. Extensive or moderate assistance with supervision from Section II No. 18 of the UAI.	The individual must require a 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 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 SIB-R would qualify; or Persons may qualify based on their Maladaptive Behaviors: • A minus twenty-two (-22) or below score. Individuals may qualify for ICF/ID level of care based on maladaptive behavior. Adults will be eligible if their general Maladaptive index on the SIB-R or subsequent revision is minus twenty-two (-22) or less • Above a Minus twenty-two (-22) score. Individuals who score above minus twenty-two (-22) may qualify for ICF/ID level of care if they engage in aggressive or self-injurious behaviors of such intensity that the behavior seriously endangers the safety of the individual or others, the behavior is directly related to developmental disability, and the person requires active treatment to control or decrease the behavior; or 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. For persons Sixteen Years of Age of Older 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 from minus seventeen (-17), up to minus twenty-two (-22) inclusive; or	

		Persons may qualify based on a 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.	

7. ☒ **Reevaluation Schedule**. Needs-based eligibility reevaluations are conducted at least every twelve months.

8. ☒**Adjustment Authority**. The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

Supplement 2 to Attachment 3.1-A, Program Description

9. **Residence in home or community**. The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State plan HCBS:
   (i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or
   (ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State. *(If applicable, specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):*

Home and Community Based Services (HCBS) are designed to allow participants with developmental disabilities to live in home or community settings. Idaho makes these services available to eligible participants in order to provide for the greatest degree of independence possible, enhance the quality of life, encourage individual choice, maintain health and safety and promote community integration

Prior to receiving State plan HCBS benefits, the Department or its contractor must verify that the participant resides in the community. As outlined in Idaho Statute and IDAPA, community residential service providers are required to facilitate the individual's full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, in the same manner as individuals without disabilities.

Residential settings, other than an individual's home/apartment or the home/apartment of a non-paid care provider, that will be approved as community living include:

- Certified Family Home (CFH)
  - A CFH is a private home setting in which a home care provider assists the participant with activities of daily living, provides protection and security, and encourages the participant toward independence. CFHs must assist the individual with establishing relationships and connecting with their community,
  - The Department monitors Certified Family Homes through the certification process described in Idaho Administrative Code. Certification for CFHs is required the year after the initial home certification study and at least every 24 months thereafter.

- Residential Assisted Living Facility (RALF)
  - A RALF is a community-based facility which provides a home-like environment that includes full access to amenities typically available in a home. A RALF must be of such character as to enhance normalization and integration of residents into the community.
  - The Department monitors RALFs through the certification process described in Idaho Administrative Code. Certification for RALFs is required within 90 days from the initial licensure followed by a survey within 15 months. Facilities receiving no core issue deficiencies during both the initial and the subsequent survey will enter a three year survey cycle.

Supplement 2 to Attachment 3.1-A, Program Description

Idaho Statute requires that Certified Family Homes and Residential Assisted Living Facilities provide a safe and homelike environment within a participant's own community. Statute requires that these homelike environments must:

- focus on integrated community living and recognize the capabilities of individuals to direct their own care.
- allow residents the opportunity to work, be involved in recreation activities and education opportunities.
- ensure that employment, recreational and educational opportunities for people with disabilities shall be offered in the most integrated setting consistent with their needs

Idaho requires that all Home and Community Based setting qualities in Certified Family Homes and Residential Assisted Living Facilities are met including:

- the participant's ability to manage their personal funds
- participation in social, religious, and community activities
- participant control of their health-related services
- participant participation in the person centered planning process including making decisions related to employment and work in competitive integrated settings
- an individual's choice and control regarding daily living activities
- the ability to personalize his/her environment
- individual choice of who and when they wish to communicate and interact
- choice of roommates when sharing units or bedrooms
- an individual's right to being treated with dignity and respect
- right to privacy (with regard to accommodations, medical and other treatment, written and telephone communications, visits and meetings of family and resident groups)
- the right to be free from coercion, restraints, restrictive interventions, and seclusion
- the right to privacy in the sleeping or living unit including lockable doors, with appropriate person(s) having keys

In the case of CFH and RALF providers, specific physical space can be owned, rented or occupied under another enforceable agreement by the individual receiving services. Residents must be granted all rights and protections established by Idaho law. The resident has the right to written advanced notice prior to non-emergency transfer as agreed to by the resident and the provider in the admission agreement.

No provider owned or controlled residential settings identified in this SPA are:

- located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;
- located in a building on the grounds of or immediately adjacent to a public institution; or
- located in a building on the grounds of or immediately adjacent to disability-specific housing.

It is noted that Idaho will through its system of oversight and remediation resolve issues when identified. Idaho monitors that setting requirements are met through the person centered planning process, licensing and certification activities and participant experience surveys. If a rule violation is identified, action will depend on the severity. Action could range from technical assistance, a corrective action plan, or termination of a provider agreement.

Supplement 2 to Attachment 3.1-A, Program Description

Person-Centered Planning & Service Delivery

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

1. ☒ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:

- An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified;
- Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;
- An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the plan of care;
- An examination of the individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
- If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
- A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.

2. ☒ Based on the independent assessment, the individualized plan of care:

- Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
- Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
- Prevents the provision of unnecessary or inappropriate care;
- Identifies the State plan HCBS that the individual is assessed to need;
- Includes any State plan HCBS in which the individual has the option to self-direct the purchase or control ;
- Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
- Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.

3. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. *(Specify qualifications):*

At a minimum, individuals conducting the independent assessment must meet the requirements for a Qualified Intellectual Disability Professional (QIDP) in accordance with 42 CFR 483.430. QIDP requirements include:

a. Having at least (1) year experience working directly with persons with mental retardation or other developmental disabilities or;

b. Being licensed as a doctor of medicine or osteopathy, or as a nurse, or:

c. Having at least a bachelor's degree in one of the following professional categories: psychology, social work occupational therapy, speech pathology, professional recreation therapy or other related human services professions.

d. Have training and experience in completing and interpreting assessments

4. Responsibility for Plan of Care Development. There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. *(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.

- 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.
- Service coordinators must be employees or contractors of an agency that has a valid provider agreement with the Department.
- 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.
- 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.
- The total caseload of a service coordinator must assure quality service delivery and participant satisfaction.

5. **Supporting the Participant in Plan of Care Development**. 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 plan of care 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, guardians, 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 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, guardian, 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.

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.

6. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the plan of care):*

During the assessment process, participants are provided with a list, organized by geographic area, of all approved providers in the state of Idaho. The list also includes website links that provide helpful resources for participants, guardians, family and person centered team members.

In addition, participants are provided with resources on interviewing potential providers and are encouraged to contact multiple providers to identify the provider that can best meet their needs. The provider list includes a statement that the participant may choose any willing and available provider in the state.

Participants are informed that the selection of a provider is their choice and that they may choose to change providers at any time. The participant's plan developer is available to assist a participant in selecting or changing service providers at the participant's or guardian's request.

Unless the participant has a guardian with appropriate authority, the participant, together with their person centered planning team, will make decisions regarding the type and amount of services required. The service coordinator is responsible for discussing service alternatives with the participant and must document that the participant has made a free choice of direct service providers and living arrangement. Service providers must ensure that the service type and settings are based on participant needs, interests or choices.

Participants have the right to review a list of other providers that may be available to meet his needs.

Supplement 2 to Attachment 3.1-A, Program Description

7. **Process for Making Plan of Care Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

All proposed Individual Support Plans and addendums must be submitted to the Department for review, approval and prior authorization. No claims for HCBS services will be paid without prior authorization. MMIS will not reimburse claims for HCBS services unless prior authorized in the MMIS system.

Medicaid has operational processes that optimize participant independence, community integration and choice in daily living. These processes include the requirement for HCBS benefits to be requested through a participant's plan. The plan is developed by the participant through a person centered planning process and prior authorized by Medicaid. This prior authorization process is to ensure provision of services that enhance health and safety, promote participant rights, self-determination and independence according to IDAPA 16.03.10.507.

8. **Maintenance of Plan of Care Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

☒	Medicaid agency	☐	Operating agency	☐	Case manager
☒	Other (*specify):*				

Supplement 2 to Attachment 3.1-A, Program Description

Services

1. State plan HCBS: Developmental Therapy

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

- 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. 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 with no more than three (3) participants per qualified staff at each session.
- Participants living in a certified family home must not receive home-based developmental therapy in a certified family home

Supplement 2 to Attachment 3.1-A, Program Description

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 for *(chose each that applies)*:
☒ Categorically needy *(specify limits)*:
Developmental therapy benefits limitation is 22 hours per week. A legally responsible individual (e.g., a parent of minor child or a spouse) 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

Supplement 2 to Attachment 3.1-A, Program Description

2. State plan HCBS: Community Crisis Support

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Community Crisis Support
Service Definition (Scope)*:*	
Community crisis supports are interventions for adult participants who are at risk of losing housing, employment or income, or are at risk of incarceration, physical harm, family altercation or other emergencies. 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. These individualized interventions are to ensure the health and safety of the participant and may include, but are not limited to: 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, and/or emergency back-up involving the direct support of the participant in crisis. 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.	

Supplement 2 to Attachment 3.1-A, Program Description

Specify limits (if any) on the amount, duration, or scope of this service for *(chose 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. 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. A legally responsible individual (e.g., a parent of minor child or a spouse) 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):*
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

Supplement 2 to Attachment 3.1-A, Program Description

Residential Habilitation Agency		Certificate as described 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):*
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

Supplement 2 to Attachment 3.1-A, Program Description

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) how the State ensures that the provision of services by such persons is in the best interest of the individual; (c) the State's strategies for ongoing monitoring of services provided by such persons; (d) the controls to ensure that payments are made only for services rendered; and (e) 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 provided by persons who are relatives of the individual.

Legally responsible individuals or legal guardians may be paid providers of Community Crisis Supports. 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 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.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (*Select one):*

☒	The State does not offer opportunity for participant-direction of State plan HCBS.

Supplement 2 to Attachment 3.1-A, Program Description

Quality Improvement Strategy

(Describe the State's quality improvement strategy in the tables below):

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** ***(Source of Data & sample size)***	**Monitoring Responsibilities** *(What agency or entity conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of Analysis and Aggregation*
Administrative Authority						
The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the program by exercising oversight of the performance of State Plan HCBS functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.	The number and percent of remediation issues identified in the Qualified Improvement Strategy (QIS) performance reports that were followed up on and monitored through QIS reporting.	Data Source: Reports to State Medicaid Agency on delegated Administrative functions Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection/generation	Quarterly	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly
1915(i) Eligibility						
An evaluation for State Plan Home and Community Based Services (HCBS) is provided to all applicants for whom there is reasonable indication that services may be needed in the future.	Number and percent of SIB-R's completed on all applicants who request HCBS services.	Data Source: Reports to State Medicaid Agency on delegated Administrative functions Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection/generation	Quarterly	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly

	Number and Percent of initial applicants that meet the needs-based HCBS eligibility during the assessment process.	Data Source: Reports to State Medicaid Agency on delegated Administrative functions Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection/generation	Quarterly	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly
The levels of care of enrolled participants are reevaluated at least annually.	Number and percent of participants who received an annual redetermination of State Plan HCBS eligibility within 364 days of their previous eligibility evaluation.	Data Source: Reports to State Medicaid Agency on delegated Administrative functions Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection/generation	Quarterly	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly
The process and instruments described in the approved State Plan Amendment are applied appropriately and according to the approved description to determine participant State Plan HCBS eligibility.	Number and percent of sampled IAP Level of Care determinations where the needs-based State plan HCBS eligibility criteria was determined appropriately.	Data Source: Reports to State Medicaid Agency on delegated Administrative functions Sampling Approach: Representative Sample. Confidence Interval = 95%	The State Medicaid Agency is responsible for data collection/generation	Quarterly	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly
Qualified Providers						
The state verifies that providers initially and continually meet required licensure and/or certification standards including HCBS setting qualities prior to furnishing services.	Number and percent of initial State Plan HCBS providers that meet certification standards	Data Source: Provider Performance Monitoring Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection/generation .	Continuously and Ongoing	The State Medicaid Agency is responsible for data aggregation and analysis	Annually
	Number and percent of ongoing State Plan HCBS providers who met certification requirements	Data Source: Provider Performance Monitoring Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection/generation .	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	The State Medicaid Agency is responsible for data aggregation and analysis	Annually

Supplement 2 to Attachment 3.1-A, Program Description

The State monitors non-licensed/non-certified providers to assure adherence to provider standards.	Number and percent of new providers that have an initial provider review within 6 months of providing services to participants.	Data Source: Provider Performance Monitoring Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection/generation .	Continuously and Ongoing	The State Medicaid Agency is responsible for data aggregation and analysis	Annually
	Number and percent of State Plan HCBS providers who received an on-site review every two years.	Data Source: Provider Performance Monitoring Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection/generation .	Every two years	The State Medicaid Agency is responsible for data aggregation and analysis	Annually
The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved state plan amendment	Number and percent State Plan HCBS direct care staff that meet state requirements for training.	Data Source: Provider Performance Monitoring Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection.	Providers who are not certified are surveyed every two years. The Department issues certificates for certified providers that are in effect for a period of no longer than three years.	The State Medicaid Agency is responsible for data aggregation and analysis	Annually
	Number and percent of participants who have the opportunity to provide feedback to the Department regarding State Plan HCBS providers.	Data Source: Reports to State Medicaid Agency on delegated Administrative functions Sampling Approach: Representative Sample Confidence Interval = 95%	The State Medicaid Agency is responsible for data collection.	Annually	The State Medicaid Agency is responsible for data aggregation and analysis	Annually
Service Plan						
Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by State Plan HCBS service or through other means.	Number and percent of service plans reviewed who had service plans that were adequate and appropriate to their needs (including health care needs) as indicated in the assessment (s).	Data Source: Analyzed collected data Sampling Approach: Representative Sample of adult participants receiving HCBS services. Confidence Interval = 95%	The State Medicaid Agency is responsible for data collection.	Annually	The State Medicaid Agency is responsible for data aggregation and analysis	Annually

Supplement 2 to Attachment 3.1-A, Program Description

	Number and percent of service plans that address participants' goals as indicated in the assessment(s).	Data Source: Analyzed collected data Sampling Approach: Representative Sample of adult participants receiving HCBS services. Confidence Interval = 95%	The State Medicaid Agency is responsible for data collection.	Annually	The State Medicaid Agency is responsible for data aggregation and analysis	Annually
	Number and percent of participant experience/satisfaction survey respondents who reported unmet needs (or unmet need in a given ADL, IADL or other area defined by the state).	Data Source: Analyzed collected data Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection.	Annually	The State Medicaid Agency is responsible for data aggregation and analysis	Annually
The state monitors service plan development in accordance with its policies and procedures.	Number and percent of participants reviewed whose service plans had adequate and appropriate strategies to address their health and safety risks as indicated in the assessment(s).	Data Source: Analyzed collected data Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection.	Annually	The State Medicaid Agency is responsible for data aggregation and analysis	Annually
	Number and percent of service plans reviewed that were submitted to the Department prior to the expiration of the current plan of service.	Data Source: Analyzed collected data Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection.	Annually	The State Medicaid Agency is responsible for data aggregation and analysis	Annually
Service plans are updated or revised at least annually or when warranted by changes in the participant's needs.	Number and percent of service plans that are updated/ revised when warranted by changes in the State Plan HCBS participant's needs/goals.	Data Source: Analyzed collected data Sampling Approach: Representative Sample. Confidence Interval = 95%	The State Medicaid Agency is responsible for data collection.	Annually Every two years	The State Medicaid Agency is responsible for data aggregation and analysis	Annually
		Data Source: Provider Performance Monitoring Sampling Approach: During the survey process, 10% of files are reviewed to ensure plan modifications occur when needed and in a timely manner	The State Medicaid Agency is responsible for data collection.			

Supplement 2 to Attachment 3.1-A, Program Description

Services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan	Number and percent of service plans reviewed that indicate services were delivered consistent with the service type, scope, amount, duration and frequency approved on service plans.	Data Source: Analyzed collected data Sampling Approach: Representative Sample of adult participants receiving HCBS services. Confidence Interval = 95%	The State Medicaid Agency is responsible for data collection.	Annually	The State Medicaid Agency is responsible for data aggregation and analysis	Annually
		Data Source: Provider Performance Monitoring Sampling Approach: During the survey process, 10% of files are reviewed to ensure services are being delivered that are consistent with the plan.	The State Medicaid Agency is responsible for data collection.	Every two years		
Health and Welfare						
The state, on an on-going basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.	Number and percent of service plans that address potential and real risks and back up plans are in place as needed.	Data Source: Analyzed collected data Sampling Approach: Representative Sample of adult participants receiving HCBS services. Confidence Interval = 95%	The State Medicaid Agency is responsible for data collection.	Annually	The State Medicaid Agency is responsible for data aggregation and analysis	Annually
		Data Source: Provider Performance Monitoring Sampling Approach: During the survey process, 10% of files are reviewed to ensure service plans adequately address the health and welfare of participants	The State Medicaid Agency is responsible for data collection.	Every 2 years		
	Number and percent of complaints reported by participants or others	Data Source: Critical events and incident reports Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection.	Continuously and Ongoing	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly and Annually

	Number and percent of substantiated complaints	Data Source: Critical events and incident reports Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection.	Continuously and Ongoing	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly and Annually
	Number and percent of critical incidents related to abuse, neglect and exploitation	Data Source: Critical events and incident reports Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection.	Continuously and Ongoing	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly and Annually
	Number and percent of substantiated critical incidents related to abuse, neglect, and exploitation with remediation	Data Source: Critical events and incident reports Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection.	Continuously and Ongoing	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly and Annually
		Data Source: Provider Performance Monitoring Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection	Continuously and Ongoing		
	Number and percent of participant (and/or family or legal guardian) who received information/education about how to report abuse, neglect, exploitation and other critical incidents as specified in the approved waiver	Data Source: Reports to State Medicaid Agency on delegate Administrative functions Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection	Quarterly	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly
Financial Accountability						
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology.	Number and percent of demonstrated State Plan HCBS service provider's fraudulent billing patterns investigated by IDHW and action taken.	Data Source: Critical events and incident reports Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection	Continuously and Ongoing	The State Medicaid Agency is responsible for data aggregation and analysis	Annually

Supplement 2 to Attachment 3.1-A, Program Description

System Improvement: *(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)*			
Methods for Analyzing Data and Prioritizing Need for System Improvement	**Roles and Responsibilities**	**Frequency**	**Method for Evaluating Effectiveness of System Changes**
The Division of Medicaid, Bureau of Developmental Disability Services (BDDS) has a Quality Assurance Management Team. This team includes: • BDDS Bureau Chief • BDDS Quality Manager • BDDS HUB Managers • BDDS Policy Staff This team is responsible for reviewing Quality Improvement Strategy findings and analysis (including trending), formulating remediation recommendations, and identifying and addressing any statewide resource or program issues identified in QA business processes. Recommended program changes or system improvement processes are then referred to the Central Office Management Team (COMT) for review and approval. The COMT is responsible for reviewing BDDS quality improvement recommendations. The COMT prioritizes recommendations taking into consideration division wide resources, coordination issues and strategies. Based on prioritization, the COMT makes final remediation decisions and implements system wide change. The BDDS Quality Manager is responsible for leading team members and the Quality Assurance tasks for State Plan HCBS services. The Quality Manager is responsible for finalizing quarterly and yearly Quality Management reports, leading the process of prioritizing needs for system improvements, and implementing approved system improvements.	State Medicaid Agency is Responsible for Remediation Data Aggregation and Analysis	Quarterly	When the Central Office Management Team (COMT) identifies system wide changes, The BDDS Quality Assurance Management Team monitors and analyzes the effectiveness of the design change. The BDDS Quality Assurance Team comprised of BDDS Regional Quality Assurance Staff and BDDS Quality Data Analyst are responsible for implementation of quality assurance related activities as defined in the quality improvement strategy All design changes are tracked through a Continuous Quality Improvement task list. This task list identifies: • the description of a task • the implementation plan • monitoring plan • outcome Quality improvement tasks are monitored on a quarterly and annual basis and updates are given to the COMT. The Division of Medicaid's BDDS Quality Manager is responsible for the management and oversight of BDDS's QA system. These duties include: • implementation and monitoring of quality improvement strategy • training and oversight of the BDDS Quality Assurance Team • related data collection • reporting • continuous quality improvement and remediation processes and activities As part of quarterly monitoring activities, the Quality Manager evaluates the quality improvement strategy for effectiveness and recommends changes as needed.