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State/Territory Name: Idaho

State Plan Amendment (SPA) #: 17-0015

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, WA 98104

Division of Medicaid & Children's Health Operations

June 19, 2018

Russell Barron, Director
Department of Health and Welfare
Towers Building – Tenth Floor
Post Office Box 83720
Boise, ID 83720-0036

RE: Idaho State Plan Amendment (SPA) Transmittal Number 17-0015: 1915(i) Benefit, Adults with Developmental Disabilities, Renewal

Dear Mr. Barron:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of State Plan Amendment (SPA) Transmittal Number 17-0015, 1915(i) Adults with Developmental Disabilities, Benefit renewal. The SPA was submitted on December 28, 2017.

This Benefit renewal is approved with an effective date of July 1, 2018, and an expiration date of June 30, 2023.

Since the state has elected to target the population who can receive Section 1915(i) State Plan HCBS, CMS approved this SPA for a five-year period, in accordance with Section 1915(i)(7) of the Act and 42 CFR Section 441.745(a)(2)(vi)(A). To renew the 1915(i) State Plan HCBS benefit for an additional five-year period, the state must provide a written request for renewal to CMS at least 180 days prior to the end of the approval period. CMS approval of a renewal request is contingent upon state adherence to federal requirements and the state meeting its objectives with respect to quality improvement and beneficiary outcomes.

It is important to note that CMS' approval of this waiver solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

Per 42 CFR §441.745(a)(1)(i), the state will annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in the 1915(i) state plan HCBS in the previous year. Additionally, in accordance with 42 CFR §441.745(b), at least 18 months prior to the end of the five-year approval period, the state must submit to CMS a report with the results of the state's quality monitoring, including an analysis of state data, findings, any remediation, and systems improvement for each of the 1915(i) requirements in accordance with the Quality Improvement Strategy in the state's approved SPA.

Thank you for the cooperation of your staff in the approval process of this Benefit renewal. If you have any additional questions related to this matter, please contact me, or have your staff contact Elizabeth (Liz) Heintzman at elizabeth.heintzman@cms.hhs.gov or (206) 615-2596.

Sincerely,

[redacted]

Associate Regional Administrator

cc:
Matt Wimmer, Idaho Department of Health and Welfare
George Gutierrez, Idaho Department of Health and Welfare
Michael Case, Idaho Department of Health and Welfare
Karen Westbrook, Idaho Department of Health and Welfare
Ronda Kadel, Idaho Department of Health and Welfare

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: **17-0015**

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
07/01/2018

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

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:
SSA § 1915(i) / 42 CFR §§ 441.700-745 (Subpart M)

7. FEDERAL BUDGET IMPACT:
a. FFY 2018 (Q4) $3,106,005.00
b. FFY 2019 $12,796,742.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A Supplement 2 (Pages 1-66)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A Supplement 2 (Pages 1-29)

10. SUBJECT OF AMENDMENT: **5-Year Renewal of § 1915(i) State Plan HCBS for Adults with Developmental Disabilities (Attachment 3.1-A Supplement 2)**

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:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
LISA HETTINGER

14. TITLE:
Deputy Director

15. DATE SUBMITTED:

16. RETURN TO:
Lisa Hettinger, Deputy Director
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 83720
Boise ID 83720-0009

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12/28/17

18. DATE APPROVED:
6/19/18

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
7/1/18

20. SIGNATURE OF REGIONAL OFFICIAL:
Digitally signed by David L. Meacham -S
[redacted]
Date: 2018.06.19 13:21:11 -07'00'

21. TYPED NAME:
David L. Meacham

22. TITLE:
Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

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

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

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

Adult – Developmental Therapy
Adult – Community Crisis Supports

2. Concurrent Operation with Other Programs. *(Indicate whether this benefit will operate concurrently with another Medicaid authority):*

Select one:

◉	**Not applicable**
○	**Applicable**

Check the applicable authority or authorities:

☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* *(b) the geographic areas served by these plans;* *(c) the specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
☐	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*

Specify the §1915(b) authorities under which this program operates *(check each that applies)*:

☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)

☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*
☐	**A program authorized under §1115 of the Act.** *Specify the program:*

3. 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)*:	Division of Medicaid: 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.		

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

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

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

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☐	☐
2 Eligibility evaluation	☑	☐	☑	☐
3 Review of participant service plans	☑	☐	☐	☐
4 Prior authorization of State plan HCBS	☑	☐	☐	☐
5 Utilization management	☑	☐	☐	☐
6 Qualified provider enrollment	☑	☐	☐	☐
7 Execution of Medicaid provider agreement	☑	☐	☐	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
10 Quality assurance and quality improvement activities	☑	☐	☐	☐

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

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

(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 entity 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 Education 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, 2018	June 30, 2019	2,450
Year 2			
Year 3			
Year 4			
Year 5			

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 Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. 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 section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.
	☐	The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

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 under contract with the State Medicaid agency*):
	The Department's contracted Independent Assessment Provider.

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.
At a minimum, a QIDP must:
a. Have at least (1) year experience working directly with persons with intellectual disabilities or other developmental disabilities;
b. Be one of the following:
• Licensed as a doctor of medicine or osteopathy, or as a nurse; or
• Have 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; and
c. Have training and experience in completing and interpreting assessments.

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

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

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

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

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

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

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

d. At the time of the face-to-face meeting, the IAP completes an Inventory of Individual Needs with the respondent. This inventory is used to calculate an initial budget according to the participant's functional abilities, behavioral limitations, medical needs and other individual factors related to the participant's disability.

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

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

PROCESS FOR ANNUAL REEVALUATION

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

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

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

c. The IAP is only required to complete a new Department-approved functional assessment 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. The IAP will make a clinical determination regarding the need for a new/updated assessment based on information provided by the respondent during the annual face-to-face eligibility re-determination meeting. This respondent is someone the participant and their decision making authority (if applicable) have identified as the person who is most qualified to provide current information regarding the participant's medical, functional, and behavioral needs.

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

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

4. ☑ **Reevaluation Schedule.** *(By checking this box the state assures that)*: Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an 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; and

- 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.

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

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
The individual requires assistance due to substantial limitations in three or more of the following major life activities – self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self- sufficiency; and The individual has a need for combination and sequence of special interdisciplinary or generic care, treatment or other services which are of life-long or extended duration and individually planned and coordinated due to a delay in developing age appropriate skills occurring before the age of 22. (end)	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 determining need for nursing facility care an adult must require the level of assistance according to the following formula: **Critical Indicator - 12 Points Each.** a. Total assistance with preparing or eating meals. b. Total or extensive assistance in toileting. c. Total or extensive assistance with medications which require decision making prior to taking, or assessment of efficacy after taking. (con't)	In addition to being part of the Target Group described in this SPA and having substantial limitations outlined in the HCBS Needs-Based Criteria, the individual must be determined to need consistent, intense and frequent services by meeting the following criteria: The individual must require a certain level of care. Persons living in the community must require the level of care provided in an ICF/ID, including active treatment, and in the absence of available intensive alternative services in the community, would require institutionalized, other than services in an institution for mental disease, in the near future; and Persons may qualify based on their functional skills. Persons with an age equivalency composite score of eight (8) years and zero (0) months or less on the Department-approved assessment tool would qualify; or Persons may qualify based on their Maladaptive Behaviors: a. A minus twenty-two (-22) or below score. Adults will be eligible if their general Maladaptive index on the Department-approved assessment tool is minus twenty-two (-22) or less (con't)	The State uses criteria defined in 42 CFR 440.10 for inpatient hospital services. (end)

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

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
	High Indicator - 6 Points Each a. Extensive assistance with preparing or eating meals. b. Total or extensive assistance with routine medications. c. Total, extensive or moderate assistance with transferring. d. Total or extensive assistance with mobility. e. Total or extensive assistance with personal hygiene. f. Total assistance with supervision from Section II of the Uniform Assessment Instrument (UAI). **Medium Indicator - 3 Points Each.** a. Moderate assistance with personal hygiene. b. Moderate assistance with preparing or eating meals. c. Moderate assistance with mobility. d. Moderate assistance with medications. e. Moderate assistance with toileting. f. Total, extensive, or moderate assistance with dressing. g. Total, extensive or moderate assistance with bathing. h. Extensive or moderate assistance with supervision from Section II No. 18 of the UAI. (end)	b. 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. An overall age equivalency up to eight and one-half (8.5) years is significant in the area of functionality when combined with a general maladaptive index on the SIB-R Department-approved assessment tool from minus seventeen (-17), up to minus twenty-two (-22) inclusive; or Persons may qualify based on their Medical Condition. Individuals may meet ICF/ID level of care based on their medical conditions if the medical condition significantly affects their functional level/capabilities and if it can be determined that they are in need of the level of services provided in an ICF/ID, including active treatment services. (end)	

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

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). *(Specify target group(s))*:

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

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. *(Specify the phase-in plan)*:

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

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).

9. Reasonable Indication of Need for Services. In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services.** The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is: 1	
ii.	**Frequency of services.** The state requires (select one):	
	◉	**The provision of 1915(i) services at least monthly**
	○	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

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

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

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

Idaho assures that the settings transition plan included with this 1915(i) State Plan Amendment will be subject to any provisions or requirements in the state's approved settings Statewide Transition Plan. The state will implement any applicable required changes upon approval of the settings Statewide Transition Plan and will make conforming changes to its 1915(i) benefit, as needed, when it submits the next amendment or renewal. The most recent version of the settings Statewide Transition Plan can be found at http://healthandwelfare.idaho.gov/Medical/Medicaid/HomeandCommunityBasedSettingsFinalRule/tabid/2710/Default.aspx.

The intention of the home and community-based services (HCBS) rule is to ensure individuals receiving HCBS long-term services and supports have full access to the benefits of community living and the opportunity to receive services in the most integrated settings appropriate. In addition, the new regulations aim to enhance the quality of HCBS and provide protections to participants. Idaho Medicaid administers several HCBS programs that fall under the scope of the new regulations, including this 1915(i) State Plan HCBS Benefit for Adults with Developmental Disabilities (Adult DD 1915(i) HCBS Benefit).

The Adult DD 1915(i) HCBS Benefit serves participants in residential and non-residential settings.

Section 1: Systemic Assessment and Systemic Remediation

Idaho completed a preliminary gap analysis of its residential HCBS settings in late summer of 2014 and a preliminary gap analysis of its non-residential HCBS settings in December 2014. The gap analysis included an in-depth review of state administrative rule and statute, Medicaid waiver and state plan language, licensing and certification requirements, Medicaid provider agreements, service definitions, administrative and operational processes, provider qualifications and training, quality assurance and monitoring activities, reimbursement methodologies, and person-centered planning processes and documentation. This analysis identified areas where the new regulations are supported in Idaho as well as areas that will need to be strengthened in order to align Idaho's HCBS programs with the regulations.

Below is an exhaustive list of all HCBS administered by Idaho Medicaid to participants in the Adult DD 1915(i) HCBS Benefit, the corresponding category for each service, and the settings in which the service can occur. Settings that are listed as "in-home" are presumed to meet HCBS compliance, as these are furnished in a participant's private residence. Settings indicated as “community” are also presumed to meet the HCBS qualities, as they are furnished in the community in which the participant resides. Quality reviews of services and participant service outcome reviews will ensure that providers do not impose restrictions on HCBS setting qualities in a participant’s own home or in the community without a supportive strategy that has been agreed to through the person-centered planning process.

Service Description	Applicable HCBS Qualities	Settings
Developmental Therapy	Non-residential	• Home • Community • DDA Center
Community Crisis Supports	Non-residential	• Home • Community • Certified Family Home • Hospital

1a. Systemic Assessment of Residential Settings

Idaho Medicaid furnishes Adult DD 1915(i) HCBS Benefit services in one type of provider owned or controlled residential setting: CFHs. The results of Idaho’s analysis of this residential setting are summarized below, including an overview of existing support for each regulation. The state has included, where applicable, the full IDAPA citations to identify where IDAPA supports the HCBS requirement, in addition to indicating if IDAPA is silent. The state did not identify any IDAPA provision that conflicts with the HCBS requirements. Additionally, the chart includes Idaho’s plan on how to transition these settings into full compliance with the new regulations.

Provider Owned or Controlled Residential Settings Gap Analysis

Federal Requirement: *Home and community-based settings must have all of the following qualities, and such other qualities as the Secretary determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan:*		**Analysis of Idaho’s Residential Settings** **Certified Family Homes (CFH)**
1. The setting is integrated in, and facilitates the individual’s full access to the greater community to the same degree of access as individuals not receiving Medicaid HCBS.	Support	Idaho licensing and certification rule (IDAPA 16.03.19.170.02, 16.03.19.170.07, 16.03.19.200.11) and provider materials support residents’ participation in community activities and access to community services.
	Gap	The state lacks standards for “the same degree of access as individuals not receiving Medicaid HCBS”.
	Remediation	Incorporate HCBS requirement into IDAPA 16.03.10.313. Develop best practices to support provider compliance with this HCBS requirement. Include it in the HCBS toolkit. Enhance existing monitoring and quality assurance activities to ensure ongoing compliance.

2. The setting includes opportunities to seek employment and work in competitive, integrated settings to the same degree of access as individuals not receiving Medicaid HCBS.	Support	Supported employment is a service available on both the A&D and DD waivers. There are no limitations to supported employment based on a participants' residential setting.
	Gap	The state lacks standards for "the same degree of access as individuals not receiving Medicaid HCBS". IDAPA is silent.
	Remediation	Incorporate HCBS requirement into IDAPA 16.03.10.313. Develop best practices to support provider compliance with this HCBS requirement. Include it in the HCBS toolkit. Enhance existing monitoring and quality assurance activities to ensure ongoing compliance.
3. The setting includes opportunities to engage in community life to the same degree of access as individuals not receiving Medicaid HCBS.	Support	Idaho rule (IDAPA 16.03.19.200.11), provider agreements, and the CFH Provider Manual support that a CFH should provide opportunities for participation in community life.
	Gap	The state lacks standards for "the same degree of access as individuals not receiving Medicaid HCBS".
	Remediation	Incorporate HCBS requirement into IDAPA 16.03.10.313. Develop best practices to support provider compliance with this HCBS requirement. Include it in the HCBS toolkit. Enhance existing monitoring and quality assurance activities to ensure ongoing compliance.
4. The setting includes opportunities to control personal resources to the same degree of access as individuals not receiving Medicaid HCBS.	Support	Idaho rule (IDAPA 16.03.19.200.05, 16.03.19.275.01), the CFH Provider Manual, and the provider agreement support the participant's right to manage funds.
	Gap	The state lacks standards for "the same degree of access as individuals not receiving Medicaid HCBS".
	Remediation	Incorporate HCBS requirement into IDAPA 16.03.10.313. Develop best practices to support provider compliance with this HCBS requirement. Include it in the HCBS toolkit. Enhance existing monitoring and quality assurance activities to ensure ongoing compliance.
5. The setting includes opportunities to receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.	Support	Rule (IDAPA 16.03.19.200.08) supports the participant's free choice on where and from whom a medical service is accessed and allows free access to religious and other services delivered in the community.
	Gap	The state lacks standards for "the same degree of access as individuals not receiving Medicaid HCBS".
	Remediation	Incorporate HCBS requirement into IDAPA 16.03.10.313. Develop best practices to support provider compliance with this HCBS requirement. Include it in the HCBS toolkit. Enhance existing monitoring and quality assurance activities to ensure ongoing compliance.

6. The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and based on the individual's needs, preferences, and resources available for room and board (for residential settings).	Support	Department processes support that participants must sign the service plan that includes documentation that choice of residential setting was offered. Waivers and State Plan language support that the service plan development process must use the preferences of the participant and that the residential setting selection must be documented.
	Gap	The state lacks support for ensuring that options are available for participants to potentially choose a private room and that the service plan must document location selection for all service settings. IDAPA is silent.
	Remediation	Idaho will enhance existing quality assurance activities to ensure compliance. Idaho incorporated the HCBS requirement into IDAPA 16.03.10.317 to ensure that service plans document location selection for ALL service settings, not just residential. Through operational processes, the state will ensure that participants are aware of options available for a private unit.
7. An individual's essential personal rights of privacy, dignity, respect, and freedom from coercion and restraint are protected.	Support	These participant rights are protected and supported in Idaho statute and licensing and certification rule (IDAPA 16.03.19.200.01, 16.03.19.200.03, 16.03.19.200.07, 16.03.22.550.02-03, 16.03.22.550.10, 16.03.22.153).
	Gap	None
	Remediation	Incorporate HCBS requirement into IDAPA 16.03.10.313.
8. Optimizes, but does not regiment individual initiative, autonomy, and independence in making life choices. This includes, but is not limited to, daily activities, physical environment, and with whom to interact.	Support	Participants' independence is supported in state statute (Idaho Statute, Title 39, Chapter 35 (39- 3501) and licensing and certification rule (IDAPA 16.03.19.200.11, 16.03.19.170.02). Previously established CFH resident rights also support this requirement.
	Gap	The state lacks support for ensuring that participants' activities are not regimented.
	Remediation	Incorporate HCBS requirement into IDAPA 16.03.10.317. Enhance existing monitoring and quality assurance activities to ensure compliance.
9. Individual choice regarding services and supports, and who provides them, is facilitated.	Support	Rule (IDAPA 16.03.19.250.04, 16.03.19.200.08, 16.03.22.320.07, 16.03.22.550.12) supports that participant choices regarding services and supports, and who provides them, are facilitated.
	Gap	None
	Remediation	Incorporate HCBS requirement into IDAPA 16.03.10.317

10. The unit or room is a specific physical place that can be owned, rented, or occupied under another legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement, or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.	Support	Administrative rules governing Certified Family Homes (IDAPA 16.03.19.260, 16.03.19.200.10) require that the timeframes and criteria for transfer or discharge be described in the Admission Agreement.
	Gap	Idaho rule requires a minimum 15- day notice of transfer or discharge from a CFH, but Idaho landlord tenant laws require a 3- or 30-day notice, depending on the circumstances.
	Remediation	Incorporate HCBS requirement into IDAPA 16.03.10. Change the Admission Agreement requirements in IDAPA 16.03.19 to align with Idaho landlord tenant laws. Enhance existing monitoring and quality assurance activities to ensure compliance.
11. Each individual has privacy in their sleeping or living unit: Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.	Support	Rule (IDAPA 16.03.19.600.02, 16.03.19.200.01, 16.03.22.550.02) supports a participant's right to privacy.
	Gap	The state lacks support for ensuring that individuals have lockable entrance doors to their sleeping or living units.
	Remediation	Incorporate HCBS requirement into IDAPA 16.03.10.314. Enhance existing monitoring and quality assurance activities to ensure compliance.
12. Individuals sharing units have a choice of roommates in that setting.	Support	None found
	Gap	The state lacks support for ensuring that individuals sharing units have a choice of roommates. IDAPA is silent.
	Remediation	Incorporate HCBS requirement into IDAPA 16.03.10.314. Enhance existing monitoring and quality assurance activities to ensure compliance.
13. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.	Support	The provider agreement supports that individuals have the right to furnish and decorate their living area.
	Gap	IDAPA is silent for CFHs.
	Remediation	Incorporate HCBS requirement into IDAPA 16.03.10.314.
14. Individuals have the freedom and support to control their own schedules and activities.	Support	Rule (IDAPA 16.03.19.200.11, 16.03.22.151.03, 16.03.22.550.15) supports a participant's freedom and support to choose services.
	Gap	The state lacks support for ensuring that individuals control their own schedules and activities.

	Remediation	Incorporate HCBS requirement into IDAPA 16.03.10.314. Enhance existing monitoring and quality assurance activities to ensure compliance.
15. Individuals have access to food at any time.	Support	None found
	Gap	The state lacks support for ensuring that individuals have access to food at any time. IDAPA is silent.
	Remediation	Incorporate HCBS requirement into IDAPA 16.03.10.314. Enhance existing monitoring and quality assurance activities to ensure compliance.
16. Individuals are able to have visitors of their choosing at any time.	Support	Rule (IDAPA 16.03.19.200.06) and the Residents Rights Policy and Notification Form support that individuals are able to have visitors of their choosing at any time.
	Gap	None
	Remediation	Strengthened support for this HCBS requirement by incorporating into IDAPA 16.03.10.314.
17. The setting is physically accessible to the individual.	Support	Rule (IDAPA 16.03.19.004, 16.03.19.700) and the Residents Rights Policy and Notification Form support that the setting must be physically accessible to the individual.
	Gap	None
	Remediation	Strengthened support for this HCBS requirement by incorporating into IDAPA 16.03.10.314.

Due to the gaps identified above, Idaho is unable to say at this time how many residential settings fully align with the federal requirements, how many do not comply and will require modifications, and how many cannot meet the federal requirements and require removal from the program and/or relocation of participants. Proposed plans to complete a full assessment are outlined in Section Three. Regulatory changes in IDAPA to support HCBS requirements have been promulgated and go into effect July 1, 2016. Regulatory changes were necessary in order to allow enforcement. The site-specific assessment of settings will occur in 2017.

Non- Provider Owned or Controlled Residential Settings

Idaho's residential habilitation services for adults include services and supports designed to assist participants to reside successfully in their own homes, with their families, or in a CFH. Residential habilitation services provided to the participant in their own home are called "supported living" and are provided by residential habilitation agencies. Supported living services can either be provided hourly or on a 24-hour basis (high or intense supports).

As part of Idaho's outreach and collaboration efforts, Medicaid initiated meetings with supported living service providers in September 2014. The goal of these meetings was to ensure that supported living providers understood the new HCBS setting requirements, how the requirements will apply to the work that they do, and to address any questions or concerns this provider group may have. During these meetings, providers expressed concern regarding how the HCBS setting requirements would impact their ability to implement strategies to reduce health and safety risks to participants receiving high and intense supports in their own homes. Because of these risk reduction strategies, supported living providers are concerned that they will be unable to ensure that all participants receiving supported living services have opportunities for full access to the greater community and that they are afforded the ability to have independence in making life choices.

Since our initial conversations with residential habilitation agency providers the state has addressed provider concerns by obtaining clarification from CMS and publishing draft HCBS rules. Our goal is that through individualized supportive strategies created by the participant and their person-centered planning team, agencies will support participants in integration, independence, and choice while maintaining the health, safety, dignity, and respect of the participant and the community.

Although the HCBS regulations allow states to presume the participant's private home meets the HCBS setting requirements, the state will enhance existing quality assurance and provider monitoring activities to ensure that participants retain decision-making authority in their home. Additionally, the state is continuing to analyze the participant population receiving intense and high supported living and how the HCBS requirements impact them.

1b. Systemic Assessment of Non-Residential Service Settings

Idaho completed a preliminary gap analysis of its non-residential service settings in December 2014. The results of Idaho's analysis of its non-residential settings are summarized below, including an overview of existing support for each regulation. The state has included, where applicable, the full IDAPA rule citation(s) to identify where IDAPA supports the HCBS requirement, in addition to indicating if IDAPA is silent. The state did not identify any IDAPA rule that conflicts with the HCBS requirements.

Additionally, the chart includes preliminary recommendations to transition these settings into full compliance with the new regulations. Please note that the analysis of existing support for each new regulation is only the first step in the assessment process. It has been used to identify where Idaho lacks documented support for the setting quality requirements. Idaho understands that more work is necessary to complete a full assessment of settings. Section Three of this document identifies the work remaining to complete a thorough assessment. That process includes soliciting input from participants receiving services, provider self- assessment, as well as on-site assessment of compliance.

Non-Residential Service Settings Gap Analysis: Adult DD 1915(i) HCBS Benefit Services

Analysis of Community Crisis Supports (Adult DD 1915(i))			
Requirement	**Requirement**	**Requirement**	**Requirement**
1. The setting is integrated in, and facilitates the individual's full access to the greater community to the same degree of access as individuals not receiving Medicaid HCBS.	Idaho rule (IDAPA 16.03.10.513.11) supports that service settings are integrated and facilitate community access.	The state lacks standards for "the same degree of access as individuals not receiving Medicaid HCBS." The state allows for crisis services to take place in an institutional setting. The state lacks sufficient regulatory support for this requirement. The state lacks quality assurance/monitoring activities to ensure this requirement is met.	Do not allow service in an institutional setting. Incorporate HCBS requirement into IDAPA 16.03.10.313. Enhance and expand existing quality assurance/monitoring activities and data collection for monitoring. Develop best practices to support provider compliance with this HCBS requirement. Include it in the HCBS toolkit.
2. The setting includes opportunities to seek employment and work in competitive, integrated settings to the same degree of access as individuals not receiving Medicaid HCBS.	Idaho rule (IDAPA 16.03.10.513.11) supports that service settings allow opportunities to see employment and work in competitive, integrated settings. The service functions to prevent loss of employment.	The state lacks standards for "the same degree of access as individuals not receiving Medicaid HCBS."	Strengthened IDAPA 16.03.10.313 to support this requirement. Develop best practices to support provider compliance with this HCBS requirement. Include it in the HCBS toolkit.
3. The setting includes opportunities to engage in community life to the same degree of access as individuals not receiving Medicaid HCBS.	Idaho rule (IDAPA 16.03.10.513.11) supports that service settings include opportunities to engage in community life when services are provided in the home and community. This service functions to prevent a participant from losing access to community life because of a crisis.	The state lacks standards for "the same degree of access as individuals not receiving Medicaid HCBS." The state allows for crisis services to take place in an institutional setting. The state lacks sufficient regulatory support for this requirement. The state lacks quality assurance/monitoring activities to ensure this requirement is met.	Do not allow service in an institutional setting. Incorporate HCBS requirement into IDAPA 16.03.10. Enhance and expand existing quality assurance/monitoring activities and data collection for monitoring. Develop best practices to support provider compliance with this HCBS requirement. Include it in the HCBS toolkit.

4. The setting includes opportunities to control personal resources to the same degree of access as individuals not receiving Medicaid HCBS.	There is no support for this requirement for this service category. However, providers have no authority in IDAPA to influence a participant's control of personal resources.	The state lacks standards for "the same degree of access as individuals not receiving Medicaid HCBS." The state lacks sufficient service specific regulatory support to enforce this requirement. IDAPA is silent. The state lacks quality assurance/monitoring activities to ensure this requirement is met.	Incorporate HCBS requirement into IDAPA 16.03.10. Enhance and expand existing quality assurance/monitoring activities and data collection for monitoring. Develop best practices to support provider compliance with this HCBS requirement. Include it in the HCBS toolkit.	
5. The setting includes opportunities to receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.	Idaho rule (IDAPA 16.03.10.513.11) supports that service settings include opportunities to receive services in the community. This service functions to prevent a participant from losing access to community life because of a crisis.	The state lacks standards for "the same degree of access as individuals not receiving Medicaid HCBS." The state allows for crisis services to take place in an institutional setting. The state lacks sufficient regulatory support for this requirement. The state lacks quality assurance/monitoring activities to ensure this requirement is met.	Disallow service from being allowed in an institutional setting. Incorporate HCBS requirement into IDAPA 16.03.10. Enhance and expand existing quality assurance/monitoring activities and data collection for monitoring. Develop best practices to support provider compliance with this HCBS requirement. Include it in the HCBS toolkit.	
6. The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and based on the individual's needs, preferences, and resources available for room and board (for residential settings).	Idaho rule (IDAPA 16.03.10.721.07, 16.03.10.728.07) supports that services/settings are selected by the participant based on their needs and preferences. Community crisis providers have no capacity to control the participant's residential setting. Private units in residential settings do not apply.	None	None	

7. An individual's essential personal rights of privacy, dignity, respect, and freedom from coercion and restraint are protected.	The Idaho Medicaid Provider Agreement and Adult Day Health Additional Terms that are signed by service providers support an individual's rights related to privacy and respect. IDAPA 16.03.21.915, 16.04.17.405.08, include the process for implementing authorized restraints.	Dignity and freedom from coercion and restraint are not specifically discussed related to Adult Day Health providers. The state lacks service-specific regulatory support to enforce this requirement. The state lacks quality assurance/monitoring activities to ensure this requirement is met. IDAPA is silent.	Incorporate HCBS requirement into IDAPA 16.03.10. Enhance and expand existing quality assurance/monitoring activities and data collection for monitoring.
8. Optimizes, but does not regiment individual initiative, autonomy, and independence in making life choices. This includes, but is not limited to, daily activities, physical environment, and with whom to interact.	There is no support for this requirement for this service category.	The state lacks sufficient rule support for this requirement. IDAPA is silent. The state lacks quality assurance/monitoring activities to ensure this requirement is met.	Do not allow service in an institutional setting. Incorporate HCBS requirement into IDAPA 16.03.10. Enhance and expand existing quality assurance/monitoring activities and data collection for monitoring.
9. Individual choice regarding services and supports, and who provides them, is facilitated.	The Idaho Medicaid Provider Agreement signed by service providers supports that participant choice is facilitated. Waiver and operational requirements also enforce participant choice regarding services and supports.	IDAPA is silent.	Idaho has strengthened its regulatory language in IDAPA 16.03.10.313 to ensure this requirement is met.

Analysis of Developmental Therapy (Adult DD 1915(i))			
Requirement	**Requirement**	**Requirement**	**Requirement**
1. The setting is integrated in, and facilitates the individual's full access to the greater community to the same degree of access as individuals not receiving Medicaid HCBS.	Idaho rule (IDAPA 16.03.10.651.01, 16.03.10.651.01.d, 16.03.10.651.01.e, 16.03.10.653.04.e, 16.03.21.520, 16.03.21.900.03, 16.03.21.905.02) supports that service settings are integrated and facilitate community access. However, integration standards for center/congregate are not specified.	The state lacks standards for integration for services provided in a congregate setting. The state lacks standards for "the same degree of access as individuals not receiving Medicaid HCBS." The state lacks quality assurance/monitoring activities to ensure this requirement is met.	Incorporate HCBS requirement into IDAPA 16.03.10. Enhance and expand existing quality assurance/monitoring activities and data collection for monitoring. Develop best practices to support provider compliance with this HCBS requirement. Include it in the HCBS toolkit.
2. The setting includes opportunities to seek employment and work in competitive, integrated settings to the same degree of access as individuals not receiving Medicaid HCBS.	Idaho rule (IDAPA16.03.10.514.02.c, 16.03.10.515.03, 16.03.10.651.03) supports that service settings allow opportunities to see employment and work in competitive, integrated settings.	The state lacks standards for "the same degree of access as individuals not receiving Medicaid HCBS."	Strengthened IDAPA 16.03.10.313 to support this requirement. Develop best practices to support provider compliance with this HCBS requirement. Include it in the HCBS toolkit.
3. The setting includes opportunities to engage in community life to the same degree of access as individuals not receiving Medicaid HCBS.	Idaho rule (IDAPA 16.03.10.651.01, 16.03.10.651.01.d, 16.03.10.651.01.e, 16.03.10.653.04.e, 16.03.21.520, 16.03.21.900.03, 16.03.21.905.02) supports that service settings include opportunities to engage in community life when services are provided in the home and community. However, integration standards for center/congregate are not specified.	The state lacks standards for integration for services provided in a congregate setting. The state lacks standards for "the same degree of access as individuals not receiving Medicaid HCBS." The state lacks quality assurance/monitoring activities to ensure this requirement is met.	Incorporate HCBS requirement into IDAPA 16.03.10. Enhance and expand existing quality assurance/monitoring activities and data collection for monitoring. Develop best practices to support provider compliance with this HCBS requirement. Include it in the HCBS toolkit.
4. The setting includes opportunities to control personal resources to the same degree of access as individuals not receiving Medicaid HCBS.	Idaho rule (IDAPA 16.03.21.905.01.g) supports that the participant has the right to retain and control their personal possessions.	The state lacks standards for "the same degree of access as individuals not receiving Medicaid HCBS."	Incorporate HCBS requirement into IDAPA 16.03.10.

		The state lacks quality assurance/monitoring activities to ensure this requirement is met.	Enhance and expand existing quality assurance/monitoring activities and data collection for monitoring. Develop best practices to support provider compliance with this HCBS requirement. Include it in the HCBS toolkit.
5. The setting includes opportunities to receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.	Idaho rule (IDAPA 16.03.10.651.01.d, 16.03.10.653.04.e, 16.03.21.900.03) supports that service settings include opportunities to receive services in the community.	The state lacks standards for integration for services provided in a congregate setting. The state lacks standards for "the same degree of access as individuals not receiving Medicaid HCBS." The state lacks quality assurance/monitoring activities to ensure this requirement is met.	Incorporate HCBS requirement into IDAPA 16.03.10. Enhance and expand existing quality assurance/monitoring activities and data collection for monitoring. Develop best practices to support provider compliance with this HCBS requirement. Include it in the HCBS toolkit.
6. The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and based on the individual's needs, preferences, and resources available for room and board (for residential settings).	Idaho rule (IDAPA 16.03.10.721.07, 16.03.10.728.07) supports that services/settings are selected by the participant based on their needs and preferences Developmental therapy providers have no capacity to control the participant's residential setting. Private units in residential settings do not apply.	None	Idaho has strengthened its regulatory language in IDAPA 16.03.10.313 to ensure this requirement is met.

7. An individual's essential personal rights of privacy, dignity, respect, and freedom from coercion and restraint are protected.	Idaho has strengthened its regulatory language in IDAPA 16.03.10.313 to ensure this requirement is met. IDAPA 16.03.21.915 includes the process for implementing authorized restraints.	None	Idaho has strengthened its regulatory language in IDAPA 16.03.10.313 to ensure this requirement is met.
8. Optimizes, but does not regiment individual initiative, autonomy, and independence in making life choices. This includes, but is not limited to, daily activities, physical environment, and with whom to interact.	Idaho rule (IDAPA16.03.10.653.04.e, 16.03.21.900.03, 16.03.21.915.08) supports that an individual's initiative, autonomy and independence in making life choices is facilitated in the home and community. However, standards for choice and autonomy in a center/congregate setting are not specified.	The state lacks standards for integration for services provided in a congregate setting. The state lacks quality assurance/monitoring activities to ensure this requirement is met.	Incorporate HCBS requirement into IDAPA 16.03.10. Enhance and expand existing quality assurance/monitoring activities and data collection for monitoring. Develop best practices to support provider compliance with this HCBS requirement. Include it in the HCBS toolkit.
9. Individual choice regarding services and supports, and who provides them, is facilitated.	Idaho rule (IDAPA 16.03.10.653.04.e, 16.03.21.900.03, 16.03.21.915.08) and the provider agreement supports that individual choice is facilitated.	None	Idaho has strengthened its regulatory language in IDAPA 16.03.10.313 to ensure this requirement is met.

Due to the gaps identified above, Idaho is unable to determine at this time how many non-residential settings fully align with the federal requirements, how many do not comply and will require modifications, and how many cannot meet the federal requirements and require removal from the program and/or relocation of participants.

Section 2: Analysis of Settings for Characteristics of an Institution

The Centers for Medicare and Medicaid Services has identified three characteristics of settings that are presumed to be institutional. Those characteristics are:

1. The setting is in a publicly or privately-owned facility providing inpatient treatment.

2. The setting is on the grounds of, or immediately adjacent to, a public institution.

3. The setting has the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS.

Idaho completed an initial assessment of all settings against the first two characteristics of an institution in early 2015. At that time there were no settings where an HCBS participant lived or received services that were located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment. Further, there were no settings on the grounds of or immediately adjacent to a public institution.

Idaho has initiated its assessment of all settings for the third characteristic on an institutional setting: the setting has the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS. That process is described in detail in Section 2a and Section 2b.

Any setting identified as potentially institutional will receive a site visit by Department staff who will examine each site for all the characteristics of an institution. If the state determines a setting is HCBS compliant and likely to overcome the presumption of being an institution, those sites will be moved forward to CMS for heightened scrutiny. Any site unable to overcome this assumption will move into the provider remediation process.

The reader should note that much of this section of the State Transition Plan has been revised as the state has modified its strategy for analysis of settings for characteristics of an institution. Versions 1- 3 of the State Transition Plan contain all previous verbiage and can be found at: www.HCBS.dhw.idaho.gov.

2a. Analysis of Residential Settings for Characteristics of an Institution

Idaho Medicaid Adult DD 1915(i) HCBS Benefit supports one type of residential setting for adults that needed to be analyzed against the characteristics established by CMS as presumptively institutional. It is CFHs.

Certified Family Homes (CFHs)

In September of 2014 Department of Health and Welfare's health facility surveyors from the CFH program were asked to identify if any CFH was in a publicly or privately-owned facility providing inpatient treatment, or on the grounds of or immediately adjacent to a public institution. Health Facility surveyors visit every CFH once a year so they have intimate knowledge of each physical location. No CFH was found to meet either of the first two characteristics of an institution.

In April 2016 that process was repeated with questions added related to isolation. Surveyors again reported that there are no CFHs that are in a publicly or privately-owned facility providing inpatient treatment, or on the grounds of, or immediately adjacent to, a public institution. However, six CFHs were identified as potentially having the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS.

2b. Analysis of Non-Residential Settings for Characteristics of an Institution

Idaho's non-residential Adult DD 1915(i) HCBS Benefit services by definition must occur in a participant's private residence, the community, in developmental disabilities agencies (DDAs).

A setting in a participant's private residence or the community is presumed to be compliant with all HCBS requirements.

In 2015 Medicaid solicited the help of Department of Health and Welfare staff responsible for completing the licensing and certification of DDA settings to assess those settings for the first two characteristics of an institution. Those characteristics are that they are in a publicly or privately owned facility providing inpatient treatment or on the grounds of, or immediately adjacent to, a public institution. A list of all DDAs was created with two questions tied to the two above mentioned characteristics of an institutional setting. Licensing and certification staff who routinely visit those settings then answered the two questions about each specific DDA. No DDAs were found to be in a publicly or privately-owned facility providing inpatient treatment or on the grounds of, or immediately adjacent to, a public institution. In April 2016 that process was repeated with questions added related to isolation. No DDAs were found to have any of the three characteristics of an institution.

Heightened Scrutiny Process

Any setting with a negative or 'unknown' response to the questions assessing the characteristics of an institution will be subject to further evaluation. This evaluation will include:

• A site visit to each setting by Medicaid staff to assess firsthand the settings characteristics to determine if the setting does or does not meet the characteristics of an institution

• A review of documented procedures for how participants access the broader community

• Barriers which are present at the setting to prevent or deter people from entering or exiting. Idaho will recognize exceptions to barriers utilized for safety measures for a particular individual.

• In residential settings the processes that are utilized to support social interactions with friends and family in the setting and outside of the setting.

The review of settings with a negative or 'unknown' response to the questions assessing the characteristics of an institution will be completed by June 30, 2017. Idaho will identify those settings it believes can overcome the assumption of being institutional and will submit evidence to CMS demonstrating such. This evidence will include such things as:

• Any documented procedures for how individuals access the broader community

• Logs which may be used for exiting or entering the setting

• Case notes on individual's activities

• Calendar of activities sponsored outside of the setting

• Documented procedures for outside visitors and outside phone calls, etc.

Settings the state believes are institutional and cannot overcome this assumption will be moved into the provider remediation process.

Section 3: Site-Specific Assessment and Site-Specific Remediation

Idaho will use a multi-component approach to assess all HCBS settings for compliance with the HCBS setting requirements. A summary of those components follows:

• Medicaid will complete a one-time site-specific assessment for a randomly selected and statistically valid sample of HCBS service providers, stratified by provider type. During those site visits each site will be assessed on all setting requirements and evidence of compliance will be examined. This work will begin on January 2, 2017 and be completed by December 31, 2017.

• At the same time, beginning January 2, 2017, Medicaid will start its ongoing monitoring of all sites for HCBS compliance. This simultaneous implementation of ongoing monitoring and the site-specific assessments will ensure that settings not selected for a site visit will still be assessed for compliance with HCBS setting requirements. Details for ongoing monitoring can be found in the Section 3d below.

Both the site-specific assessments and the ongoing monitoring work can potentially lead to discovery of a non-compliance issue. Discovery of non-compliance issues will result in remediation activities; see Section 3b for details on provider remediation.

In preparation for initiation of the site-specific assessment and resulting remediation work, the state has completed regulatory changes in IDAPA to support the HCBS setting requirements. Rule changes are effective July 1, 2016, and providers are given six months before enforcement actions begin. Idaho will begin its formal assessment of settings in January2017, which is expected to take one year. Tasks designed to assist the state in preparing for the assessment are currently underway. Activities include operational readiness tasks, materials development, staff training, and participant and provider training and communications, all of which will occur prior to the assessment start date of January 2, 2017. In addition, there have been numerous training opportunities for providers to date and the HCBS regulations have been shared.

The assessment plan described below in 3a covers provider owned or controlled residential and nonresidential settings that are not the participants' own home. These are settings in which providers have the capacity to influence setting qualities. The provider types and number of current setting are:

• Developmental Disability Agencies – 75 service sites

• Certified Family Homes – 2,212 service sites

By January 1, 2018, all HCBS settings in Idaho will have been assessed for compliance with the HCBS setting qualities. While not all setting sites will receive an on-site assessment, all settings are subject to the ongoing monitoring activities that will be established by January 1, 2017 (see section 3d.). Data collected during ongoing monitoring activities will inform the state's determination of compliance vs. noncompliance of the settings not selected for an on-site assessment.

Section 3b describes the proposed plan for site-specific provider remediation. Section 3c describes Idaho's plan for relocating participants in non-compliant settings or with non-compliant service providers. Finally, Section 3d describes the ongoing monitoring plan and, includes all settings where Medicaid HCBS are delivered. While Idaho Medicaid presumes that services delivered in community settings or in a participant's private residence meet HCBS setting quality requirements, an ongoing monitoring system will ensure that Medicaid providers do not arbitrarily impose restrictions on setting qualities while delivering those services. Monitoring will be used to hold all providers of HCBS accountable for setting quality compliance and to ensure participant rights are honored.

Please see the most recent version of the settings Statewide Transition Plan found at http://healthandwelfare.idaho.gov/Medical/Medicaid/HomeandCommunityBasedSettingsFinalRule/tabid/2710/Default.aspx for more information regarding the following:

• Site-specific assessment and remediation process details;

• Major milestones for outstanding work under the Statewide Transition Plan; and

• The public input process for reviewing and approving the Statewide Transition Plan.

Person-Centered Planning & Service Delivery

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

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☑ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. **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 need 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 intellectual disabilities or other developmental disabilities; and

b. Being one of the following:
- Licensed as a doctor of medicine or osteopathy, or as a nurse; or
- Have 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; and

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

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

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

a. Neither a provider of direct service to the participant nor the assessor may be chosen to be the paid plan developer. Family members and all others who wish to be paid for plan development must be employed as a service coordinator.

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

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

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

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

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

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

The plan of service is developed by the participant and their person-centered planning team. This group includes, at a minimum, the participant, their decision-making authority (if applicable) and the service coordinator or plan developer chosen by the participant. With the participant's consent, the person-centered planning team may include family members, or individuals who are significant to the participant. A plan developer's responsibility for developing a service plan using a person-centered planning process is supported by IDAPA 16.03.10.730.731.

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.

7. **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 person-centered service plan):*

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, their decision-making authority, 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 their decision-making authority's request.

The participant and their decision-making authority (if applicable), 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 their needs.

8. Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency)*:

The independent assessment meets federal requirements at 42 CFR § 441.720 and is used to develop the individual plan of service. Additionally, the person-centered service plan is developed using a person-centered planning process in accordance with 42 CFR § 441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR § 441.725(b).

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.

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

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

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

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

Services

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

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Adult - Developmental Therapy
Service Definition (Scope):	
Developmental therapy may be delivered in a developmental disabilities agency center-based program, the community, or the home of the participant. Developmental therapy includes individual developmental therapy and group developmental therapy. Developmental therapy services must be delivered by Developmental Specialists or paraprofessionals based on a comprehensive developmental assessment completed prior to the delivery of services. • Areas of service. These services must be directed toward the rehabilitation or habilitation of physical or mental disabilities in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. • Age-appropriate. Developmental therapy includes instruction in daily living skills the participant has not gained at the normal developmental stages in his life, or is not likely to develop without training or therapy. Developmental therapy must be age-appropriate. • Tutorial activities and educational tasks are excluded. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the participant's disability. • Settings for developmental therapy. Developmental therapy, in both individual and group formats, must be available in both community-based and home-based settings, and be based on participant needs, interests, or choices. • Staff-to-participant ratio. 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. The services under the 1915(i) State Plan Option HCBS Benefit for Adults with Developmental Disabilities are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.	
Additional needs-based criteria for receiving the service, if applicable *(specify)*:	
N/A	

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

☑ Categorically needy *(specify limits)*:

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

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

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

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

☐ Medically needy *(specify limits)*:

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

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

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

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

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

Community crisis supports are interventions 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 referral of the participant to community resources to resolve the crisis, direct consultation and clinical evaluation of the participant, training and staff development related to the needs of a participant, emergency back-up involving the direct support of the participant in crisis, and/or other assistance that is appropriate to resolve the crisis and does not duplicate another service that is the same in nature and scope regardless of source, including Federal, state, local and private entities.

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

Community crisis supports are based on a crisis plan that outlines interventions used to resolve the crisis. After community crisis supports are provided, the crisis provider must supply the Department with documentation of the crisis outcome, identification of factors contributing to the crisis and a proactive strategy that will address the factors that resulted in a crisis in order to minimize the opportunity for future occurrences.

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

Participant is at risk of losing housing, employment or income, or who are at risk of incarceration, physical harm, family altercations or other emergencies.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☑	Categorically needy *(specify limits)*:
	Community crisis support is limited to a maximum of 20 hours during any consecutive five-day period. In order to initiate a request for community crisis supports, the targeted service coordinator, in coordination with the person-centered planning team, submits a request for community crisis supports to the Department. The Department case manager will review the request to ensure that the supports requested are not duplicative of other services being delivered to the participant. Community crisis supports will only be approved if all service hours previously prior authorized that may be appropriate to address the crisis have already been exhausted. When Community Crisis Supports has been accessed, the proactive strategy used to address the factors that resulted in a crisis should be incorporated as goals into the participant's person-centered plan of service. Community crisis support may be retroactively authorized within seventy-two hours of providing the service if there is a documented need for immediate intervention, no other means of support are available and the services are appropriate to rectify the crisis. Participants who are not currently receiving developmental disability services may receive community crisis supports after completing an abbreviated person-centered planning process. In these cases, after eligibility for the service is determined, the participant and their planning team will develop a crisis plan to address the immediate crisis. This crisis plan will subsequently be incorporated into the overall person-centered planning process and development of the initial DD plan of service. Legally responsible individuals (e.g., a parent of minor child or a spouse) and relatives may not be paid for the provision of Community Crisis services.
☐	Medically needy *(specify limits)*:

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

Provider Type *(Specify):*	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Service Coordination Agency			Service Coordination Agency providers must meet provider qualifications as outlined in IDAPA 16.03.10.721 and 729.

Behavioral Consultation			Behavioral Consultation Providers must meet provider qualifications as outlined in IDAPA 16.03.10.705.12
Supported Employment Services			Supported Employment Providers must meet provider qualifications as outlined in 16.03.10.705.05
Residential Habilitation Agency		Certificate as described in IDAPA 16.04.17 and 16.03.705	
Certified Family Home		Certified Family Home certificate as described in IDAPA at 16.03.19	

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

Provider Type *(Specify):*	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Service Coordination Agency	Department of Health and Welfare	At least every two years
Behavioral Consultation	Department of Health and Welfare	At least every two years
Supported Employment Services	Department of Health and Welfare	At least every two years
Residential Habilitation Agency	Department of Health and Welfare	Residential habilitation providers are surveyed when they seek renewal of their certificate. The Department issues certificates that are in effect for a period of no longer than three years
Certified Family Home	Department of Health and Welfare	Certification for Certified Family Homes is required the year after the initial home certification study and at least every twenty-four (24) months thereafter.

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

☐	Participant-directed	☑	Provider managed

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

Idaho does not allow payment for Adult Developmental Therapy or Community Crisis Supports provided by persons who are relatives of the participant nor by persons who are legally responsible individuals for the participant.

Legal guardians may be paid providers of Community Crisis Supports, but not Adult Developmental Therapy. Community crisis support is only authorized if there is a documented need for immediate intervention related to an unanticipated event, circumstance or life situation that places a participant at risk of at least one of the following: loss of housing, loss of employment or income, incarceration, physical harm, family altercation, or other emergencies. In order to closely monitor this service, authorization is limited to a maximum of twenty hours during any consecutive five-day period. Payment is authorized based on a crisis support plan and assessment. During the authorization process, Department Care Managers review the plan to ensure that services authorized do not duplicate any other paid Medicaid services. If applicable, guardian papers are available to the Department Care Manager at the time the plan is review and approved to ensure services are not prior authorized if they duplicate services the legal guardian is required to provide. After community crisis support has been provided, the provider must complete a crisis resolution plan and submit it to the Department within three business days. The crisis resolution plan shall identify the factors contributing to the crisis and must include a proactive strategy to address these factors in order to minimize future occurrences.

Participant-Direction of Services

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

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

◉	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. (Specify criteria):

1. **Description of Participant-Direction.** *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

2. **Limited Implementation of Participant-Direction.** *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to state wideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. *(Specify the areas of the state affected by this option):*

3. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

4. Financial Management. *(Select one):*

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

5. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and: Specifies the State plan HCBS that the individual will be responsible for directing; Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget; Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual; Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

8. Opportunities for Participant-Direction

a. Participant–Employer Authority *(individual can select, manage, and dismiss State plan HCBS providers). (Select one):*

○	The state does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority (Check each that applies):	
	☐	**Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority *(individual directs a budget that does not result in payment for medical assistance to the individual). (Select one):*

○	The state does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and c) document choice of services and providers.
2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
3. Providers meet required qualifications.
4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).
5. The SMA retains authority and responsibility for program operations and oversight.
6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement 1 ***(Service Plans)***	***Sub-Requirement 1-a*** Service plans address all 1915(i) participants' assessed needs (including health and safety risk factors) and personal goals, either by 1915(i) HCBS service or through other means.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 1 (PM1)*** Number and percent of service plans reviewed that address participants' assessed needs (including health and safety risks) as identified in the individual's assessment(s). Numerator: Number of service plans reviewed that document participants' assessed needs (including health and safety risk factors) as identified in the individual's assessment(s). Denominator: Number of service plans reviewed in the representative sample.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Adult Services Outcome Review (record reviews and participant interviews) Sampling Approach: Representative Sample of adult participants receiving 1915(i) HCBS. Confidence Interval = +/- 5% and Confidence Level = 95%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 1 ***(Service Plans)***	***Sub-Requirement 1-a*** Service plans address all 1915(i) participants' assessed needs (including health and safety risk factors) and personal goals, either by 1915(i) HCBS service or through other means.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 2 (PM2)*** Number and percent of service plans reviewed that address potential and real risks and have back up plan interventions in place. Numerator: Number of service plans reviewed that address potential and real risks and have back up plan interventions in place. Denominator: Number of service plans reviewed in the representative sample.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Adult Services Outcome Review (record reviews and participant interviews) Sampling Approach: Representative Sample of adult participants receiving 1915(i) HCBS. Confidence Interval = +/- 5% and Confidence Level = 95%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 1 ***(Service Plans)***	***Sub-Requirement 1-a*** Service plans address all 1915(i) participants' assessed needs (including health and safety risk factors) and personal goals, either by 1915(i) HCBS service or through other means.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 3 (PM3)*** Number and percent of service plans reviewed that address participants' personal goals. Numerator: Number of service plans reviewed that document participants' personal goals. Denominator: Number of service plans reviewed in the representative sample.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Adult Services Outcome Review (record reviews and participant interviews) Sampling Approach: Representative Sample of adult participants receiving 1915(i) HCBS. Confidence Interval = +/- 5% and Confidence Level = 95%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 1 ***(Service Plans)***	***Sub-Requirement 1-a*** Service plans address all 1915(i) participants' assessed needs (including health and safety risk factors) and personal goals, either by 1915(i) HCBS service or through other means.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 4 (PM4)*** Number and percent of participant records reviewed that indicate services were delivered consistent with the service type, scope, amount, duration and frequency approved on service plans. Numerator: Number of participant records reviewed that indicate services were delivered consistent with the approved service plans. Denominator: Number of participant records reviewed in the representative sample.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Adult Services Outcome Review (record reviews and participant interviews) Sampling Approach: Representative Sample of adult participants receiving 1915(i) HCBS. Confidence Interval = +/- 5% and Confidence Level = 95%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis
Frequency *(of Analysis and Aggregation)*	Annually

Requirement 1 ***(Service Plans)***	***Sub-Requirement 1-b*** Service plans are updated or revised at least annually or when warranted by changes in the participant's needs.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 5 (PM5)*** Number and percent of service plans reviewed that were updated at least annually. Numerator: Number of service plans reviewed that were updated at least annually. Denominator: Number of service plans reviewed in the representative sample requiring annual update.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Adult Services Outcome Review (record reviews and participant interviews) Sampling Approach: Representative Sample of adult participants receiving 1915(i) HCBS. Confidence Interval = +/- 5% and Confidence Level = 95%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 1 ***(Service Plans)***	***Sub-Requirement 1-b*** Service plans are updated or revised at least annually or when warranted by changes in the participant's needs.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 6 (PM6)*** Number and percent of service plans that were revised when warranted by changes in the 1915(i) HCBS participant's needs. Numerator: Number of service plans reviewed that were revised when warranted by changes in the 1915(i) HCBS participant's needs. Denominator: Number of service plans reviewed in the representative sample requiring revision warranted by changes in the 1915(i) participant's needs.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Adult Services Outcome Review (record reviews and participant interviews) Sampling Approach: Representative Sample of adult participants receiving 1915(i) HCBS. Confidence Interval = +/- 5% and Confidence Level = 95%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 1 ***(Service Plans)***	***Sub-Requirement 1-c*** 1915(i) HCBS participants are afforded choice: Between/among 1915(i) services and providers.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 7 (PM7)*** Number and percent of participant records reviewed that indicated participants were given a choice when selecting 1915(i) services. Numerator: Number of participant records reviewed that indicated participants were given a choice of 1915(i) services. Denominator: Number of participant records reviewed in the representative sample.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Adult Services Outcome Review (record reviews and participant interviews) Sampling Approach: Representative Sample of adult participants receiving 1915(i) HCBS. Confidence Interval = +/- 5% and Confidence Level = 95%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 1 ***(Service Plans)***	***Sub-Requirement 1-c*** 1915(i) HCBS participants are afforded choice: Between/among 1915(i) services and providers.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 8 (PM8)*** Number and percent of participant records reviewed that indicated participants were given a choice when selecting 1915(i) HCBS providers. Numerator: Number of participant records reviewed that indicated participants were given a choice of 1915(i) HCBS providers. Denominator: Number of participant records reviewed in the representative sample.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Adult Services Outcome Review (record reviews and participant interviews) Sampling Approach: Representative Sample of adult participants receiving 1915(i) HCBS. Confidence Interval = +/- 5% and Confidence Level = 95%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 2 ***(Eligibility)***	***Sub-Requirement 2-a*** An evaluation for 1915(i) Benefit eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 9 (PM9)*** Number and percent of initial applicants for whom an evaluation of the 1915(i) Benefit needs-based eligibility criteria was completed prior to receiving 1915(i) services. Numerator: Number of initial applicants for whom an evaluation of the 1915(i) Benefit needs-based eligibility criteria was completed prior to receiving 1915(i) services. Denominator: Number of initial applicants receiving 1915(i) services.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Reports to State Medicaid Agency on delegated Administrative functions Sampling Approach: 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation
Frequency	Continuously and Ongoing, and Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement 2 ***(Eligibility)***	***Sub-Requirement 2-b*** The process and instruments for determining 1915(i) Benefit eligibility as described in the approved state plan are applied appropriately.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 10 (PM10)*** Number and percent of reviewed 1915(i) Benefit eligibility determinations that were made according to the 1915(i) Benefit needs-based eligibility criteria. Numerator: Number reviewed 1915(i) Benefit eligibility determinations that were made according to the 1915(i) Benefit needs-based eligibility criteria. Denominator: Number of reviewed 1915(i) Benefit eligibility determinations in the representative sample.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Reports to State Medicaid Agency on delegated Administrative functions Sampling Approach: Representative Sample. Confidence Interval = +/- 5% and Confidence Level = 95%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement 2 ***(Eligibility)***	***Sub-Requirement 2-c*** The 1915(i) Benefit eligibility of enrolled participants is reevaluated at least annually, or if more frequently, then as specified in the approved state plan.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 11 (PM11)*** Number and percent of enrolled participants who received an annual redetermination of 1915(i) Benefit eligibility within 364 days of their previous eligibility evaluation. Numerator: Number of enrolled participants who received an annual redetermination of 1915(i) Benefit eligibility within 364 days of their previous eligibility evaluation. Denominator: Number of enrolled participants who received an annual redetermination of 1915(i) Benefit eligibility.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Reports to State Medicaid Agency on delegated Administrative functions Sampling Approach: 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement 3 ***(Qualified Providers)***	***Sub-Requirement 3-a*** The state verifies that 1915(i) Benefit providers initially and continually meet required licensure and/or certification standards including HCBS setting qualities prior to furnishing 1915(i) services.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 12 (PM12)*** Number and percent of new 1915(i) Benefit providers, which are required by the State to be certified, that meet the State's certification standards prior to providing services. Numerator: Number of new 1915(i)_Benefit providers, which are required by the State to be certified, that meet the State's certification standards prior to providing services. Denominator: Number of initial 1915(i)_Benefit providers, which are required by the State to be certified.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Record Reviews – Off-Site Sampling Approach: 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Continuously and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 3 ***(Qualified Providers)***	***Sub-Requirement 3-a*** The state verifies that 1915(i) Benefit providers initially and continually meet required licensure and/or certification standards including HCBS setting qualities prior to furnishing 1915(i) services.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 13 (PM13)*** Number and percent of ongoing 1915(i) Benefit providers, which are required by the State to be certified, that meet the State's certification standards. Numerator: Number of ongoing 1915(i) Benefit providers, which are required by the State to be certified, that meet the State's certification standards. Denominator: Number of ongoing 1915(i) Benefit providers, which are required by the State to be certified.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Record Reviews – On-Site Sampling Approach: 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	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
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 3 ***(Qualified Providers)***	***Sub-Requirement 3-b*** The State monitors non-licensed/non-certified 1915(i) Benefit providers to assure adherence to provider standards.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 14 (PM14)*** Number and percent of new 1915(i) Benefit providers, which are not required by the State to be licensed or certified, that received an initial provider quality review within 6 months of providing 1915(i) services to 1915(i) participants. Numerator: Number of new 1915(i) Benefit providers, which are not required by the State to be licensed or certified, that received an initial provider quality review within 6 months of providing 1915(i) services to 1915(i) participants. Denominator: Number of new 1915(i) Benefit providers, which are not required by the State to be licensed or certified.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Record Reviews – On-Site and Off-Site Sampling Approach: 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Continuously and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 3 ***(Qualified Providers)***	***Sub-Requirement 3-b*** The State monitors non-licensed/non-certified 1915(i) Benefit providers to assure adherence to provider standards.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 15 (PM15)*** Number and percent of ongoing 1915(i) Benefit providers, which are not required by the State to be licensed or certified, that received a quality review every two years. Numerator: Number of ongoing 1915(i) Benefit providers, which are not required by the State to be licensed or certified, that received a quality review every two years. Denominator: Number of ongoing 1915(i) Benefit providers, which are not required by the State, to be licensed or certified.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Record Reviews – On-Site and Off-Site Sampling Approach: 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Every two years
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 3 ***(Qualified Providers)***	***Sub-Requirement 3-b*** The state implements its policies and procedures for verifying that 1915(i) provider training is conducted in accordance with state requirements and the approved state plan.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 16 (PM16)*** Number and percent of direct care staff training deficiencies identified by the State that were remediated. Numerator: Number of direct care staff training deficiencies identified by the State that were remediated. Denominator: Number of direct care staff training deficiencies identified by the State.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Record Reviews – On-Site and Off-Site Sampling Approach: 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection.
Frequency	The Department issues certificates for certified providers that are in effect for a period of no longer than three years. Providers, who are not certified, are surveyed every two years.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 4 ***(HCBS Settings)***	***Sub-Requirement 4-a*** Settings meet the home and community-based services (HCBS) setting requirements as specified in this state plan amendment and in accordance with 42 CFR 441.701(a)(1) and (2)
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 17 (PM17)*** Number and percent of HCBS settings reviewed that meet the HCBS setting requirements as specified in this state plan amendment and in accordance with 42 CFR 441.701(a)(1) and (2). Numerator: Number of HCBS providers reviewed who meet compliance standards. Denominator: Number of HCBS providers reviewed in the representative sample.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Record Reviews – On-Site and Off-Site Sampling Approach: 100% of reviewed HCBS providers
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 5 ***(Administrative Authority)***	***Sub-Requirement 5-a*** The State Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the program by exercising oversight of the performance of 1915(i) Benefit functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.	
Discovery		
Discovery Evidence *(Performance Measure)*	***Performance Measure 18 (PM18)*** The number and percent of issues requiring remediation identified in contract monitoring reports that were addressed by the State. Numerator: Number of identified issues requiring remediation that were addressed by the State. Denominator: Number of issues requiring remediation identified in contract monitoring reports.	
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Reports to State Medicaid Agency on delegated Administrative functions Sampling Approach: 100% Review	
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation	
Frequency	Quarterly	
Remediation		
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*		The State Medicaid Agency is responsible for data aggregation and analysis
Frequency *(of Analysis and Aggregation)*		Quarterly

Requirement 6 ***(Financial Accountability)***	***Sub-Requirement 6-a*** The State Medicaid Agency maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 19 (PM19)*** Number and percent of claims paid to 1915(i) service providers that are qualified to furnish 1915(i) services to 1915(i) participants. Numerator: Number of claims paid to 1915(i) service providers that are qualified to furnish 1915(i) services to 1915(i) participants. Denominator: Number of claims paid to all 1915(i) service providers.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: 100% Review of billing for a one-week period on an annual basis
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation
Frequency	Quarterly and Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 6 ***(Financial Accountability)***	***Sub-Requirement 6-a*** The State Medicaid Agency maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 20 (PM20)*** Number and percent of demonstrated 1915(i) service provider's fraudulent billing patterns investigated by IDHW and action taken. Numerator: Number of demonstrated 1915(i) service provider's fraudulent billing patterns investigated by IDHW and action taken. Denominator: Number of demonstrated 1915(i)) service provider's fraudulent billing patterns investigated by IDHW.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Critical events and incident reports Sampling Approach: 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection
Frequency	Continuously and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis
Frequency *(of Analysis and Aggregation)*	Annually

Requirement 7 ***(Health and Welfare)***	***Sub-Requirement 7-a*** The state identifies, addresses, and seeks to prevent incidents of abuse, neglect and exploitation, including the use of restraints.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 21 (PM21)*** Number and percent of critical incidents (related to abuse, neglect, and exploitation) substantiated by the State that were remediated. Numerator: Number of critical incidents (related to abuse, neglect, and exploitation) substantiated by the State that were remediated. Denominator: Number of critical incidents (related to abuse, neglect, and exploitation) substantiated by the State.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Critical events and incident reports Sampling Approach: 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection.
Frequency	Continuously and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 7 ***(Health and Welfare)***	***Sub-Requirement 7-a*** The state identifies, addresses, and seeks to prevent incidents of abuse, neglect and exploitation, including the use of restraints.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 22 (PM22)*** Number and percent of reviewed services plans with restrictive interventions (including restraints and seclusion) that were approved according to criteria in the approved state plan. Numerator: Number of reviewed service plans with restrictive interventions that were approved according to criteria in the approved state plan. Denominator: Number of reviewed service plans reviewed with restrictive interventions in the representative sample.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Reports to State Medicaid Agency on delegated Administrative functions Sampling Approach: Representative Sample of adult participants receiving 1915(i) HCBS with restrictive interventions. Confidence Interval = +/- 5% and Confidence Level = 95%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 7 ***(Health and Welfare)***	***Sub-Requirement 7-a*** The state identifies, addresses, and seeks to prevent incidents of abuse, neglect and exploitation, including the use of restraints.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 23 (PM23)*** Number and percent of 1915(i) participants (and/or family or legal guardians) who received information/education about how to report abuse, neglect, exploitation and other critical incidents as specified in the approved state plan.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Reports to State Medicaid Agency on delegate Administrative functions Sampling Approach: 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. **Methods for Analyzing Data and Prioritizing Need for System Improvement**

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.

2. **Roles and Responsibilities**

State Medicaid Agency is Responsible for Remediation Data Aggregation and Analysis

3. **Frequency**

Quarterly

4. Method for Evaluating Effectiveness of System Changes

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.