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State/Territory Name: Idaho

State Plan Amendment (SPA) #: 17-0013

This file contains the following documents in the order listed:

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- 2) CMS 179 Form
- 3) Approved SPA Page

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

April 20, 2018

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

RE: Idaho State Plan Amendment (SPA) Transmittal Number 17-0013, New 1915(i) Benefit, Youth Empowerment Services (YES)

Dear Mr. Barron:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of State Plan Amendment (SPA) Transmittal Number 17-0013, 1915(i) Youth Empowerment Services (YES), submitted on October 5, 2017. This initial application for a 1915(i) State Plan HCBS benefit targets a population of children with serious emotional disturbances (SED). Idaho SPA number 17-0013 was approved on April 12, 2018.

The initial SPA is approved with an effective date of January 1, 2018, and an expiration date of December 31, 2022.

CMS is approving the 1915(i) State Plan benefit based on the understanding that the approved SPA includes a fee-for-service rate methodology and that 1915(i) services will be billed as fee-for-service. In order to deliver 1915(i) services through the state's managed care system, the state must first submit and receive prospective CMS approval of an amendment that adds 1915(i) services to its 1915(b) waiver for the Idaho Behavioral Health Plan.

Since the state has elected to target the population who can receive Section 1915(i) State Plan HCBS, CMS approves this SPA for a five-year period, in accordance with Section 1915(i)(7) of the Act 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.

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

Page 2 – Mr. Armstrong

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 amendment. 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,

Digitally signed by David L. Meacham -S



David L. Meacham
Associate Regional Administrator

cc:

Matt Wimmer, Idaho Department of Health and Welfare
George Gutierrez, Idaho Department of Health and Welfare
Lord Clay, Idaho Department of Health and Welfare
Michael Case, Idaho Department of Health and Welfare
Karen Westbook, Idaho Department of Health and Welfare
Carolyn Burt, Idaho Department of Health and Welfare
Teresa Martin, Idaho Department of Health and Welfare
Tiffany Kinzler, Idaho Department of Health and Welfare

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 17-0013	2. STATE IDAHO
FOR: HEALTH CARE FINANCING ADMINISTRATION	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 January 1, 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 §§ 1902(a)(10)(A)(ii)(XXII), 1902(r)(2), 1915(i); 42 CFR 435.219	7. FEDERAL BUDGET IMPACT: a. FFY 2018 \$2,968,400 b. FFY 2019 \$5,936,800
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 2.2-A, pages 23f and 23g [superseding] Supplement 8a to Attachment 2.6-A, page 3 [NEW] Supplement 3 to Attachment 3.1-A, pages 1-2 1-34 (P&I) [NEW] Attachment 4.19-B, page 51 (P&I) (NEW)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 2.2-A, pages 23f and 23g

10. SUBJECT OF AMENDMENT:
As required by a court-ordered settlement agreement, this SPA defines a new eligibility group for children with serious emotional disturbance (SED) under Attachment 2.2-A; amends Supplement 8a of Attachment 2.6-A to target a 1902(r)(2) income disregard for this eligibility group; and adds a new Supplement 3 to Attachment 3.1-A to implement the 1915(i) State plan option to provide HCBS to this target population.

11. GOVERNOR'S REVIEW (*Check One*):

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Lisa Hettinger, Deputy Director Idaho Department of Health and Welfare Division of Medicaid PO Box 83720 Boise ID 83720-0009
13. TYPED NAME: LISA HETTINGER	
14. TITLE: Deputy Director	
15. DATE SUBMITTED: 10-5-2017	

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED: 10/5/17	18. DATE APPROVED: 4/12/18
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/1/18	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: David L. Meacham	22. TITLE: Associate Regional Administrator

23. REMARKS:
1-26-18- State authorized P&I change to block 8.

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):*

Respite Care.

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

Select one:

<input type="radio"/>	Not applicable
<input checked="" type="radio"/>	Applicable
Check the applicable authority or authorities:	
<input type="checkbox"/>	<p>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 <i>voluntarily</i> elect to receive <i>waiver</i> and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. <i>Specify:</i></p> <p><i>(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);</i></p> <p><i>(b) the geographic areas served by these plans;</i></p> <p><i>(c) the specific 1915(i) State plan HCBS furnished by these plans;</i></p> <p><i>(d) how payments are made to the health plans; and</i></p> <p><i>(e) whether the 1915(a) contract has been submitted or previously approved.</i></p>
<input checked="" type="checkbox"/>	<p>Waiver(s) authorized under §1915(b) of the Act.</p> <p><i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved: Idaho Behavioral Health Waiver, ID.02.R01. This waiver application has been previously approved.</i></p>
Specify the §1915(b) authorities under which this program operates <i>(check each that applies):</i>	
<input checked="" type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)
<input type="checkbox"/>	§1915(b)(3) (employ cost savings to furnish additional services)

State: ID
TN: 17-0013
Effective: 1/1/2018

§1915(i) State plan HCBS
Approved: 4/12/18

Supplement 3 to Attachment 3.1–A:
Page 2

Supersedes: NEW

<input type="checkbox"/>	§1915(b)(2) (central broker)	<input checked="" type="checkbox"/>	§1915(b)(4) (selective contracting/limit number of providers)
<input type="checkbox"/>	A program operated under §1932(a) of the Act. <i>Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:</i>		
<input type="checkbox"/>	A program authorized under §1115 of the Act. <i>Specify the program:</i>		

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

<input checked="" type="radio"/>	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 (<i>select one</i>):	
	<input checked="" type="radio"/>	The Medical Assistance Unit (<i>name of unit</i>): Division of Medicaid
	<input type="radio"/>	Another division/unit within the SMA that is separate from the Medical Assistance Unit <i>(name of division/unit)</i> <i>This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.</i>
<input type="radio"/>	The State plan HCBS benefit is operated by (<i>name of agency</i>) 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	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2 Eligibility evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3 Review of participant service plans	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4 Prior authorization of State plan HCBS	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5 Utilization management	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6 Qualified provider enrollment	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7 Execution of Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8 Establishment of a consistent rate methodology for each State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10 Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

1. Independent Assessment Provider
2. Independent Assessment Provider confirms SED status; the Department evaluates applicants for all other eligibility criteria (e.g., family income)
3. IBHP (Idaho Behavioral Health Plan) Contractor
4. IBHP Contractor

5. IBHP Contractor
6. Credentialed behavioral health agency verifies qualifications of respite providers, IBHP Contractor
7. IBHP Contractor
8. IBHP Contractor
9. IBHP Contractor
10. IBHP Contractor
11. IBHP Contractor

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

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

N/A

6. **Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.
7. **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.
8. **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	January 1, 2018	December 31, 2018	4,000
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 Level (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):*

<input checked="" type="checkbox"/> The State does not provide State plan HCBS to the medically needy.
<input type="checkbox"/> The State provides State plan HCBS to the medically needy <i>(select one):</i>
<input type="checkbox"/> The state elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.
<input type="checkbox"/> The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

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

<input type="radio"/>	Directly by the Medicaid agency
<input checked="" type="radio"/>	By Other (<i>specify State agency or entity under contract with the State Medicaid agency</i>): Contracted Independent Assessment provider(s) will be determined according to state purchasing requirements.

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*):

State-licensed, CANS (Child-Adolescent Needs and Strengths)-certified, master’s-level clinicians or higher. Independent Assessors receive specific training in the use of the CANS, a Department-approved tool for assessing children who may require HCBS and may qualify to be participants in the Medicaid SED program in support of the Youth Empowerment Services (YES) system of care.

The regulations that specify the state’s licensure criteria applicable to independent assessors appear in Idaho Code in the locations cited below:

- **Psychologists:** Title 54, Chapter 23 (Psychologists), with specific criteria listed in §54-2307, Qualifications for License.
- **Counselors and Therapists:** Title 54, Chapter 34 (Counselors and Therapists), with specific criteria listed in §§54-3405, 54-3405A, 54-3405B, and 54-3405C, Qualifications for Licensure.
- **Clinical Social Workers:** Title 54, Chapter 34 (Social Work Licensing Act), with specific criteria listed in §54-3206, Licensing – Qualifications.

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:

Potential program participants seeking 1915(i) state plan option services will be referred to the independent assessment provider (IAP), who will determine whether the child meets the diagnostic and functional impairment criteria required to access 1915(i) services through this program.

The independent assessment will include a comprehensive clinical diagnostic assessment, or review of a current CDA, to verify a diagnosis that is consistent with serious emotional disturbance (SED), and the administration of the CANS (Child-Adolescent Needs and Strengths) assessment tool, which will identify the child’s needs, strengths, and initial functional impairment score. (See assessment scoring criteria on the following page.) The initial assessment process also includes:

- a. Evaluation of the child’s current behavioral health, living situation, relationships, and family functioning;
- b. Contacts, as necessary, with significant individuals such as family and teachers; and
- c. A review of information regarding the child’s clinical, educational, social, behavioral health, and juvenile/criminal justice history.

The independent assessment, however, is only one component of the eligibility process; the other component, Medicaid eligibility, is determined by the Self-Reliance (Welfare) Division of the Department. They will verify other eligibility criteria—state residency, age, family income, etc. Once determined to be Medicaid-eligible, the plan facilitator will initiate the person-centered planning process.

The reevaluation includes a review of a current CDA (one that has been updated from the original CDA utilized at the initial evaluation), and conducting an updated CANS assessment. A review of additional materials could take place if necessary to inform any diagnostic changes.

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):

Participants eligible to receive services under this 1915(i) have a substantial functional impairment that is measured by and documented through the use of a standardized instrument conducted or supervised by a qualified independent assessor clinician.

Substantial Functional Impairment

The CANS assessment tool is used to measure substantial functional impairment, which is a condition of participation in the Medicaid SED program in support of the YES system of care. Using the CANS, the independent assessor assigns the child a rating from 0 to 3 (where 0 = no evidence of a need, 1 = monitoring for need, 2 = need requiring intervention, and 3 = need requiring immediate or intensive intervention) on each item. The following three domains are central to a determination of substantial functional impairment associated with a treatable mental health condition:

- 1) Behavioral and Emotional Needs (this subscale contains 12 items on which the child is rated);
- 2) Life Domain Functioning (8 items);
- 3) Risk Behaviors (14 items).

The child is considered to have substantial functional impairment when the following criteria are met:

- 1) Behavioral and emotional needs—at least one item is rated a “2” or higher (indicating the presence of a psychiatric syndrome requiring treatment); AND
- 2) Life domain functioning—at least one item is rated a “2” or higher, (indicating substantial functional impairment associated with the psychiatric syndrome); OR
- 3) Risk behaviors—at least one item rated at least a “2” (indicating danger to self or others associated with the psychiatric syndrome).

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* LOC (& Hospital LOC waivers)
<p>Participants eligible to receive services under this 1915(i) have a substantial functional impairment that is measured by and documented through the use of a standardized instrument conducted or supervised by a qualified independent assessor clinician.</p> <p>Substantial Functional Impairment</p> <p>The CANS assessment tool is used to measure substantial functional impairment, which is a condition of participation in this program. Using the CANS, the independent assessor assigns the child a rating from 0 to 3 (where 0 = no evidence of a need, 1 = monitoring for need, 2 = need requiring intervention, and 3 =</p>	<p>[Excerpted/adapted from IDAPA 16.03.10.223]</p> <p>The participant requires nursing facility level of care when a child meets one (1) or more of the following criteria:</p> <p>01. Supervision Required for Children. Where the inherent complexity of a service prescribed by the physician is such that it can be safely and effectively performed only by or under the supervision of a licensed nurse or licensed physical or occupational therapist.</p> <p>02. Preventing Deterioration for Children. Skilled care is needed to prevent, to the extent possible, deterioration of the child's condition or to</p>	<p>[Excerpted/adapted from IDAPA 16.03.10.584]</p> <p>01. Diagnosis. Persons must be financially eligible for Medicaid; must have a primary diagnosis of being intellectually disabled or have a related condition defined in Section 66-402, Idaho Code and IDAPA Sections 500 through 506; and persons must qualify based on functional assessment, maladaptive behavior, a combination of both, or medical condition.</p> <p>02. Must Require Certain Level of Care. Persons living in the community must require the level of care provided in an ICF/ID, including active treatment, and in the absence of available</p>	<p>[Excerpted/adapted from IDAPA 16.03.09.701]</p> <p>Participants must have a DSM-5 diagnosis with substantial impairment in thought, mood, perception or behavior.</p> <p>01. Medical Necessity Criteria. Both severity of illness and intensity of services criteria must be met for admission to a psychiatric unit of a general hospital.</p> <p>a. Severity of illness criteria. The child must meet one (1) of the following criteria related to the severity of his psychiatric illness:</p> <ol style="list-style-type: none"> i. Is currently dangerous to self, as defined in IDAPA 16.03.09.701.01.a; ii. Is actively violent or aggressive and exhibits homicidal ideation or other symptoms which indicate he is a probable danger to others, as defined in IDAPA 16.03.09.701.01.a; <p>or</p>

<p>need requiring immediate or intensive intervention) on each item. The following three domains are central to a determination of substantial functional impairment associated with a treatable mental health condition:</p> <ol style="list-style-type: none"> 1) Behavioral and Emotional Needs (this subscale contains 12 items on which the child is rated); 2) Life Domain Functioning (8 items); 3) Risk Behaviors (14 items). <p>The child is considered to have substantial functional impairment when the following criteria are met:</p> <ol style="list-style-type: none"> 1) Behavioral and emotional needs—at least one item is rated a “2” or higher (indicating the presence of a psychiatric syndrome requiring treatment); AND 2) Life domain functioning—at least one item is rated a “2” or higher, (indicating substantial functional impairment associated with the psychiatric syndrome); OR 3) Risk behaviors—at least one item rated at least a “2” (indicating danger to self or others associated with the psychiatric syndrome). 	<p>sustain current capacities, regardless of the restoration potential of a child, even where full recovery or medical improvement is not possible.</p> <p>03. Specific Needs for Children. When the plan of care, risk factors, and aggregate of health care needs is such that the assessments, interventions, or supervision of the child necessitate the skills of a licensed nurse or a licensed physical therapist or licensed occupational therapist. In such cases, the specific needs or activities must be documented by the physician’s orders, progress notes, plan of care, and nursing and therapy notes.</p> <p>04. Nursing Facility Level of Care for Children. Using the above criteria, plus consideration of the developmental milestones, based on the age of the child, the Department will determine nursing facility level of care.</p>	<p>intensive alternative services in the community, would require institutionalization, other than services in an institution for mental disease, in the near future.</p> <p>03. Functional Limitations.</p> <ol style="list-style-type: none"> a. Persons Sixteen Years of Age or Older. Persons sixteen (16) years of age or older may qualify based on their functional skills. Persons with an age equivalency composite score of eight (8) years and zero (0) months or less on a full scale functional assessment (SIB-R, or subsequent revisions) would qualify. b. Persons Under Sixteen Years of Age. Persons under sixteen (16) years of age qualify if their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age. <p>04. Combination Functional and Maladaptive Behaviors. Persons may qualify for ICF/ID level of care if they display a combination of criteria as described in IDAPA 16.03.10.584 at a level that is significant and it can be determined they are in need of the level of services provided in an</p>	<p>iii. Is gravely impaired, as defined in IDAPA 16.03.09.701.01.a., which specifies that the individual meet at least (1) of the following criteria:</p> <ol style="list-style-type: none"> (1) The child has such limited functioning that his physical safety and well being are in jeopardy due to his inability for basic self-care, judgment and decision making (details of the functional limitations must be documented); or (2) The acute onset of psychosis or severe thought disorganization or clinical deterioration has rendered the child unmanageable and unable to cooperate in non-hospital treatment (details of the child’s behaviors must be documented); or (3) There is a need for treatment, evaluation or complex diagnostic testing where the child’s level of functioning or communication precludes assessment and/or treatment in a non-hospital based setting, and may require close supervision of medication or behavior or both. <p>b. Intensity of service criteria. The child must meet all of the criteria set forth in IDAPA 16.03.09.701.01.b.:</p> <ol style="list-style-type: none"> i. It is documented that the child has been unresponsive to treatment at a less intensive level of care; ii. The services provided in the hospital can reasonably be expected to improve the child's condition or prevent further regression so that inpatient services will no longer be needed; and
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		ICF/ID, including active treatment services. 05. Medical Condition. Individuals may meet ICF/ID level of care based on their medical condition if the medical condition significantly affects their functional level/capabilities and it can be determined that they are in need of the level of services provided in an ICF/ID, including active treatment services.	iii. Treatment of the child's psychiatric condition requires services on an inpatient basis, including twenty-four (24) hour nursing observation, under the direction of a psychiatrist.
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*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*):

Children, under eighteen (18) years, who are determined to have serious emotional disturbance (SED) in accordance with Section 16-2403, Idaho Code, and have a Diagnostic and Statistical Manual of Mental Disorders (DSM, per the most current edition) mental health condition diagnosable by a practitioner of the healing arts operating within the scope of his/her practice as defined by Idaho state law.

- 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 box the State assures that):

8. **Adjustment Authority.** As provided in 42 CFR §441.715(c), 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 State plan HCBS:

i.	<p>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:</p>
1	
ii.	<p>Frequency of services. The state requires (select one): At least annual provision of 1915(i) services.</p>
<input type="radio"/>	<p>The provision of 1915(i) services at least monthly</p>
<input checked="" type="radio"/>	<p>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: At least annual provision of 1915(i) services.</p>

Monthly monitoring. The state will designate a contractor as the party responsible for conducting monthly monitoring to identify any potential issues. The contractor will be responsible for tracking the frequency of utilization for all Medicaid services specified in the person-centered plan. In addition, telephonic outreach or face-to-face contact with the participant and family will take place at meetings to update the results of the CANS or to modify the person-centered service plan. During such meetings and contacts, the planning team, which includes the plan facilitator, the participant and family, will examine the ongoing implementation of the person-centered service plan, and determine how well the services on the plan are meeting the participant’s needs and whether the participant has experienced any health and welfare issues, or issues accessing Medicaid services or exercising free choice of providers. The plan facilitator will notify the contractor within one business day of any issues regarding the ongoing implementation of the plan or affecting the health and welfare of the participant.

The following methods will ensure that any identified problems receive prompt follow-up and remediation by the Department:

- Should any issues come to light in the course of monthly monitoring, or should the contractor become aware of any problems identified by the participant/family or the participant’s service providers, the contractor will be responsible for reporting them to the SMA within one business day of their discovery.
- Should any issues come to light in the course of service plan evaluation and adjustment, the plan facilitator will be responsible for reporting them to the SMA within one business day of their discovery.

Home and Community-Based Settings

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

- 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.)

Description of the settings where individuals will reside: Residential locations are limited to the participant's family home or a foster family home.

Description of the settings where individuals will receive HCBS Respite Care: Respite may be provided by a credentialed behavioral health agency in the participant's home, another private residence, the credentialed agency, or in community locations that are not institutional in nature, such as parks, malls, stores, and other activity centers.

All settings mentioned above are presumed to meet HCBS compliance, since none have the qualities of an institutional setting as set forth in 42 CFR §441.530.

In contrast with both of the state's existing State Plan options for participants with developmental disabilities, this 1915(i) does not involve any of the following types of settings: Certified Family Homes; Residential Assisted Living Facilities; residential treatment facilities; DD agency facilities; or day health centers.

IDAPA 16.03.10.318 states that new HCBS providers or service settings are expected to fully comply with the HCBS requirements and qualities as a condition of becoming a Medicaid provider. The Department is responsible for ongoing enforcement of quality assurance compliance. Regarding settings where services and supports are delivered under this program, IDAPA 16.03.10.318 also requires all current providers of HCBS to complete a Department-approved self assessment form related to the setting requirements and qualities described in 42 CFR 441, Subpart M.

The self-assessment form, which is included as an attachment with this submission, will identify the provider and agency, and require that the provider complete a table for every setting in which the provider delivers HCBS under this program. The provider is required to complete assurances of the following (by means of a checkbox) for each HCBS setting:

1. None of the following facility types describe this setting: nursing facility, institution for mental diseases, intermediate care facility for persons with intellectual disabilities (ICF/ID), or hospital.
2. This setting is not located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment.

3. This setting is not located on the grounds of, or immediately adjacent to, a state or federally operated inpatient treatment facility.
4. The qualities of this setting do not have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS.

The IBHP contractor will ensure that every current provider of HCBS to program participants completes this form as part of the process of enrolling providers in its network for this program.

Person-Centered Planning & Service Delivery

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

1. There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment 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 planning process in accordance with 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 participant's circumstances or needs change significantly, and at the request of the participant.
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 physical and mental needs for HCBS. (*Specify qualifications*):

Responsibility for face-to-face, independent assessment of an applicant's needs and capabilities is assigned to state-licensed, CANS (Child-Adolescent Needs and Strengths)-certified, master's-level clinicians or higher. Independent Assessors receive specific training in the use of the CANS, a Department-approved tool for assessing children who may require HCBS and may qualify to be participants in this program. The Department assures that independent assessors will not be involved in providing 1915(i) services to participants.

The regulations that specify the state's licensure criteria applicable to independent assessors appear in Idaho Code in the locations cited below:

- **Psychologists:** Title 54, Chapter 23 (Psychologists), with specific criteria listed in §54-2307, Qualifications for License.
- **Counselors and Therapists:** Title 54, Chapter 34 (Counselors and Therapists), with specific criteria listed in §§54-3405, 54-3405A, 54-3405B, and 54-3405C, Qualifications for Licensure.
- **Clinical Social Workers:** Title 54, Chapter 34 (Social Work Licensing Act), with specific criteria listed in §54-3206, Licensing – Qualifications.

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

The plan facilitator is primarily responsible for the development of the individualized, person-centered service plan, and the facilitator works closely with the person-centered planning team to accomplish this objective. The members of the person-centered planning team are selected by the participant and family, and will work together in accordance with a Child and Family Team (CFT) model.

Qualifications for the plan facilitator include a bachelor's degree in a human-services field, experience working with the SED population, and state-required training in person-centered plan development. The Department or its designee will employ plan facilitators, and the state assures that plan facilitators will not be involved in providing direct services to participants.

The goal is for the team to develop the person-centered plan and submit it to the designated contractor for approval within 30 days; the contractor will have five business days to review and approve or reject the plan. The review will ensure that all requirements established by Medicaid and CFR, as well as all services needed by the participant, are properly documented on the plan. If the plan does not meet all applicable CFR and Medicaid requirements, the contractor will send the plan back to the plan facilitator for revision by the person-centered planning team.

Once the plan is approved and approval is communicated to the plan facilitator, treatment providers specified in the plan may submit Service Request Forms (SRFs) for authorization. After review of SRFs, which will include determination of the appropriate frequency and intensity for the services being requested, Service Authorizations will be issued for services documented as necessary on the person-centered plan, while requests for services not included on the plan will be denied. (In addition, SRFs for any services where the reviewer determines that the provider has incorrectly specified the frequency and/or intensity of the service will receive a partial denial.) Participants will be informed in writing of any denials, and that communication will also include instructions on how to appeal adverse decisions and the opportunities for the participant to request a fair hearing.

- 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*):

The primary supports for the participant during plan development are the plan facilitator and the other members of the person-centered planning team, who are selected by the participant and family. The facilitator and team will support the participant in selecting among the many qualified providers available in the IBHP provider network.

Item #7 below describes information that the independent assessor provides to applicants; this information, which includes lists of community resources and qualified service providers, may be reviewed by the planning team and plan facilitator during development and included in the person-centered service plan.

- 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 initial assessment process, the independent assessor links applicants with the resources needed to take full advantage of Medicaid services and this program, including lists of community resources and qualified service providers, as well as contact information for the agency responsible for supplying the facilitators who—if the applicant is determined as qualified to become a program participant—will be responsible for convening the person-centered planning team and developing the person-centered service plan.

On an ongoing basis, the plan facilitator and/or case manager will be able to provide the participant and the planning team with ready access to information concerning selection of qualified providers and available service providers.

8. Process for Making Plan of Care 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):

While every service plan is reviewed and approved on a day-to-day basis by a designee of the Department (i.e., contractor), the SMA will retain ultimate oversight for service plan approval through a retrospective review process. Furthermore, as the basis of one of the reporting requirements documented elsewhere in this application (see Service Plans, Sub-requirement (a) in the QIS section), for every approved service plan included in the sample, Medicaid staff will compare the service plan against the independent assessment for accuracy, and will also ensure that plans:

- Have been developed in accordance with the policies and procedures set forth in this 1915(i);
- Initially approved by the contractor do in fact accurately reflect participant’s needs, goals, and risk factors as identified in the assessment;
- Meet other required criteria set forth in applicable CFR; and
- Comply with all applicable Medicaid requirements.

The retrospective review process will entail pulling a statistically significant sample every quarter that is representative of the total population receiving services through the 1915(i) benefit for each month in that quarter, then completing the analysis and review activities quarterly. Consistent with the QIS activity documented under Service Plans, Sub-requirement (a), the SMA will compile the results of the retrospective plan review process annually.

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):

<input type="checkbox"/>	Medicaid agency	<input type="checkbox"/>	Operating agency	<input checked="" type="checkbox"/>	Case manager
<input checked="" type="checkbox"/>	Other (specify):	IBHP Contractor, or if applicable for the service being provided, Network Providers			

Services

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

Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>			
Service Title:	Respite Care		
Service Definition (Scope):			
<p>Respite care is short-term or temporary care for a child/youth with SED provided in the least restrictive environment that provides relief for the usual caretaker and is aimed at de-escalation of stressful situations.</p> <p>Respite may be provided by a credentialed behavioral health agency in the participant’s home, another private residence, the credentialed agency, or in community locations that are not institutional in nature, such as parks, malls, stores, and other activity centers.</p>			
Additional needs-based criteria for receiving the service, if applicable <i>(specify)</i> :			
N/A			
Specify limits (if any) on the amount, duration, or scope of this service for <i>(choose each that applies)</i> :			
<input checked="" type="checkbox"/>	Categorically needy <i>(specify limits)</i> :		
	<p>Limitations:</p> <ul style="list-style-type: none"> Maximum of 72 hours of respite care consecutively when respite is not delivered in a community location; maximum of 10 hours consecutively when respite is delivered in a community location; and 300 hours total in a 12-month calendar period. Payment for respite services are not made for room and board. Respite services shall 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. In addition, as a result of care coordination efforts, a participant who may be receiving services under 1915(c) waiver programs will not receive duplicate services. As part of the reimbursement process, the IBHP contractor will verify that there are not multiple claims for providing respite care to the same participant on the same dates of service. This will preclude potential duplication of respite services. 		
<input type="checkbox"/>	Medically needy <i>(specify limits)</i> :		
Provider Qualifications <i>(For each type of provider. Copy rows as needed):</i>			
Provider Type <i>(Specify)</i> :	License <i>(Specify)</i> :	Certification <i>(Specify)</i> :	Other Standard <i>(Specify)</i> :
Respite Care Provider			<p>To provide respite, providers must be affiliated with a Medicaid-enrolled, credentialed behavioral health agency and:</p> <p>1) Be at least twenty-one (21) years of age with a high school diploma or GED;</p>

			2) Have at least six (6) months’ full-time (1,040 hours) work or volunteer experience working with children experiencing SED and their families; 3) Have the knowledge and skills to provide the service and effectively address participants’ needs; 4) Successfully complete the training for respite care developed by the IBHP contractor; 5) Have received classroom or on-the-job training on the following: a. Characteristics of an SED; b. Behavior management principles and strategies; c. How to de-escalate and prevent, as well as manage, a crisis; d. Confidentiality and mandated reporting requirements; e. Basic First Aid training.
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):	
Respite Care Provider	Credentialed behavioral health agency	<ul style="list-style-type: none"> • At initial provider agreement approval or renewal • At least every two years, and as needed based on service monitoring concerns 	
Service Delivery Method. (Check each that applies):			
<input type="checkbox"/> Participant-directed		<input checked="" type="checkbox"/> Provider managed	

8. **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):*

A parent/legal guardian, relative, or legally responsible individual cannot furnish paid State plan HCBS.

Providers are not allowed to be in a position to both influence a participant and parent/legal guardian’s decision-making and benefit financially from these decisions. Additionally, the participant’s case manager and the Department are available to address any potential conflicts of interest that may arise.

Participant-Direction of Services

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

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

<input checked="" type="radio"/>	The State does not offer opportunity for participant-direction of State plan HCBS.
<input type="radio"/>	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.
<input type="radio"/>	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. <i>(Specify criteria):</i>

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	Service Plans, Sub-requirement (a): Plans address assessed needs of 1915(i) participants
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of approved service plans that: <ul style="list-style-type: none"> • Have been developed in accordance with the policies and procedures specified in this 1915(i); • Accurately reflect the participant’s needs, goals, and risk factors as identified in the assessment; • Meet other required criteria set forth in applicable CFR; and • Comply with all applicable Medicaid requirements. <p>a. Numerator: Number of approved plans reviewed that meet the requirements specified in the bulleted list above.</p> <p>b. Denominator: Number of approved plans reviewed.</p>

Discovery Activity <i>(Source of Data & sample size)</i>	<p>Data Source: Analysis of individual service plans by Medicaid staff to ensure the accuracy of plan approvals will determine whether the plan: (1) is accurately aligned with the needs, goals, and risk factors as identified in the independent assessment; (2) is in accordance with the policies and procedures specified in this 1915(i); (3) meets other required criteria set forth in applicable CFR; and (4) complies with all applicable Medicaid requirements.</p> <p>Sampling Approach: Statistically significant sample of service plans that were reviewed and approved by the IBHP contractor each month during the previous quarter. This sample will be representative of the total population receiving services through the 1915(i) benefit.</p> <p>Confidence interval = 95% with +/- 5% margin of error.</p>
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	<p>The State Medicaid Agency is responsible for data collection/generation.</p>
Frequency	<p>Annual</p>
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<p>The State Medicaid Agency is responsible for data aggregation and analysis.</p>
Frequency <i>(of Analysis and Aggregation)</i>	<p>Annual</p>

Requirement	<p>Service Plans, Sub-requirement (b): Plans are updated annually</p>
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	<p>Number and percent of service plans reviewed and approved by the Department or its designee prior to the expiration of the current plan of service.</p> <p>a. Numerator: Number of service plans that were reviewed and approved by the Department or its designee prior to the expiration of the current plan of service.</p> <p>b. Denominator: Number of service plans reviewed and authorized by the Department or its designee.</p>
Discovery Activity <i>(Source of Data & sample size)</i>	<p>Data Source: Reports to State Medicaid Agency on delegated administrative functions.</p> <p>Sampling Approach: Representative sample of service plans developed for program participants receiving HCBS services.</p> <p>Confidence interval = 95% with +/- 5% margin of error.</p>

Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Annual
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency <i>(of Analysis and Aggregation)</i>	Annual

Requirement	Service Plans, Sub-requirement (c): Plans document choice of services and providers
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	<p>Number and percent of approved service plans that document, for every service whose need was indicated by the results of the independent assessment, either:</p> <ul style="list-style-type: none"> • The participant’s choice among the available providers qualified to deliver that service; or • In cases where a given service was called for by the results of the independent assessment but was declined, the participant’s choice not to receive that service. <p>a. Numerator: Number of approved plans reviewed whose content meets the criteria specified in the bulleted list above.</p> <p>b. Denominator: Number of approved service plans reviewed.</p>
Discovery Activity <i>(Source of Data & sample size)</i>	<p>Data Source: Reports to State Medicaid Agency on delegated administrative functions.</p> <p>Sampling Approach: Representative sample of service plans developed for program participants receiving HCBS services.</p> <p>Confidence interval = 95% with +/- 5% margin of error.</p>
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Annual
Remediation	
Remediation Responsibilities <i>(Who corrects,</i>	The State Medicaid Agency is responsible for data aggregation and analysis.

<i>analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	
Frequency <i>(of Analysis and Aggregation)</i>	Annual

Requirement	Eligibility Requirements: Sub-requirement (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
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of SED-likely applicants referred to Medicaid for services (e.g., by referral sources such as schools, Idaho Department of Juvenile Corrections, primary care physicians, etc.) who receive a completed assessment by the independent assessor. a. Numerator: Number of applicants referred for program services who received a completed assessment. b. Denominator: Number of applicants referred for program services.
Discovery Activity <i>(Source of Data & sample size)</i>	Data Source: Reports to State Medicaid Agency from the independent assessor on delegated administrative functions. Sampling Approach: 100% review of remediation issues.
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Annual
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency <i>(of Analysis and Aggregation)</i>	Annual

Requirement	Eligibility Requirements: Sub-requirement (b): The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately
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Discovery	
Discovery Evidence <i>(Performance Measure)</i>	<p>Number and percent of eligibility determinations for which criteria were evaluated appropriately and in accordance with policy (criteria such as income limit, substantial functional impairment, qualifying diagnosis).</p> <p>a. Numerator: Number of eligibility determinations that were resolved appropriately and in accordance with policy.</p> <p>b. Denominator: Number of eligibility determinations performed.</p>
Discovery Activity <i>(Source of Data & sample size)</i>	<p>Data Source: Reports to State Medicaid Agency on delegated administrative functions.</p> <p>Sampling Approach: Representative sample of eligibility determinations performed.</p> <p>Confidence interval = 95% with -/+ 5% margin of error.</p>
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Quarterly
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency <i>(of Analysis and Aggregation)</i>	Quarterly

Requirement	Eligibility Requirements: Sub-requirement (c): The 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	<p>Number and percent of participants in the calendar quarter being examined who received an annual redetermination of eligibility within 365 days of their previous eligibility assessment.</p> <p>a. Numerator: Number of participants who were screened for annual eligibility redetermination prior to expiration of their eligibility.</p> <p>b. Denominator: Number of participants who received an annual redetermination of eligibility during the quarter.</p>
Discovery Activity <i>(Source of Data & sample size)</i>	<p>Data Source: Reports to State Medicaid Agency on delegated administrative functions.</p> <p>Sampling Approach: 100% review of annual redetermination of eligibility.</p>

Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Annual
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency <i>(of Analysis and Aggregation)</i>	Annual

Requirement	Providers meet required qualifications
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	<p>Number and percent of enrolled program service providers who meet state and program requirements for certification and have successfully completed state-required training.</p> <p>a. Numerator: For a given 1915(i) service, the number of enrolled providers delivering that service who meet required licensure or certification standards and have completed state-required training, and are therefore qualified to be program service providers.</p> <p>b. Denominator: For a given 1915(i) service, the number of enrolled providers delivering that service to participants.</p>
Discovery Activity <i>(Source of Data & sample size)</i>	<p>Data Source: Reports to State Medicaid Agency on delegated administrative functions.</p> <p>Sampling Approach: 100% review.</p>
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Continuously and ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required</i>	The State Medicaid Agency is responsible for data aggregation and analysis.

<i>timeframes for remediation)</i>	
Frequency <i>(of Analysis and Aggregation)</i>	Annual

Requirement	Compliance with HCBS Settings Requirements
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	<p>Number and percent of providers whose Department-required self-assessment forms confirm that the provider’s settings meet HCBS settings requirements as stated in this SPA and applicable CFR.</p> <p>a. Numerator: Number of HCBS providers whose self-assessment forms were approved by the Department or its designee.</p> <p>b. Denominator: Number of HCBS providers who submitted self-assessment forms for review and approval.</p>
Discovery Activity <i>(Source of Data & sample size)</i>	<p>Data Source: Reports from contractor to the SMA, giving statistics regarding Department-approved self-assessment forms related to setting requirements and qualities, which all current providers of HCBS are required to complete as a condition of becoming a Medicaid provider, in accordance with IDAPA 16.03.10.318.</p> <p>Sampling Approach: 100% review of providers’ self-assessment forms by the Department or its designee.</p>
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Continuously and ongoing.
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency <i>(of Analysis and Aggregation)</i>	Annual

Requirement	Administrative Authority and Program Oversight
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	The number and percent of remediation issues that the state followed up on that were identified in the contract monitoring reports. a. Numerator: Number of remediation issues followed up on identified in the contract monitoring reports. b. Denominator: Number of remediation issues identified in the contract monitoring reports.
Discovery Activity <i>(Source of Data & sample size)</i>	Data Source: Reports to State Medicaid Agency on all delegated administrative functions. Quality Management Improvement and Accountability Plan will monitor key quality performance management indicators from implementation through ongoing operation. Sampling Approach: 100% review of remediation issues
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Quarterly
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	The State Medicaid Agency shares responsibility for data aggregation and analysis with the State Medicaid Authority and assigned contractors.
Frequency <i>(of Analysis and Aggregation)</i>	Quarterly

Requirement	Financial Accountability: Claims are paid for services that are authorized and are delivered by qualified providers
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of claims denied for 1915(i) services that were not authorized or were furnished by unqualified providers. a. Numerator: Number of claims denied because services were not authorized or were furnished by unqualified providers. b. Denominator: Total claims submitted for 1915(i) services.

Discovery Activity <i>(Source of Data & sample size)</i>	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: Representative sample of child participants receiving SED services. Confidence interval = 95% with +/- 5% margin of error.
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Continuously and ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency <i>(of Analysis and Aggregation)</i>	Annual

Requirement	Identifying, addressing and preventing incidents of abuse, neglect, and exploitation: Sub-requirement (a)
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of reported incidents of abuse, neglect or exploitation—to include reported incidents involving the use of restraints—for which follow-up was completed within policy timelines. a. Numerator: Number of reported incidents related to abuse, neglect or exploitation where action/resolution was completed within policy timelines. b. Denominator: Number of reported incidents related to abuse, neglect or exploitation.
Discovery Activity <i>(Source of Data & sample size)</i>	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: 100% review of critical reports.
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Annual
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and</i>	The State Medicaid Agency is responsible for data aggregation and analysis.

<i>aggregates remediation activities; required timeframes for remediation)</i>	
Frequency <i>(of Analysis and Aggregation)</i>	Annual

Requirement	Identifying, addressing and preventing incidents of abuse, neglect, and exploitation: Sub-requirement (b)
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of participants and/or family who received information/education about how to report abuse, neglect, exploitation, the use of restraints, and other critical incidents. a. Numerator: Number of participants or family who received information/education about how to report critical incidents. b. Denominator: Number of participants receiving services.
Discovery Activity <i>(Source of Data & sample size)</i>	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: 100% review.
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Annual
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency <i>(of Analysis and Aggregation)</i>	Annual

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

- a. Complaints and incident reports are investigated.
- b. Services are delivered in accordance with care plans.
- c. How are children and families showing improvement in functioning?
- d. Annual QM Report.
- e. Are children provided services in the least restrictive environment appropriate for their care?

2. Roles and Responsibilities

- a. **Quality Management, Improvement and Accountability (QMIA):** This is a group of dedicated state agency employees who will look at complaints and issues across the continuum of care.
- b. **Department Analyst:** This resource will examine quality management issues across the continuum of care.
- c. **QMIA:** The QMIA team is responsible for steering the quality assessment and improvement process.
- d. **Medicaid’s Office of Mental Health and Substance Abuse (OMHSA) program manager:** The OMHSA program manager takes overall responsibility for leading team members, finalizing annual QM reports, leading the process of prioritizing needs for system improvements, and implementing approved system improvements.
- e. **QMIA:** The QMIA team is responsible for steering the quality assessment and improvement process.

3. Frequency

- a. Ongoing.
- b. Ongoing.
- c. Annual
- d. Annual Report.
- e. Annual.

4. Method for Evaluating Effectiveness of System Changes

- a. Annual QM report is submitted to administration.
- b. Annual QM report is submitted to administration.
- c. Annual QM report is submitted to administration.
- d. Annual QM report is submitted to administration.

State: ID
TN: 17-0013
Effective: 1/1/2018

§1915(i) State plan HCBS

Approved: 4/12/18

Supplement 3 to Attachment 3.1–A:

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Supersedes: NEW

e. Annual report is submitted to administration.

Methods and Standards for Establishing Payment Rates

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

<input type="checkbox"/>	HCBS Case Management
<input type="checkbox"/>	HCBS Homemaker
<input type="checkbox"/>	HCBS Home Health Aide
<input type="checkbox"/>	HCBS Personal Care
<input type="checkbox"/>	HCBS Adult Day Health
<input type="checkbox"/>	HCBS Habilitation
<input checked="" type="checkbox"/>	HCBS Respite Care
	The state's rates for respite reimbursement—\$6.50 per unit of 15 minutes for individual respite, and \$3.00 per unit of 15 minutes for group respite—were determined by a comparative analysis of other states' Medicare/Medicaid rates for code S5150, which was conducted by a national pricing consultant retained by the IBHP contractor. Specifically, the rates above were those found to be most closely aligned with the current Medicare/Medicaid rates of other states providing the same service.
For Individuals with Chronic Mental Illness, the following services:	
<input type="checkbox"/>	HCBS Day Treatment or Other Partial Hospitalization Services
<input type="checkbox"/>	HCBS Psychosocial Rehabilitation
<input type="checkbox"/>	HCBS Clinic Services (whether or not furnished in a facility for CMI)
<input type="checkbox"/>	Other Services (specify below)

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

No. Does not apply. State does not cover optional categorically needy groups.

Yes. State covers the following optional categorically needy groups.
(*Select all that apply*):

(a) Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group.
Methodology used: (*Select one*):

SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

OTHER (*describe*):

The State selects to cover children, birth through the month of their eighteenth (18th) birthday, who are determined to have a severe emotional disturbance in accordance with Section 16-2403, Idaho Code, and meet the needs-based HCBS eligibility criteria of the 1915(i) benefit for Children with Serious Emotional Disturbance (Supplement 3 to Attachment 3.1-A, Program Description), whose income (calculated using a MAGI-like methodology) does not exceed 300% FPL.

OTHER (*describe*):

The State selects to cover children, birth through age seventeen (17), who are determined to have a developmental disability in accordance with Section 66-402, Idaho Code and Section 500 through 506 under IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits" and meet the needs-based HCBS eligibility criteria of the 1915(i) benefit for Children with Developmental Disabilities (Supplement 1 to Attachment 3.1-A, Program Description), whose income (calculated using a MAGI-like methodology) does not exceed 150% FPL.

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STANDARD STATE PLAN

- (b) Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.

Income limit: *(Select one)*:

- 300% of the SSI/FBR
- Less than 300% of the SSI/FBR *(Specify)*: %

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s))*:

Children's DD Waiver, ID 0859, Children's Act Early Waiver, ID 0887, and Idaho Developmental Disabilities Waiver, ID 0076

- (c) Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s))*:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: IDAHO

MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT*

/ / Section 1902(f) State

/ X / Non-Section 1902(f) State

5. The State will disregard the difference in income between 150% FPL and 300% FPL for children under age eighteen (18), who are determined to have a severe emotional disturbance in accordance with Section 16-2403, Idaho Code, and meet the needs-based HCBS eligibility criteria of the 1915(i) benefit for Children with Serious Emotional Disturbance (Supplement 3 to Attachment 3.1-A, Program Description), and who are designated by the State as an Optional Covered Group under 1902(a)(10)(A)(ii)(XXII) as set forth in Attachment 2.2-A.