Table of Contents

State/Territory Name: Idaho

State Plan Amendment (SPA) #: 20-0020

This file contains the following documents in the order listed:

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: **ID 20-0020**

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 **07-01-2021**

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 (Subpart M)

7. FEDERAL BUDGET IMPACT:
None

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A Supplement 1 (Pages 1-72)
Attachment 4.19-B (Pages 45-46)
Attachment 3.1-A Supplement 1 (Removal of pages 2a, 11a-11e, 13a, 14a, 23a, 25a, 33-33e, and 46a)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 3.1-A Supplement 1 (Pages 1-47)

10. SUBJECT OF AMENDMENT:
5-Year Renewal of § 1915(i) Stat Plan Option HCBS Benefit for Children with Developmental Disabilities (Attachment 3.1-A Supplement 1)

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:

Matt Wimmer

13. TYPED NAME:
MATT WIMMER

14. TITLE:
Administrator

15. DATE SUBMITTED: December 31, 2020

16. RETURN TO:

Matt Wimmer, Administrator
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 83720
Boise ID 83720-0009

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/31/2020
3/26/2021

18. DATE APPROVED:
6/17/2021

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
7/1/2021

20. SIGNATURE OF REGIONAL OFFICIAL:
George P. Failla Jr -S
Digitally signed by George P. Failla Jr -S
Date: 2021.06.17 14:33:15 -04'00'

21. TYPED NAME:
George P. Failla, Jr.

22. TITLE:
Acting Division Director

23. REMARKS:

FORM HCFA-179 (07-92)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

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

Medicaid and CHIP Operations Group

June 17, 2021

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

Re: ID-20-0020 §1915(i) home and community-based services (HCBS) state plan children benefit renewal

Dear Mr. Jepppesen,

We reviewed your proposed Medicaid State Plan Amendment (SPA) submitted under transmittal number ID-20-0020. This amendment proposes to renew Idaho's Children 1915(i) Benefit.

This Benefit renewal is approved with an effective date of July 1, 2021, and an expiration date of June 30, 2026. Enclosed is a copy of the approved SPA.

Since the state has elected to target the population who can receive these §1915(i) State Plan HCBS, CMS approves this SPA for a five-year period, in accordance with §1915(i)(7) of the Social Security Act. To renew the §1915(i) State Plan HCBS benefit for an additional five-year period, the state must submit a renewal application 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)(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, at least 21 months prior to the end of the five-year approval period, the state must submit evidence of the state's quality monitoring in accordance with the Quality Improvement Strategy in their approved SPA. The evidence must include data analysis, findings, remediation, and describe any system improvement for each of the §1915(i) requirements.

It is important to note that CMS' approval of this 1915(i) HCBS state plan benefit renewal 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.

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 at (410) 786-7561 or you may contact Elizabeth (Liz) Heintzman at elizabeth.heintzman@cms.hhs.gov or (206) 615-2596.

Sincerely,

George P. Failla Jr -S

Digitally signed by George P. Failla Jr -S
Date: 2021.06.17 14:45:49 -04'00'

George P. Failla, Jr., Acting Director
Division of HCBS Operations and Oversight

cc: Dominique Mathurin, CMS
Deanna Clark, CMS
Kathy Poisal, CMS
Wendy Hill Petras, CMS
Matt Wimmer, IDHW
Michael Case, IDHW
Amanda Morales, IDHW
Charles Beal, IDHW

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
Community-Based Supports
Family Education
Home Modification
Service Dog
Adaptive and Therapeutic Equipment
Family-Directed Personal Support
Family-Directed Goods and Services
Family-Directed Non-Medical Transportation
Financial Management Services
Support Broker Services

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)*:		
	⊙ 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 Division of Family and Community Services (FACS) within the Idaho Department of Health and Welfare (the Department), operationalizes the services within the HCBS benefit.
○	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):

(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
Year 1	July 1, 2021	June 30, 2022	4,040
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 – The Department makes the final eligibility determination after the Independent Assessment Provider (IAP) completes the assessment process.
○	By Other (*specify State agency or entity under contract with the State Medicaid agency*):

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):*

Individuals performing 1915(i) evaluation/re-evaluation must be a Qualified Intellectual Disability Professional (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:

Individuals applying for Children's 1915(i) State Plan HCBS Benefit services must submit an Application for Medicaid Services for Children with Developmental Disabilities to the Division of FACS within the Department. Applications are completed in paper format and may be submitted to FACS by hand delivery, U.S. mail, fax, or email. Upon receipt of the application, FACS verifies if the individual is financially eligible for Medicaid. After verifying an individual's financial eligibility, the application is forwarded to the Independent Assessment Provider (IAP) to determine if the individual meets the Needs-based HCBS Eligibility Criteria for this HCBS benefit.

The IAP is responsible for completing the assessment process within thirty (30) days of receiving a complete application. This process includes the following:

a. The IAP requests medical records/assessments, diagnostic assessments, and/or psychometric testing, which are necessary to make an eligibility determination, from the individual/decision-making authority;

b. The IAP contacts the individual/decision-making authority to identify who will serve as the individual's representative/respondent for the assessment. The decision-making authority must be involved throughout the process. The individual/decision-making authority is responsible for identifying a respondent who has knowledge about the individual's current level of functioning. The individual is required to be present with the respondent for a meeting with the IAP to complete the assessment and will lead the process to the extent possible. An individual's representative/respondent means the following:

i. The individual's legal guardian or other person who is authorized under State law to represent the individual for the purpose of making decisions related to the person's care or well-being.

ii. Any other person who is authorized under 42 CFR §435.923 or under the policy of the State Medicaid Agency to represent the individual, including but not limited to, a parent, a family member, or an advocate for the individual.

c. During the meeting with the IAP, the respondent will assist the IAP in completing the individual's functional assessment using an assessment instrument approved by the Department (Vineland Adaptive Behavior Scales Third Edition – Vineland-3), and the individual's medical, social, and developmental assessment summary.

d. The IAP communicates eligibility determinations (including set budget amounts) to the individual/decision-making authority through a written Notice of Decision. Individuals/decision-making authorities who do not agree with a decision regarding eligibility or the set budget amount may appeal and request a fair hearing.

PROCESS FOR ANNUAL REEVALUATION

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

a. A new Application for Medicaid Services for Children with Developmental Disabilities does not have to be submitted by the individual on an annual basis.

b. If a change in income results in the termination of Medicaid financial eligibility, the individual/decision-making authority may appeal the Department's decision, in accordance with 42 CFR §431, Subpart E. Medicaid providers are required to verify participant eligibility prior to providing services as approved on the annual Plan of Service.

c. The IAP is required to complete an assessment of need, including a functional assessment, at least every twelve months and as needed when the individual's support needs or circumstances change significantly. The functional assessment includes a review of the individual's most recent assessment tool to ensure it is accurate. The IAP is required to complete a new assessment tool every three years. For intervening years, the IAP is only required to complete a new assessment tool when it is determined that the existing tool does not accurately describe the current status of the individual. The IAP will make a clinical determination regarding the need for a new/updated assessment tool based on information provided by the respondent (someone the participant/decision making authority have identified as the person who is most qualified to provide current information regarding the participant's medical, functional, and behavioral needs) during the annual eligibility re-evaluation meeting.

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

e. Information from the assessments that are 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 must require assistance due to substantial limitations in three (3) 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 must have the need for a 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 twenty-two (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 must require 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 must have the need for a 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)	The participant requires nursing facility level of care when a child meets one (1) or more of the following criteria: **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. **02. Preventing Deterioration for Children**. Skilled care is needed to prevent, to the extent possible, deterioration of the child's condition or to sustain current capacities, regardless of the restoration potential of a child, even where full recovery or medical improvement is not possible. (con't)	**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 persons must qualify based on functional assessment, maladaptive behavior, a combination of both, or medical condition; and **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 intensive alternative services in the community, would require institutionalization, other than services in an institution for mental disease, in the near future; and (con't)	The state uses criteria defined in 42 CFR 440.10 for inpatient hospital services. (end)

	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 necessitates 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. **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's will determine nursing facility level of care. (end)	**03. Functional Limitations**. **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 using a Department-approved assessment tool would qualify; or **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; or **04. Maladaptive Behavior**. **a**. A Minus Twenty-Two (-22) or Below Score. Individuals may qualify for ICF/ID level of care based on maladaptive behavior. Persons will be eligible if their General Maladaptive Index on a Department-approved assessment tool is minus twenty-two (-22) or less; or **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 (con't)	

		5. Combination Functional and Maladaptive Behaviors. Persons may qualify for ICF/ID level of care if they display a combination of criteria as described above at a level that is significant and it can be determined they are in need of the level of care services provided in an ICF/ID, including active treatment services. Significance would be defined as: **a**. Persons Sixteen Years of Age or Older. For persons sixteen (16) years of age or older, an overall age equivalency up to eight and one-half (8 1/2) years is significant in the area of functionality when combined with a General Maladaptive Index on a Department-approved assessment tool between minus seventeen (-17), minus twenty-two (-22) inclusive; or **b**. Persons Under Sixteen Years of Age. For persons under sixteen (16) years of age, an overall age equivalency up to fifty-three percent (53%) of their chronological age is considered significant when combined with a General Maladaptive Index on a Department-approved assessment tool between minus seventeen (-17), and minus twenty-one (-21) inclusive; or **06. 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. (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)*):

Children, birth through age seventeen (17), who are determined to have a developmental disability in accordance with Section 66-402, Idaho Code.

☐ **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**. 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: Participants will receive at least one 1915(i) service annually in accordance with their person-centered plan. Respite and Family Education are services only accessed as needed, according to participant/decision-making authority choice.

Home and Community-Based Settings

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

1. ☑ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

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

   The state assures that this 1915(i) State plan HCBS Benefit renewal will be subject to any provisions or requirements included in the state's approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

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 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):*

Individuals conducting the independent assessment must meet the requirements for a Qualified Intellectual Disability Professional (QIDP) in accordance with 42 CFR 483.430.

At a minimum, a QIDP must:

a. Have at least one (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;
- Having at least a bachelor's degree in one of the following professional categories: psychology, social work, occupational therapy, speech pathology, professional recreational therapy, or other related human services professions; and

c. Have 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):*

In accordance with regulations contained in Idaho Administrative Procedures Act (IDAPA) 16.03.10, Home and Community-Based Services (HCBS) rules, a paid or non-paid person who, under the direction of the participant or their decision-making authority, is responsible for developing a single plan of service and subsequent addenda. The service plan must cover all services and supports identified during the person-centered planning process and must meet the HCBS person-centered plan requirements as described in the IDAPA rules previously identified.

The responsibility for service plan development and qualifications differ slightly based on the participant's selection of either traditional services or family-directed services.

Traditional Services:

Plan development under the traditional services option must be provided by the Department or its contractor in accordance with the noted HCBS rules. Neither a provider of direct services to the participant nor the assessor may be chosen to develop the plan of service.

Plan developers are called Case Managers. Case Management Qualifications:

Case Manager - Minimum of a Bachelor's Degree in a human services field from a nationally accredited university or college and have 24 months supervised experience working with children with disabilities, and pass a Department criminal history background check.

Clinical Case Management Supervisor - Minimum of a Master's Degree in a human services field from a nationally accredited university or college and have 12 months supervised experience working with children with disabilities, and pass a Department criminal history background check.

Family-Directed Services:

The family may choose to hire a Department approved Support Broker to assist with plan development and purchase specific duties as needed. Alternatively, plan development under the Family-Directed Services option may be provided by the Department or its contractor in accordance with the noted HCBS rules. Neither a provider of direct services to the individual nor the assessor may be chosen to develop the plan of service. Plan developers under the Family-Directed Services option are called Support Brokers.

Specific qualifications for support brokers are outlined in IDAPA 16.03.13. The qualification requirements include review of the individual’s education and experience. Support Brokers must demonstrate successful completion of the Department’s Support Broker training and of the required ongoing education. Support Brokers must comply with conflict of interest standards at 42 CFR 441.730(b).

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):*

Participants who are eligible for and select State plan HCBS are given an orientation to the available developmental disability services by the Independent Assessment Provider (IAP) and their case manager or support broker. The person-centered planning team must include people chosen by the participant, the family, and the participant's decision-making authority, if applicable.

Participants and their decision-making authority that choose the Family-Directed Services option receive an orientation on family-direction and program training from the Department. Families direct the person-centered planning meetings and select a qualified Support Broker to assist with writing of the Support and Spending Plan. As outlined in IDAPA 16.03.13, "Consumer-Directed Services," the participant and the participant's decision –making authority decide who will participate in the planning sessions in order to ensure the participant's choices are honored and promoted. The family may direct the person-centered planning meetings, or these meetings may be facilitated by a chosen Support Broker. In addition, the participant and the participant's decision-making authority select a circle of support. Members of the circle of support attend the person-centered planning meetings and commit to work within the group to help promote and improve the life of the participant in accordance with the participant's choices and preferences. They also agree to meet on a regular basis to assist the participant and participant's decision-making authority to accomplish their expressed goals. In developing the plan of service, the person-centered planning team must identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals.

Plan developers and Support Brokers are responsible for the documentation of the developed plan and any subsequent plan changes as determined by the person-centered planning team. Individuals responsible for facilitating the person-centered planning meeting and developing the plan of service cannot be providers of direct services to the participant.

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):*

Once participants are determined eligible for services, they and their families are given an opportunity to participate in orientation training about developmental disability services in Idaho. During family orientation, participants and their families are provided with a list of all approved providers in the state of Idaho, which is organized by geographic area. The printed materials provided to families include the website link for the Idaho State Children's DD website at https://healthandwelfare.idaho.gov/services-programs/medicaid-health/about-childrens-developmental-disabilities where electronic versions of documents are available. Both the orientation materials and the provider list include a statement that the family may choose any willing and available provider in the state. Families are also informed of how to navigate the website to access the list of providers as well as how to access other helpful resources available to them.

Families are also provided with resources on interviewing potential providers and are encouraged to contact multiple providers to identify the provider that can best meet their needs. In addition, families are informed that who they select is their choice and they may change their choice of providers if they want. Families are encouraged to access the Department Case Manager if needed to assist families in selecting or changing service providers.

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):*

Children's State plan HCBS participants may receive a variety of services and supports to address their needs and wants. The person-centered planning team works to ensure the plan of service (plan) adequately reflects the necessary services and supports. This is a single plan developed from a participant's assessment results that includes the goals and objectives for all of a participant's services and supports in their system of care. The plan will demonstrate collaboration is taking place among providers and that objectives are directly related to the goals of the participant. The plan is referred to as the Plan of Service for participant's that choose traditional services and is referred to as the Support and Spending Plan for participant's that choose Family-Directed services.

The Department has operational processes that optimize participant independence, community integration and choices in daily living. These processes include the requirement for HCBS benefits to be requested through the plan. Once the plan is developed through the person-centered planning process, it is submitted to the Division of FACS within the Department for review and approval. Upon approval, a prior authorization for services is issued. The prior authorization process is used to prevent the provision of unnecessary or inappropriate services and supplies, ensure enhanced health and safety, and to promote participant rights, self-determination and independence.

When approving the plan, the Department ensures:

- The plan is developed by the participant, the participant's decision-making authority and the person-centered planning team as selected by the participant and family using a qualified plan developer and a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written plan meets federal requirements at 42 CFR §441.725(b); and

- The plan summarizes the participant's health status, needs, goals, strengths, preferences and desired outcomes to be addressed within the plan year as determined from review of all assessments and input of the participant and parent/decision-making authority; and
- The plan identifies all services and supports determined through the person-centered planning process, including the participant's safety and the safety of those around the participant, target dates, and methods of collaboration for service delivery; and
- The plan is developed in accordance with the Home and Community-Based Services (HCBS) requirements outlined in IDAPA; and
- The plan is finalized and agreed to by the participant or the participant's decision-making authority, and signed to indicate the plan is correct, complete, and represents the participant and parent/decision-making authority's needs and wants, and informed consent; and
- The plan is signed by all individuals and providers responsible for its implementation indicating they will deliver services according to the authorized plan and consistent with HCBS requirements as described in IDAPA; and
- The results of a physical examination by the participant's primary care provider are submitted to the Department on an annual basis, and reviewed to ensure health and safety needs are assessed and addressed in the plan; and
- The services included on the plan are not duplicative, and are complementary and appropriate.

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:	Respite
Service Definition (Scope):	
Respite provides supervision to a participant on an intermittent or short-term basis because of the need for relief of the primary unpaid caregiver or in response to a family emergency or crisis. Respite may be delivered as an individual or group service. When respite is provided in a group, the following applies: 1. When group respite is center-based, there must be a minimum of one (1) qualified staff providing direct services for two (2) to six (6) participants. As the number and severity of the participants with functional impairments or behavioral issues increases, the participant ratio must be adjusted accordingly. 2. When group respite is community-based, there must be a minimum of one (1) qualified staff providing direct services for two (2) to three (3) participants. As the number and severity of participants with functional impairments or behavioral issues increases, the participant ratio must be adjusted from three (3) to two (2). 3. When group respite is provided by an independent provider, the independent respite provider must be a relative. May provide direct services for two (2) to three (3) siblings and must be delivered in the home of the participants or the independent respite provider. For participants using traditional services, respite may be provided by a qualified agency provider (Developmental Disability Agency – DDA) or by an independent respite provider. An independent provider may be a relative of the participant. For Participant's using family-directed services, respite may be provided by a qualified Community Support Agency or Community Support Provider. Respite may be provided in the participant's home, the private home of an independent respite provider, in a DDA, or in community settings. Assurances: • Not to be provided during the same time other Medicaid services are being provided to a participant with the exception of when an unpaid caregiver is receiving the 1915(i) Family Education service and no other natural supports are available to provide respite; • Not to be used to pay for room and board; • Not to be provided on a continuous, long-term basis as a daily service to enable an unpaid caregiver to work; • Not to be provided by an independent respite provider as center-based respite; or • The respite provider must not use restraints on participants, other than physical restraints in the case of an emergency to prevent injury to the participant or others and must be documents in the participant's record.	
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):*
	• Subject to individual budget maximums. • A parent or legal guardian cannot receive respite for childcare to enable the parent or legal guardian to work. • Not to exceed fourteen (14) days.
☐	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 Disability Agency (DDA)		Developmental Disabilities Agency (DDA) certificate as described in IDAPA.	Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide respite through a DDA: • Must have received instructions in the needs of the participant who will be provided the service; • Must demonstrate the ability to provide services according to a plan of service; • Must pass a criminal history and background check; • Must be certified in CPR and first aid and must maintain current certification thereafter. • Must be at least sixteen (16) years of age and employed by a DDA if serving ages three (3) to eighteen (18).

Independent Respite Care Provider			Individuals must meet the following qualifications to provide independent respite: • Be at least eighteen (18) years of age and be a high school graduate, or have a GED; • Be enrolled as an Idaho Medicaid Provider; • Have received instructions in the needs of the individual who will be provided the service; • Demonstrate the ability to provide services according to a plan of service; • Pass a criminal background check; and Be certified in CPR and first aid and must maintain current certification thereafter.
Community Support Agency	If required to identify goods or supports. For example, a Community Support providing speech-language pathology must have a current speech-language pathology licensure.	If required to identify goods or supports.	Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and statement of qualification to provide identified supports.
Community Support Provider	If required for identified goods or supports. For example, a Community Support providing speech-language pathology must have current speech-language pathology license.	If required for identified goods and supports.	Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and statement of qualification to provide identified supports.

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 Disability Agency (DDA)	The Department	- At initial provider agreement approval or renewal - At least every three years, and as needed based on service monitoring concerns
Independent Respite Care Provider	The Department	- At initial provider agreement approval or renewal - At least every two years, and as needed based on service monitoring concerns
Community Support Agency	Participant and parent/decision-making authority Paid Support Broker (if applicable) The Department (during retrospective quality assurance reviews)	Initially and annually, with review of employment/vendor agreement
Community Support Provider	Participant and parent/ decision-making authority Paid Support Broker (if applicable) The Department (during retrospective quality assurance reviews)	Initially and annually, with review of employment/vendor agreement

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

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

Service Title: Community-Based Supports

Service Definition (Scope)*:*

Community-Based Supports provide assistance to participants with disabilities by facilitating the participant's independence and integration into the community. This service provides an opportunity for participants to explore their interests, practice skills learned in other therapeutic environments, and learn through interactions in typical community activities. Integration into the community enables participants to expand their skills related to activities of daily living and reinforces skills to achieve or maintain mobility, sensory-motor, communication, socialization, personal care, relationship building, and participation in leisure and community activities. Services include individual or group supports.

Group services must be provided by one (1) qualified staff providing direct services for two (2) or three (3) participants. As the number and needs of the participants increase, the participant ratio in the group must be adjusted from three (3) to two (2).

For participants using traditional services, Community-Based Supports may be provided by a qualified agency provider (Developmental Disability Agency – DDA) or by an independent Community-Based Supports provider. For participant's using family-directed services, Community-Based Supports may be provided by a Community Support Agency or a Community Support Provider. Community-Based Supports may be provided in the participant's home, in a DDA, or in community settings.

Assurances:

- Community-Based Supports are not intended to supplant services provided in school or therapy, or to supplant the role of the primary caregiver.
- Participant must be involved in age-appropriate activities in environments typical peers access according to the ability of the participant

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):*
	Subject to individual budget maximums.
☐	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 Disability Agency (DDA)		Developmental Disabilities Agency (DDA) certificate as described in IDAPA.	Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide Community-Based Supports when provided by a DDA: • Must be at least 18 years of age; • Demonstrate the ability to provide services according to a plan of service; • Have received instructions in the needs of the participant who will be provided the service; • Pass a criminal background check; • Complete a competency course approved by the Department related to the support staff job requirements; and • Have 1,040 hours supervised experience working with children with developmental disabilities. Experience can be achieved by having previous work experience gained through paid employment, university practicum experience, or internship; or have on-the-job supervised experience gained through employment at a DDA with increased supervision. Community-Based Support staff serving infants and toddlers from birth to three (3) years of age must have 1,040 hours of documented experience with infants, toddlers or children birth through five (5) years of age with developmental delays or disabilities.

Independent Community-Based Supports Provider			Individuals must meet the following qualifications to provide independent Community-Based Supports: • Be enrolled as an Idaho Medicaid Provider; • Have received instructions in the needs of the participant who will be provided the service; • Demonstrate the ability to provide services according to a plan of service; • Have six (6) months supervised experience working with children with developmental disabilities. This can be achieved in the following ways: o Have previous work experience gained through paid employment, university practicum experience, or internship; or o Have on-the-job supervised experience gained through employment with increased supervision. Experience is gained by completing at least six (6) hours of job shadowing prior to the delivery of direct support services, and a minimum of weekly face-to-face supervision with the supervisor for a period of six (6) months while delivering services; o For individuals providing community-based supports to children birth to age three (3), the six (6) months of documented experience must be with infants, toddlers, or children birth to age three (3) years of age with developmental delays or disabilities. • Complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide community-based supports; • Pass a criminal background check; and • Be certified in CPR and first aid and must maintain current certification thereafter.

Community Support Agency	If required to identify goods or supports. For example, a Community Support providing speech-language pathology must have a current speech-language pathology licensure.	If required to identify goods or supports.	Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and statement of qualification to provide identified supports.
Community Support Provider	If required for identified goods or supports. For example, a Community Support providing speech-language pathology must have current speech-language pathology license.	If required for identified goods and supports.	Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and statement of qualification to provide identified supports.

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):*
DDA	The Department	- At initial provider agreement approval or renewal - At least every three years, and as needed based on service monitoring concerns
Independent Community-Based Supports Provider	The Department	- At initial provider agreement approval or renewal - At least every two years, and as needed based on service monitoring concerns
Community Support Agency	Participant and parent/decision-making authority Paid Support Broker (if applicable) The Department (during retrospective quality assurance reviews)	Initially and annually, with review of employment/vendor agreement

Community Support Provider	Participant and parent/ decision-making authority Paid Support Broker (if applicable) The Department (during retrospective quality assurance reviews)	Initially and annually, with review of employment/vendor agreement

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: Family Education

Service Definition (Scope)*:*

Family education is professional assistance to family members, or others who participate in caring for the eligible participant, to help them better meet the needs of the participant by providing an orientation to developmental disabilities and to educate families on generalized strategies for behavioral modification and intervention techniques specific to the participant's diagnosis. It offers education that is specific to the family and participant as identified on the plan of service.

This service is not intended to instruct paid staff on the competencies relative to their field they are required to have or to provide training required to meet provider qualifications, but rather to support staff in meeting the individualized and specific needs of the 1915(i) participant.

Family education providers must maintain documentation of the training in the participant's record including the provision of activities outlined in the plan of service. Family Education may be provided in a group setting not to exceed five (5) participants' families.

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):*
	Subject to individual budget maximums.
☐	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 Disability Agency		Developmental Disabilities Agency (DDA) certificate as described in IDAPA.	Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide family education when provided by a DDA: • Must hold at least a bachelor's degree in a human services field from a nationally accredited university or college; • Must meet competency as approved by the Department to demonstrate competencies related to the requirements to provide family education; • Must pass a criminal history and background check; • Must complete at least twelve (12) hours of yearly training; and • Must have 1,040 experience providing care to children with developmental disabilities if serving ages three (3) to eighteen (18); or • Must have 1,040 hours of professionally-supervised experience providing assessment/evaluation, curriculum development, and service provision in the areas of communication, cognition, motor, adaptive (self-help), and social-emotional development with infants and toddlers birth to five (5) with developmental delays or disabilities if serving ages birth to three (3).
Independent Family Education Provider			Individuals must meet the following qualifications to provide independent Family Education: • Holds an independent habilitation intervention provider agreement with the Department; and • Meet the intervention specialist or professional qualifications as outlined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits."

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 Disability Agency	The Department	- At initial provider agreement approval or renewal - At least every three years, and as needed based on service monitoring concerns
Independent Family Education Provider	The Department	- 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)*:			
☐	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:	Home Modification
Service Definition (Scope)*:*	

Home Modification provides minor home modifications required in a participant's residence to allow the participant to remain safely in the community and/or function with greater independence when the participant does not have the funds to purchase the item or service or the item or service is not available through another source. Home Modifications are specific modifications, adaptations, or changes to the participant's existing home setting which, based on their specific needs, are necessary to ensure their health and safety.

Home Modification, adaptations, or changes may include, but are not limited to:

- Purchase or repair of wheelchair ramps and protective awnings over wheelchair ramps.
- Bathroom modification/additions, such as: wheelchair accessible showers; sink modification; bathtub and toilet modifications; water faucet controls; floor urinal and bidet adaptations; plumbing modifications/additions to existing fixtures; and turnaround space modifications.
- Kitchen modifications/additions, such as: sink modifications; sink cutouts; turnaround space modifications; water faucet controls; plumbing modifications/additions; work table/work surface adjustments/additions; and cabinet adjustments/additions.
- Specialized accessibility/safety adaptations/additions, including repair and maintenance.

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

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

(Choose each that applies):

☑ Categorically needy *(specify limits):*

- Subject to individual budget maximums.
- Minor home modifications may include installation, maintenance and repair not coved by warranty.
- Minor home modification must not: create a new structure; add square footage to the home; be for the purpose of remodeling; or be for general utility or renovation (e.g., carpeting, roof repair, a carbon monoxide detector, central air conditioning, etc.).
- Permanent environmental modifications are limited to modification to a home that is owned by the participant's family when the home is the participant's principal residence.
- Portable or non-stationary modifications may be made to rental units when such modifications can follow the participant to the next place of residency.

☐ 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):*
Individual Provider	Licenses are required when mandated by State or local building codes for particular types of environmental accessibility adaptations. For instance, a provider must have a plumbing license to be permitted to complete plumbing work.	Certificates are required when mandated by State or local building codes for particular types of environmental accessibility adaptations.	Environmental Accessibility Adaptions are delivered through an executed provider agreement with the provider and Medicaid.

Agency Provider	Licenses are required when mandated by State or local building codes for particular types of environmental accessibility adaptations. For instance, a provider must have a plumbing license to be permitted to complete plumbing work.	Certificates are required when mandated by State or local building codes for particular types of environmental accessibility adaptations.	Environmental Accessibility Adaptions are delivered through an executed provider agreement with the provider and Medicaid.

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):*
Individual Provider	The Department	Providers are reviewed during the initial provider agreement approval process and when services are authorized.
Agency Provider	The Department	Providers are reviewed during the initial provider agreement approval process and when services are authorized.

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: Service Dog

Service Definition (Scope)*:*

Service dog provides assistance a participant requires to allow the participant to remain safely in the community and/or function with greater independence when the participant does not have the funds to purchase the item or service or the item or service is not available through another source. Service dog is professionally trained to complete tasks for an individual with a developmental disability.

Service dog must meet the following requirements:

- The animal must be healthy and pass aptitude and public access testing, and complete professional obedience and task training.
- The animal must meet ADA requirement, must be being trained on at least three (3) tasks, and must be needed to address issues related to the participant's developmental disability diagnosis.
- Training, annual healthcare, and up to $500.00 annually of ongoing maintenance of the animal.
- A Service Dog must be recommended by the participant's Primary Care Provider, Neurologist, or Physical Therapist.

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

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

(Choose each that applies):

☑ Categorically needy *(specify limits):*

- Subject to individual budget maximums.
- This service excludes emotional support animals.

☐ 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 Dog Breeder			• Knowledge and experience selecting dogs suitable for service dog work; and • Knowledge and experience in screening homes for dog placement.

Service Dog Trainer			• Knowledge and experience in training service dogs for individuals with developmental disabilities; and • Knowledge of the Americans with Disabilities Act, Idaho Statute 56, Chapter 7; and • References from clients or colleagues regarding their experience as a trainer.

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 Dog Breeder	The Department	Providers are reviewed when services are authorized.
Service Dog Trainer	The Department	Providers are reviewed when services are authorized.

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: Adaptive and Therapeutic Equipment

Service Definition (Scope)*:*

Adaptive and Therapeutic Equipment provides goods and supports that are medically necessary and/or minimize the participant's need for institutionalization and meets a medical or accessibility need and promotes increased independence when the participant does not have the funds to purchase the item or service or the item or service is not available through another source.

Adaptive Equipment for Activities of Daily Living may include:

- **Lifts:** hydraulic, manual or other electronic lifts; wheelchair lifts; porch or stair lifts; stairway lifts; bathtub seat lifts; ceiling lifts and tracks; transfer bench; prescribed therapy aids.
- **Assistive devices:** reachers; stabilizing devices; holders; visual alert systems; specialized or modified items for children with muscular weakness in upper body or who lack manual dexterity.
- **Mobility Aids:** scooters to aid in mobility; mobility bases for customized chairs; portable ramps; support rails.
- **Environmental Control Units:** electronic devices; voice activated/oral motion activated devices; alarms/alarm systems.

Communication Aids (as recommended by a Speech Language Pathologist) may include:

- **Augmentative Communication Devices:** direct selection communicators; alphanumeric communicators; scanning communicators; encoding communicators.
- **Control Switches/Pneumatic Switches and Devices:** Sip and puff controls; adaptive switches/devices.

Preference will be given to equipment and supplies that are the most cost-effective option to meet the participant's needs.

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):*		
	• Subject to individual budget maximums. • Adaptive and therapeutic equipment are not otherwise covered under Durable Medical Equipment (DME). • Services and equipment that are available through this 1915(i) benefit or the Medicaid State plan as 1905(a) services for children per Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements are not allowed as payable under family-directed community support services. • Experimental or prohibited treatments are excluded.		
☐	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):*
Agency Provider			Providers of adaptive and therapeutic equipment must be an enrolled Medicaid provider, or a participating medical vendor specifying the goods or supports to be provided. Providers must demonstrate qualifications to provided identified supports and ensure all items must meet applicable standards of manufacture, design and installation.

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):*
Agency Provider	The Department	Providers are reviewed during the initial provider agreement/vendor agreement approval process and when services are authorized.

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: Family-Directed Personal Support

Service Definition (Scope)*:*

Family-Directed Personal Support services provide supports that are medically necessary and/or minimize the participant's need for institutionalization and help the participant maintain health, safety, and basic quality of life. Family-Directed Personal Support services may include support needed, due to the participant's developmental disability, to practice and/or complete daily living activities such as bathing, dressing, and other activities of daily living beyond what is typically provided by a parent. These services may provide support needed by a participant to practice and/or complete an ADL for themselves but cannot duplicate other Medicaid Personal Care Services. Participants who do not select the family-directed option may access like services through Community-Based Supports.

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):*

- Only participants who select the family-directed option may access this service.
- Subject to individual budget maximums.
- This service excludes emotional support animals.
- Limited to services not otherwise covered under the State Plan.

☐ 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):*
Community Support Agency	If required to identify goods or supports. For example, a Community Support providing speech-language pathology must have a current speech-language pathology licensure.	If required to identify goods or supports.	Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and statement of qualification to provide identified supports.

Community Support Provider	If required for identified goods or supports. For example, a Community Support providing speech-language pathology must have current speech-language pathology license.	If required for identified goods and supports.	Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and statement of qualification to provide identified supports.

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):*
Community Support Agency	Participant and parent/decision-making authority Paid Support Broker (if applicable) The Department (during retrospective quality assurance reviews)	Initially and annually, with review of employment/vendor agreement
Community Support Provider	Participant and parent/ decision-making authority Paid Support Broker (if applicable) The Department (during retrospective quality assurance reviews)	Initially and annually, with review of employment/vendor agreement

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:	Family-Directed Goods and Services
Service Definition (Scope)*:*	
Family-Directed Goods and Services are services, equipment or supplies not otherwise provided through this 1915(i) State Plan Option benefit or through the Medicaid state plan that address an identified need in the service plan (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR increase the participant's safety in the home environment; AND, the participant does not have the funds to purchase the item or service or the item or service is not available through another source. Family-Directed Goods and Services are purchased from the participant-directed budget. Experimental or prohibited treatments are excluded. Family-Directed Goods and Services must be documented in the service plan.	
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):*
	• Only participants who select the family-directed option may access this service. • Subject to individual budget maximums.
☐	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):*
Community Support Agency	If required to identify goods or supports. For example, a Community Support providing speech-language pathology must have a current speech-language pathology licensure.	If required to identify goods or supports.	Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and statement of qualification to provide identified supports.

Community Support Provider	If required for identified goods or supports. For example, a Community Support providing speech-language pathology must have current speech-language pathology license.	If required for identified goods and supports.	Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and statement of qualification to provide identified supports.

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):*
Community Support Agency	Participant and parent/decision-making authority Paid Support Broker (if applicable) The Department (during retrospective quality assurance reviews)	Initially and annually, with review of employment/vendor agreement
Community Support Provider	Participant and parent/ decision-making authority Paid Support Broker (if applicable) The Department (during retrospective quality assurance reviews)	Initially and annually, with review of employment/vendor agreement

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: Family-Directed Non-Medical Transportation

Service Definition (Scope)*:*

Family-Directed Non-Medical Transportation is used to help accomplish goals identified on the Support and Spending Plan, and may include:

- Assistance for the participant aimed at accessing and using public transportation, independent travel or movement within the community.
- Payment for transportation expenses to a Community Support Worker (CSW), when the CSW is providing a direct service at the destination and the services are identified on the Support and Spending Plan.

Participants who do not select the family-directed option may access like services through Community-Based Supports.

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):*

- Only participants who select the family-directed option may access this service.
- Subject to individual budget maximums.
- Transpiration services must be provided through the most cost-efficient mode available and cannot supplant the role of the parent.
- This service cannot be used in place of Non-Emergency Medical Transportation available through the State plan.

☐ 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):*
Community Support Agency	If required to identify goods or supports. For example, a Community Support providing speech-language pathology must have a current speech-language pathology licensure.	If required to identify goods or supports.	Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and statement of qualification to provide identified supports.
Community Support Provider	If required for identified goods or supports. For example, a Community Support providing speech-language pathology must have current speech-language pathology license.	If required for identified goods and supports.	Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and statement of qualification to provide identified supports.

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):*
Community Support Agency	Participant and parent/decision-making authority Paid Support Broker (if applicable) The Department (during retrospective quality assurance reviews)	Initially and annually, with review of employment/vendor agreement
Community Support Provider	Participant and parent/ decision-making authority Paid Support Broker (if applicable) The Department (during retrospective quality assurance reviews)	Initially and annually, with review of employment/vendor agreement

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: Financial Management Services

Service Definition (Scope)*:*

The Department will offer financial management services through any qualified fiscal employer agent (FEA) provider through a provider agreement. FEA providers will complete financial consultation and services for a participant who has chosen to family-direct their services in order to assure that the financial information and budgeting information is accurate and available to them as is necessary in order for successful family-direction to occur. Once the participant or the participant's decision making-authority have entered into a written agreement, the FEA performs the following:

- Payroll and Accounting. Provides payroll and accounting supports to the participant that has chosen the family-directed community supports option;
- Financial Reporting. Perform financial reporting for employees of the participant;
- Financial Information Packet. Prepare and distribute a packet of information, including department approved forms for agreements, in order for the participant and family to hire their own staff;
- Time Sheets and Invoices. Process and pay timesheets for community support workers and support brokers, as authorized by the participant and parent/decision-making authority according to the participant's Department authorized support and spending plan;
- Taxes. Manages and processes payment of required state and federal employment taxes for the participant's community support worker and support broker.
- Payments for goods and services. Processes and pay invoices for goods and services, as authorized by the participant and parent/decision-making authority according to the participant's support and spending plan;
- Spending information. Provides participant and parent/decision-making authority with reporting information and data that will assist the participant and parent/decision-making authority with managing the individual budget;
- Quality assurance and improvement. Participates in department quality assurance activities.

FEA qualifications and requirements and responsibilities as well as allowable activities are described in IDAPA.

Only participants who select the family-directed option may access these services.

The FEA must not either provider any other direct services (including support brokerage) to the participant to ensure there is no conflict of interest; or employ the parent/decision-making authority of the participant or have direct control over the participant's choice.

The FEA providers may only provide financial consultation, financial information and financial data to the participant and their parent/decision-making authority, and may not provide counseling or information to the participant and parent/decision-making authority about other goods and services.

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):*
☐	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):*
Fiscal Employer/Agent			Agencies that provide financial management services as a FEA must be qualified to provide such services as indicated in section 3504 of the Internal Revenue Code and in accordance with the requirements outlined in the signed provider agreement with the Department.

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):*
Fiscal Employer/Agent	The Department	At the time of application, as indicated by a readiness review to be conducted by the Department for all FEA providers and thereafter at least every three years by Department review.
Fiscal Employer/Agent	The Department	At the time of application, as indicated by a readiness review to be conducted by the Department for all FEA providers and thereafter at least every three years by Department review.

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: Support Broker Services

Service Definition (Scope)*:*

Support Brokers provide guidance and assistance for participants and their parent/decision-making authority with arranging, directing, and managing services. They serve as the agent or representative of the participant to assist in identifying immediate and long-term needs, developing options to meet those needs, and accessing identified supports and services. This includes providing participants and their parent/decision-making authority with any assistance they need for gathering and reviewing their budget and financial data and reports prepared and issued to them by the FEA. Practical skills training is offered to enable families to remain independent. Examples of skills training include helping families understand the responsibilities involved with directing services, providing information on recruiting and hiring community support workers, managing workers and providing information on effective communication and problem-solving. The extent of Support Broker services furnished to the participant and parent or decision-making authority must be specified on the support and spending plan. Support Broker qualifications, requirements and responsibilities as well as allowable activities are described in IDAPA 16.03.13.135-136. Support Broker services may include only a few required tasks or may be provided as a comprehensive service package depending on the participant and parent or decision-making authority's needs and preferences.

At a minimum, the Support Broker must:

- Participate in the person-centered planning process.
- Develop a written Support and Spending plan with the participant and family that includes the supports the participant needs and wants, related risks identified with the participant's wants and preferences, and a comprehensive risk plan for each potential risk that includes at least three backup plans should a support fall out.
- Assist the participant and family to monitor and review their budget through data and financial information provided by the FEA.
- Submit documentation regarding the participant and parent/decision-making authority's satisfaction with identified supports as requested by the Department.
- Participate with Department quality assurance measures, as requested.
- Assist the participant and parent/decision-making authority with scheduling required assessments to complete the Department's annual re-evaluation process as needed, including assisting the participant and parent/decision-making authority to update the support and spending plan and submit it to the Department for authorization. In addition to the required minimum Support Broker duties, the Support Broker must be able to provide the following services when requested by the participant and parent/decision-making authority:
  - Assist the participant and parent/decision-making authority to develop and maintain a circle of support.
  - Help the participant and family learn and implement the skills needed to recruit, hire, and monitor community supports.
  - Assist the participant and parent/decision-making authority to negotiate rates for paid Community Support Workers.
  - Maintain documentation of supports provided by each Community Support Worker and participant and parent/decision-making authority's satisfaction with these supports.
  - Assist the participant and parent/decision-making authority to monitor community supports.
  - Assist the participant and parent/decision-making authority to resolve employment-related problems.
  - Assist the participant and parent/decision-making authority to identify and develop community resources to meet specific needs.

Only participants who select the Family-Directed Option may access this service.

Support Brokers may not act as a Fiscal Employer Agent, instead Support Brokers work together with the participant and parent/decision-making authority to review participant financial information that is produced and maintained by the Fiscal Employer Agent.

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):*
☐	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):*
Support Broker			Specific requirements outlined in IDAPA 16.03.13 include review of education, experience, successful completion of Support Broker training and ongoing education.

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):*
Support Broker	The Department	At the time of application, annual review of ongoing education requirement, and by participant and parent/decision-making authority when entering into employment agreement.

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):*

Respite is the only State plan HCBS that may be reimbursed when provided by relatives of a participant. A parent/decision-making authority cannot furnish State plan HCBS, but other relatives may be paid to provide respite services whenever the relative is qualified to provide respite as defined in this application. There are numerous safeguards in place to ensure that payments are only made for services rendered including oversight by provider agencies, person-centered planning teams, circles of supports, fiscal/employer agent, and by the Department through review and approval of the plan of service and retrospective quality assurance reviews.

All providers are precluded from being in a position to both influence a participant and parent/decision-making authority's decision making and benefit financially from these decisions. Payments for family-directed services rendered are made only after review and approval by the participant and parent/decision-making authority and review by the Fiscal Employer Agent. Additionally, the participant's Support Broker and Circle of Supports are available to address any conflicts of interest.

Participant-Direction of Services

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

Election of Participant-Direction. (S*elect 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):*

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

Once participants are determined eligible for State plan HCBS, an individualized budget is developed for each participant. The budget model provides participants with an individual budget and a maximum level of funding that varies according to individual needs, and allows for spending flexibility within the set budgeted dollars. The support need is determined from an evaluation completed using a uniform assessment tool. Upon completion of the assessment, the individualized budget is reviewed with the participant and parent/decision-making authority by the Department or its contractor.

Participants then have the option to choose Family-Directed Services (FDS). The FDS option allows eligible participants and their parent/decision-making authority to choose the type and frequency of supports they want, to negotiate the rate of payment, and to hire the person or agency they prefer to provide those supports. Participants and the parent/decision-making authority must use a support broker to assist them with the family-directed process.

Paid Support Broker services are included as part of the community support services that participants and their parent/decision-making authority may purchase out of their allotted budget dollars.

Support Broker duties include planning, accessing, negotiating, and monitoring the family's chosen services to their satisfaction. They can assist families to make informed choices, participate in a person-centered planning process, and become skilled at managing their own supports. The Support Broker assists participants and parents/decision-making authorities to convene a circle of supports team and engages in a person-centered planning process. The circle of supports team assists participants and parents/decision-making authorities in planning for and accessing needed services and supports based on their wants and needs within their established budget.

The FDS option gives participants and their parent/decision-making authority the freedom to make choices and plan their own lives, authority to control the resources allocated to them to acquire needed supports, the opportunity to choose their own supports and the responsibility to make choices and take responsibility for those choices. Families and Support Brokers are responsible for the following:

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

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

Participants and their parent/decision-making authority choose support services, categorized as "family-directed community supports," that will provide greater flexibility to meet the participant's needs in the following areas:

My Personal Needs – focuses on identifying supports and services needed to assure the person's health, safety, and basic quality of life.

My Relationship Needs – identifies strategies in assisting an individual to maintain relationships with immediate family members, friends, spouse, or other persons and build their natural support network.

My Emotional Needs – addresses strategies in assisting an individual to practice behaviors consistent with the person's identified goals and wishes while minimizing interfering behaviors.

My Learning Needs – identifies activities that support an individual practicing established skills that relate to a goal that the person has identified.

Participants and their parent/decision-making authority choosing the Family-Directed Services option in Idaho are required to choose a qualified financial management services provider to provide Financial Management Services (FMS). The FMS provider is utilized to process and make payments to community support workers for the community support services contained in their support and spending plan. FMS providers have primary responsibility for the monitoring the dollars spending in accordance with the itemized spending plan and for ensuring payment itemization and accuracy. Financial management services providers also manage payroll expenses including required tax withholding, unemployment/workers compensation insurance; ensuring completion of criminal history checks and providing monthly reports to the participant, parent/decision-making authority and support broker if applicable. Financial Management services providers offer services on behalf of the participant in accordance with Section 3504 of the IRS code and the IRS Revenue Procedure 70-6, which outlines requirements of financial management service providers who are Fiscal Employer Agents.

2. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness 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
Family-Directed Personal Support	☑	☑
Family-Directed Goods and Services	☑	☑
Family-Directed Non-Medical Transportation	☑	☑
Financial Management Services	☑	☑
Support Broker Services	☑	☑

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.

6. 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):*

The Department assists participants and the parent/decision-making authority with this transition and assures that authorization for services under family-direction do not expire until new services are in place. The Department provides technical assistance and guidance as requested by participants and their parent/decision-making authority, Support Brokers, and circles of support. Transition from Family-Directed Services option to Traditional services will not take more than 120 days and in most cases will be accomplished in 60 to 90 days. This transition time is spent re-evaluating the assessment of needs, development of a new plan, and review and authorization of the new plan. The participant remains in Family-Directed Services option until this process is completed so that there is no interruption in services. If at any time there are health and safety issues, the Department works closely with the participant and parent/decision-making authority to ensure that the participant's health and safety is protected. This may include utilizing the Crisis Network Team to address any immediate crises and/or authorizing an emergency 120-day transition plan to assure a smooth transition from Family-Directed Services option to Traditional services.

Only demonstrated danger to the participant's health and safety would result in the involuntary termination of the participant's use of Family-Directed Services option. In these cases, the Department will work closely with the parent/decision-making authority and Support Broker to identify necessary changes to the plan of service, authorize emergency services if necessary, and facilitate any other activities necessary to assure continuity of services during this transition.

7. 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.):*
	The same budget methodology used for the traditional option is applied for the Family-Directed Services option.
	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.*
	The participant and parent/decision-making authority's selected Fiscal Employer Agent will have the individual budget and the approved supports and services from the Support and Spending Plan. They will send monthly statements to participants and their parent/decision-making authority to inform them on the status of expenditures. The Support Broker will assist the family to review these statements to assure spending is on track. Employment agreements are developed for each Community Support Worker that describe what is expected and how the support worker will be paid. As a part of the QA process, Medicaid staff monitors FEAs to assure that processes are in place to monitor these expenditures. Each fiscal agent is required to: 1) Have a system in place to perform a quarterly quality management (QM) analysis activity on a statistically significant sample of overall participant records; 2) Have documented, approved policies and procedures with stated timeframes for preforming a quarterly quality management analysis activity on a statistically significant sample of overall participant records; 3) Have internal controls documented and in place for preforming a quarterly QM analysis activity on a statistically significant sample of overall participant records; 4) Forward QM reports to the Department within thirty (30) working days from the end of each quarter. In addition to reviewing these quarterly reports, the Department also conducts a full-service performance check on each fiscal agent provider at least every 3 years (all policies and procedures, and all the task and services as agreed upon in the provider agreement).

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 assessed needs of 1915(i) participants.***	
Discovery		
Discovery Evidence *(Performance Measure)*	***Performance Measure 1 (PM1)*** Number and percent of service plans reviewed that address 1915(i) participants' needs as identified in their assessment(s). a. **Numerator:** Number of service plans reviewed that address 1915(i) participants' needs as identified in their assessment(s). b. **Denominator:** Number of service plans reviewed 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 child participants receiving 1915(i) HCBS services. Confidence interval = 95% with -/+ 5% margin of error.	
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 1 ***(Service Plans)***	***Sub-Requirement 1-b*** ***Service plans are updated annually.***	
Discovery		
Discovery Evidence *(Performance Measure)*	***Performance Measure 2 (PM2)*** Number and percent of service plans reviewed that were updated/revised at least annually. a. **Numerator:** Number of service plans reviewed that were updated/revised at least annually. b. **Denominator:** Number of service plans in the representative sample requiring annual updates.	
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: Representative sample of child participants receiving 1915(i) HCBS services. Confidence interval = 95% with -/+ 5% margin of error.	
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 1 ***(Service Plans)***	***Sub-Requirement 1-b*** ***Service plans are updated annually.***	
Discovery		
Discovery Evidence *(Performance Measure)*	***Performance Measure 3 (PM3)*** Number and percent of service plans reviewed that were updated/revised when requested and warranted by changes in the 1915(i) participant's needs. a. **Numerator:** Number of service plans reviewed that were updated/revised when requested and warranted by changes in the 1915(i) participant's needs. b. **Denominator:** Number of service plans in the representative sample requiring revision(s) requested and warranted by changes in the 1915(i) participant's needs.	
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: Representative sample of 1915(i) participants. Confidence interval = 95% with -/+ 5% margin of error.	
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 1 ***(Service Plans)***	***Sub-Requirement 1-c*** ***Service plans document the 1915(i) participant's choice of services and providers.***	
Discovery		
Discovery Evidence *(Performance Measure)*	***Performance Measure 4 (PM4)*** Number and percent of 1915(i) participant records reviewed that indicated 1915(i) participants were given a choice when selecting providers. a. **Numerator:** Number of 1915(i) participant records reviewed that indicated 1915(i) participants were given a choice when selecting providers. b. **Denominator:** Number of 1915(i) participant records reviewed in the representative sample.	
Discovery Activity *(Source of Data & sample size)*	Data Source: Analyzed collected data Sampling Approach: Representative sample of 1915(i) participants. Confidence interval = 95% with -/+ 5% margin of error.	
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*		The State Medicaid Agency is responsible for data collection.
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 1 ***(Service Plans)***	***Sub-Requirement 1-c*** ***Service plans document the 1915(i) participant's choice of services and providers.***	
Discovery		
Discovery Evidence *(Performance Measure)*	***Performance Measure 5(PM5)*** Number and percent of 1915(i) participant records reviewed that indicated 1915(i) participants were given a choice when selecting services. a. **Numerator:** Number of 1915(i) participant records reviewed that indicated 1915(i) participants were given a choice when selecting services. b. **Denominator:** Number of 1915(i) participant records 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 1915(i) participants. Confidence interval = 95% with -/+ 5% margin of error.	
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 2 ***(Eligibility)***	***Sub-Requirement 2-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 *(Performance Measure)*	***Performance Measure 6 (PM6)*** Number and percent of initial 1915(i) applicants for whom an evaluation of the needs-based eligibility criteria was completed prior to receiving 1915(i) services. a. **Numerator:** Number of initial 1915(i) applicants for whom an evaluation of the needs-based eligibility criteria was completed prior to receiving 1915(i) services. b. **Denominator:** Number of initial 1915(i) 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		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 2 ***(Eligibility)***	***Sub-Requirement 2-b*** ***The processes and instruments described in the approved State plan for determining 1915(i) eligibility are applied appropriately.***	
Discovery		
Discovery Evidence *(Performance Measure)*	***Performance Measure 7 (PM7)*** Number and percent of reviewed 1915(i) eligibility determinations that were made according to the processes and instruments for determining eligibility described in this 1915(i) HCBS Benefit. a. **Numerator:** Number of reviewed 1915(i) eligibility determinations that were made according to the processes and instruments for determining eligibility described in this 1915(i) HCBS Benefit. b. **Denominator:** Number of 1915(i) 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 of 1915(i) participants. Confidence interval = 95% with -/+ 5% margin of error.	
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 2 ***(Eligibility)***	***Sub-Requirement 2-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.***	
Discovery		
Discovery Evidence *(Performance Measure)*	The SMA is required to conduct annual re-evaluations, however, per the CMS March 2014 guidance the state is not required to report on the number and percent of participants who received an annual redetermination of eligibility within 364 days of their previous eligibility assessment.	
Discovery Activity *(Source of Data & sample size)*	N/A	
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*		N/A
Frequency		N/A
Remediation		
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*		N/A
Frequency *(of Analysis and Aggregation)*		N/A

Requirement 3 ***(Qualified Providers)***	***Providers meet required qualifications.***	
Discovery		
Discovery Evidence *(Performance Measure)*	***Performance Measure 8 (PM8)*** Number and percent of new 1915(i) providers, which are required by the State to be licensed/certified, that meet the State's licensure or certification standards prior to providing 1915(i) services. a. **Numerator:** Number of new 1915(i) providers, which are required by the State to be licensed/certified, that meet the State's licensure or certification standards prior to providing 1915(i) services. b. **Denominator:** Number of new 1915(i) providers, which are required by the State to be licensed/certified that were surveyed during the relevant annual period.	
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 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 3 ***(Qualified Providers)***	***Providers meet required qualifications.***	
Discovery		
Discovery Evidence *(Performance Measure)*	***Performance Measure 9 (PM9)*** Number and percent of ongoing 1915(i) providers, which are required by the State to be licensed/certified, that continue to meet the State's licensure/certification standards. a. **Numerator:** Number of reviewed ongoing 1915(i) providers, which are required by the State to be licensed/certified, that continue to meet the State's licensure/certification standards. b. **Denominator:** Number of ongoing 1915(i) providers, which are required by the State to be licensed/certified that were surveyed during the relevant annual period.	
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: 100% Review of 1915(i) providers that were required to be surveyed during the relevant annual period.	
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 3 ***(Qualified Providers)***	***Providers meet required qualifications.***	
Discovery		
Discovery Evidence *(Performance Measure)*	***Performance Measure 10 (PM10)*** Number and percent of new 1915(i) providers, which are not required by the State to be licensed/certified, that received an initial provider quality review within 6 months of providing 1915(i) services to 1915(i) participants. a. **Numerator:** Number of new 1915(i) providers, which are not required by the State to be licensed/certified, that received an initial provider quality review within 6 months of providing 1915(i) services to 1915(i) participants. b. **Denominator:** Number of new 1915(i) providers, which are not required by the State to be licensed/certified.	
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 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 3 ***(Qualified Providers)***	***Providers meet required qualifications.***	
Discovery		
Discovery Evidence *(Performance Measure)*	***Performance Measure 11 (PM11)*** Number and percent of ongoing 1915(i) providers, which are not required by the State to be licensed/certified, that received a provider quality review every two years. a. **Numerator:** Number of reviewed ongoing 1915(i) providers, which were not required by the State to be licensed /certified, that received at least one quality review during the preceding two years. b. **Denominator:** Number of ongoing 1915(i) providers, which were not required by the State to be licensed /certified that were surveyed during the relevant annual period.	
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: 100% Review of 1915(i) providers that were required to be reviewed during the relevant annual period.	
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 3 ***(Qualified Providers)***	***Providers meet required qualifications.***	
Discovery		
Discovery Evidence *(Performance Measure)*	***Performance Measure 12 (PM12)*** Number and percent of 1915(i) providers that meet the State's requirements for training. a. **Numerator:** Number of 1915(i) providers reviewed that meet State's requirements for training. b. **Denominator:** Number of 1915(i) providers that were surveyed during the relevant annual period.	
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: 100% Review of 1915(i) providers who were reviewed during the relevant annual period.	
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 4 ***(HCBS Settings)***	***Settings meet the home and community-based setting requirements as specified in this 1915(i) Benefit and in accordance with 42 CFR 441.705(a)(1) and (2).***	
Discovery		
Discovery Evidence *(Performance Measure)*	***Performance Measure 13 (PM13)*** Number and percent of HCBS settings reviewed that meet the HCBS setting requirements as specified in this 1915(i) Benefit and in accordance with42 CFR 441.705(a)(1) and (2). a. **Numerator:** Number of 1915(i) HCBS settings reviewed that meet the HCBS setting requirements as specified in this 1915(i) Benefit and in accordance with 42 CFR 441.705(a)(1) and (2). b. **Denominator:** Number of 1915(i) HCBS settings in the representative sample.	
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports to the State Medicaid Agency on delegated administrative functions. Sampling Approach: Representative sample of 1915(i) HCBS settings. Confidence interval = 95% with -/+ 5% margin of error.	
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)*		Annually

Requirement 5 ***(Administrative Authority)***	***The State Medicaid Agency (SMA) retains authority and responsibility for the program operations and oversight.***	
Discovery		
Discovery Evidence *(Performance Measure)*	***Performance Measure 14 (PM14)*** The number and percent of issues requiring remediation identified in IAP contract monitoring reports that were addressed by the State. a. **Numerator:** Number of issues requiring remediation identified in IAP contract monitoring reports that were addressed by the State. b. **Denominator:** Number of issues requiring remediation identified in IAP 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 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)***	***The State Medicaid Agency (SMA) 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 15 (PM15)*** Number and percent of claims paid for 1915(i) services according to the posted fee schedule for 1915(i) services. a. **Numerator:** Number of reviewed claims paid for 1915(i) services (by procedure code) according to the posted fee schedule for 1915(i) services. b. **Denominator:** Number of claims paid for 1915(i) services (by procedure code) in the sample specified below.	
Discovery Activity *(Source of Data & sample size)*	Data Source: Other – MMIS Claims Paid Report. Sampling Approach: 100% Review of claims paid for 1915(i) services (by procedure code) for a one-week period each calendar quarter.	
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)***	***The State Medicaid Agency (SMA) 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 16 (PM16)*** Number and percent of rates for 1915(i) services on the posted fee schedule that are consistent with the approved rate methodology in Attachment 4.19-B of the state plan. a. **Numerator:** Number of rates for 1915(i) services (by procedure code) on the posted fee schedule that are consistent with the approved rate methodology in Attachment 4.19-B of the state plan. b. **Denominator:** Number of rates for 1915(i) services (by procedure code) on the posted fee schedule.	
Discovery Activity *(Source of Data & sample size)*	Data Source: Onsite record reviews. Sampling Approach: 100% review.	
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)*		Annually

Requirement 6 ***(Financial Accountability)***	***The State Medicaid Agency (SMA) 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 17 (PM17)*** Number and percent of claims paid for 1915(i) services on behalf of eligible 1915(i) participants. a. **Numerator:** Number of reviewed claims paid for 1915(i) services (by procedure code) on behalf of eligible 1915(i) participants. b. **Denominator:** Number of claims paid for 1915(i) services (by procedure code) in the sample specified below.	
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: 100% Review of claims paid for 1915(i) services (by procedure code) for a one-week period each annual period.	
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)*		Annually

Requirement 6 ***(Financial Accountability)***	***The State Medicaid Agency (SMA) 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 18 (PM18)*** Number and percent of 1915(i) claims paid to 1915(i) providers that are qualified to furnish 1915(i) services. a. **Numerator:** Number of reviewed 1915(i) claims paid to 1915(i) providers that are qualified to furnish 1915(i) services. b. **Denominator:** Number of claims paid to 1915(i) providers in the sample specified below.	
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: 100% review of claims paid to 1915(i) providers for a one-week period each annual period.	
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)*		Annually

Requirement 7 ***(Health and Welfare)***	***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 19 (PM19)*** Number and percent of reported critical incidents (related to abuse, neglect, exploitation, and/or unexplained death) requiring referral to child protection or law enforcement that were referred within policy timelines. a. **Numerator:** Number of reported critical incidents (related to abuse, neglect, exploitation, and/or unexplained death) requiring referral to child protection or law enforcement that were referred within policy timelines. b. **Denominator:** Number of reported critical incidents (related to abuse, neglect, exploitation, and/or unexplained death) requiring referral to child protection or law enforcement.	
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
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)***	***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 20 (PM20)*** Number and percent of 1915(i) participants and/or legal guardians who received information/education about how to report abuse, neglect, exploitation, unexplained death, and other critical incidents. a. **Numerator:** Number of 1915(i) participants and/or legal guardians who received information/education about how to report abuse, neglect, exploitation, unexplained death, and other critical incidents. b. **Denominator:** Number of 1915(i) participants receiving 1915(i) services.	
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: Representative sample of 1915(i) participants. Confidence interval = 95% with -/+ 5% margin of error.	
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*		The State Medicaid Agency is responsible for data collection/generation.
Frequency		Quarterly, 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, Annually

Requirement 7 ***(Health and Welfare)***	***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 1915(i) service plans with restrictive interventions (including restraints and seclusion) that were approved according to criteria in the approved 1915(i) Benefit. a. **Numerator:** Number of reviewed 1915(i) service plans with restrictive interventions (including restraints and seclusion) that were approved according to criteria in the approved 195(i) Benefit. b. **Denominator:** Number of 1915(i) service plans with restrictive interventions (including restraints and seclusion).	
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, 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, 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 State Medicaid Authority (SMA) has developed the following process/method for prioritizing, and implementing system improvements prompted as a result of an analysis of discovery and remediation information:

The Quality Management (QM) staff in the Division of FACS within the Department perform discovery and remediation quality improvement activities, including gathering children's service outcome reviews, investigating regional complaints and incident reports and reviewing plans of service and remediating identified issues. The results of these quality improvement activities are submitted to the FACS QM Data Analyst for review, analysis, tabulation, and reporting.

The Quality Management Committee reviews analyzed data in each quarterly quality management report to develops and prioritizes recommendations for system improvements. Recommendations are prioritizes based on need, available resources, and SMA overall operational strategies. System Improvement recommendations for the coming year are compiled into an annual quality management report that is submitted to SMA administration for review and final approval.

2. Roles and Responsibilities

Quality Management Team: Team of FACS Quality Assurance (QA) staff persons across the seven regions of Idaho, with knowledge of quality improvement interventions, and who are responsible for collecting and reporting data to the SMA.

Data Analyst: FACS staff person who is responsible for leading statewide data collection activities, analysis, and reporting activities related to quality management. This staff person is also responsible for creating and implementing data collection tools.

Quality Management Committee: The QM Committee is responsible for steering the quality assessment and improvement process, and issues related to data collection. It is responsible for formally recommending specific program improvements to SMA administration.

FACS DD Policy Program Manager: FACS DD policy program manager takes overall responsibility for leading team members, finalizing quarterly and yearly QM reports, leading the process of prioritizing needs for system improvements, and implementing approved system improvements.

3. Frequency

Ongoing monitoring, remediation and analysis activities with quarterly oversight and quarterly and annual reporting.

4. Method for Evaluating Effectiveness of System Changes

The Quality Management Committee is responsible for evaluating the effectiveness of system change. During each quarterly meeting, the Quality Management Committee review actions taken by the Quality Management Team and reviews progress made toward implementing previous approved system improvements. When necessary, the Quality Management Committee seeks evaluation and feedback from impacted stakeholders and recommends changes to the implementation process to ensure approved system improvements are fully implemented.

Methods and Standards for Establishing Payment Rates

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

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☑	HCBS Habilitation (Community-Based Supports)
	Individual and Group - The reimbursement methodology adds many cost components together to arrive at a 15 min unit rate for the Community-Based Supports Individual and Group, we use the (BLS) mean wage (Idaho) for all others (BLS code 31-1011) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using (GI) index. In SFY 2010 (2 months) it was .5% and SFY 2011 it is .8%. Using the Survey results we use direct care staff multipliers for employer related, program related, and general & administrative percentages. These multipliers are decreased to accommodate the average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS (MWD) report. The dollar figure arriving from the calculations is divided by the ratio provided. The hourly rate then is brought into a quarterly unit rate, or the target rate. The final unit rate is 85.5% of the target rate. We are using the most current DD/MH rates dictated by Idaho code 56-118 and used to calculate the 85.5% adjusted target rate.
☑	HCBS Respite Care
	Individual and Group - The reimbursement methodology adds many cost components together to arrive at a 15 min unit rate for the Respite Individual and Group, we use the Bureau of Labor statistics (BLS) mean wage (Idaho) for all others (BLS code 39-9099) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using Global Insights Mountain States Market Basket (GI) inflation index. In SFY 2010 (2 months) it was .5% and SFY 2011 it is .8%. Using the Survey results we use direct care staff multipliers for employer related, program related, and general & administrative percentages. These multipliers are decreased to accommodate the average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS Mountain West Division's (MWD) report.

	The dollar figure arriving from the calculations is divided by the ratio provided. The hourly rate then is brought into a quarterly unit rate, or the target rate. The final unit rate for Respite Individual is 77% of the target rate. The final unit rate for Respite group is 100% of the target rate. We are using the most current DD/MH rates dictated by Idaho code 56-118 and used to calculate the 77% and the 100% respectfully for the adjusted target rate.	
For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☑	Other Services (specify below)	
	☑	Family Education:
	The reimbursement methodology adds many cost components together to arrive at a 15 min unit rate for Family Education Individual and Group, we use the (BLS) mean wage (Idaho) for all others (BLS code 29-1129) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using (01) index. In SFY 2010 (2 months) it was .5% and SFY 2011 it is .8%, Using the Survey results we use direct care staff multipliers for employer related, program related, and general & administrative percentages. These multipliers are decreased to accommodate the average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS (MWO) report. The dollar figure arriving from the calculations is divided by the ratio provided. The hourly rate then is brought into a quarterly unit rate, or the target rate. The final unit rate is 76.6% of the target rate. We are using the most current OO/MH rates dictated by Idaho code 56-118 and used to calculate the 76.6% adjusted target rate.	
	☑	Home Modification:
	For adaptations over $500, three bids are required if it is possible to obtain three bids. The lowest bid which meets the participant's needs is selected.	
	☑	Service Dog:
	For service animals costing over $2,000.00, three bids are required if it is possible to obtain three bids. The lowest bid which meets the participant’s needs is selected. For training, annual healthcare, and ongoing maintenance of the animal costing over $500.00, three bids are required if it is possible to obtain three bids. The lowest bid which meets the participant’s need is selected	
	☑	Adaptive and Therapeutic Equipment:
	For equipment and supplies that are manually priced, including miscellaneous codes, a copy of the manufacturer's suggested retail pricing (MSRP) or an invoice or quote from the manufacturer is required. Reimbursement will be seventy-five percent (75%) of MSRP. If pricing documentation is the invoice, reimbursement will be at cost plus ten percent (10%), plus shipping (if that documentation is provided). For equipment and supplies that are not manually priced, the rate is based on the Medicaid fee schedule price.	

☑	Supports for Participant Direction (specify below)	
	☑	Family-Directed Personal Support:
	The participant and parent/legal guardian negotiates the rate with community support staff, ensuring the rates negotiated do not exceed the prevailing market rate.	
	☑	Family-Directed Goods and Services:
	The participant and parent/legal guardian negotiates the rate with community support staff, ensuring the rates negotiated do not exceed the prevailing market rate.	
	☑	Family-Directed Non-Medical Transportation:
	The participant and parent/legal guardian negotiates the rate with community support staff, ensuring the rates negotiated do not exceed the prevailing market rate.	
	☑	Financial Management Services:
	Financial Management Services -Reimbursement methodology for FMS is based on a market study of other state Medicaid program rates for FMS to gather a range which allows the Department to accept a Per Member Per Month (PMPM) rate within the range determined from the market study. The established PMPM payment rates for each department approved qualified FMS provider will be published on a fee schedule by the Department. This fee schedule will be updated at least yearly, and when new providers are approved. This information will be published for consumer convenience to the IDHW Medicaid website, and by request.	
	☑	Support Broker Services:
	The participant and parent/legal guardian negotiates the rate with the support broker, ensuring the negotiated rate does not exceed the maximum hourly rate for support broker services established by the Department.	

PRA Disclosure Statement 6/17/2021

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 114 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.