Table of Contents

State/Territory Name: Idaho

State Plan Amendment (SPA) #: 22-0009

This file contains the following documents in the order listed:

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

Medicaid and CHIP Operations Group

December 21, 2022

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

RE: 1915(i) ID Benefit 22-0009 & 1915(b) Waiver ID-02.R02 Concurrent Renewal Approval

Dear Director Jeppesen:

The Centers for Medicare & Medicaid Services (CMS) is approving your request to renew Idaho's Home and Community Base Services (HCBS)1915(i), Yes Empowerment Services (YES)State Plan Benefit, targeting children with serious emotional disturbances (SED). This benefit will provide respite services for children and youth who have a substantial functional impairment that is measured by and documented through the use of a standardized instrument conducted or supervised by a qualified independent assessor clinician. CMS will engage the state in future discussions regarding the 1915(i) needs based criteria. This 1915(i) SPA is assigned control number ID-22-0009, which should be referenced in all future correspondence relating to this program. 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.

Concurrently, the CMS is approving Idaho's request to renew its 1915(b) Waiver, CMS control number ID-02.R02, titled Idaho Behavioral Health Plan. This waiver allows Idaho to continue to serve beneficiaries eligible for behavioral health services through managed care. This 1915(b) waiver is authorized under section(s): 1915(b)(1) and 1915(b)(4) of the Social Security Act (the Act) and provides a waiver of the following section of Title XIX:

- Section 1902(a)(23) Freedom of Choice
- Section 1902 (a)(4) and 1932(a)(3) Mandatory Enrollment into a Single PIHP or PAHP

Our decision is based on the evidence submitted to CMS demonstrating that the state's proposal is consistent with the purposes of the Medicaid program, will meet all of the statutory and

regulatory requirements for assuring beneficiaries' access to and quality of services, and will be a cost-effective means of providing services to enrollees under this waiver.

The 1915(i) SPA will offer the following services: Respite Care.

The 1915(b) waiver and the 1915(i) SPA are effective for five years beginning January 1, 2023 through December 31, 2027 and operate concurrently. The state may request renewal of these authorities by providing evidence and documentation of satisfactory performance and oversight. Idaho's request that these authorities be renewed should be submitted to the CMS no later than September 30, 2027. 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.

The state will report all managed care waiver expenditures on the CMS 64-9 and 1915(b) waiver expenditures on the CMS64 Schedule D report. Respite services included under the 1915(i) authority are included in the capitation rate for the Contractor providing services under the 1915(b) authority. Idaho is also responsible for documenting cost- effectiveness, access and quality in subsequent renewal requests.

Idaho will be responsible for documenting the applicable cost-effectiveness and quality in subsequent renewal requests for this authority. On a quarterly basis, the state is required to submit to CMS the previous quarter's member months by approved MEG on the attached "1915(b) Worksheet for State Reporting of Member Months." The report is due 30 days after the end of each quarter and should be submitted to the DMCO Actions mailbox, MCOGDMCOActions@cms.hhs.gov.

The State should also conduct its own quarterly calculations using Tab D6 of the approved 1915(b) Waiver Cost Effectiveness Worksheets and request an amendment to the waiver should the State discover the waiver's actual costs are exceeding projections. Additionally, the State must submit a waiver amendment to reflect any major changes impacting the program, including changes in waivers/statutory authority needed, type/number of delivery systems, geographic areas, populations, services, quality/access, monitoring plan.

The state has identified its intent to use money realized from section 9817 of the American Rescue Plan (ARP). Approval of this action does not constitute approval of the state's spending

plan. The state must have an approved spending plan to use the money realized from section 9817 of the ARP.

We appreciate the cooperation and effort provided by you and your staff during the review of these waiver renewals. If you have any questions concerning this information, please contact Elizabeth Heintzman at (206) 615-2596 or via email at Elizabeth.Heintzman@cms.hhs.gov for the 1915(i) SPA or Aimée Campbell-OConnor at (207) 441-2788 or via email at Aimee.Campbell-OConnor1@cms.hhs.gov for the 1915(b) waiver.

Sincerely,

cc: Charles Beal, David Bell, David Welsh, Jenna Tetrault, State of Idaho
Lynn Delvecchio, DMCO Branch Chief
Erin Cassady, FMG CMS-64 Analyst
Wendy Hill Petras, CMS
Dominique Mathurin, CMS
Courtenay Savage, CMS
Kevin Patterson, CMS
James Moreth, CMS
Katherine Berland, CMS

Enclosure: 1915(b) Worksheet for State Reporting of Member Months
Special Terms and Conditions

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22-0009

2. STATE: ID

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
01-01-2023

5. FEDERAL STATUTE/REGULATION CITATION
SSA 1902(a)(10)(A); SSA 1902(r)(2)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 0 $6,107,258.
b. FFY 2024 $ 0 $6,346,432

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-i, pages 1-33
Attachment 4.19B

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-i, pages 1-36
Attachment 4.19B

9. SUBJECT OF AMENDMENT
Renewal for a period of five years of the state's 1915(i) State plan option to continue providing HCBS to the target population of children with serious emotional disturbance (SED).

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
Juliet Charron

12. TYPED NAME
JULIET CHARRON

13. TITLE
Administrator

14. DATE SUBMITTED
07-12-2022

15. RETURN TO
JULIET CHARRON, Administrator
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 83720
Boise, ID 83720-0009

FOR CMS USE ONLY

16. DATE RECEIVED
7/12/2022

17. DATE APPROVED
12/20/2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
1/1/2023

19. SIGNATURE OF APPROVING OFFICIAL
George P.

20. TYPED NAME OF APPROVING OFFICIAL
George P. Failla, Jr.

21. TITLE OF APPROVING OFFICIAL
Director, Division of HCBS Operations and Oversight

22. REMARKS
12/1/2022-State authorized CMS to make P&I changes to Blocks #6, #7, and #8

12/8/2022-State authorized MS to make P&I change to block #6

Instructions on Back

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

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

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

Respite Care.

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

Select one:

○	**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);* ***Contractor for the Idaho Behavioral Health Plan (IBHP)*** *(b) the geographic areas served by these plans;* ***Statewide*** *(c) the specific 1915(i) State plan HCBS furnished by these plans;* ***Respite*** *(d) how payments are made to the health plans; and* ***PMPM capitated rate*** *(e) whether the 1915(a) contract has been submitted or previously approved.* ***Yes, the contract has previously been 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:* ***Idaho Behavioral Health Waiver, ID.02.R01. This waiver application has been previously approved.***

Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
☑	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)

☐	§1915(b)(2) (central broker)	☑	§1915(b)(4) (selective contracting/limit number of providers)
☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*		
☐	**A program authorized under §1115 of the Act.** *Specify the program:*		

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

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

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

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

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

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

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

3, 4, 5:	IBHP (Idaho Behavioral Health Plan) Contractor
6:	Credentialed behavioral health agency verifies qualifications of respite providers, IBHP Contractor
7, 8:	IBHP Contractor

9: IBHP Contractor, appropriate IDHW program
10: IBHP Contractor

The State Medicaid Agency (SMA) is the final determination for approval of service plans.

The state will employee a variety of administrative tools in its oversight, including use of sampling.

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

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

N/A

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

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

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

Number Served

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

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

Annual Period	From	To	Projected Number of Participants
Year 1	January 1, 2023	December 31, 2023	1,454
Year 2			
Year 3			
Year 4			
Year 5			

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

Financial Eligibility

1. ☒ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Level (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act.) States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.

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

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

Needs-Based Evaluation/Reevaluation

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

◉	Directly by the Medicaid agency
○	By Other *(specify State agency or entity 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):*

Independent Assessors are state-licensed, master's-level clinicians or higher. Independent Assessors receive specialized training in how to conduct the functional assessment, and hold certification in a Department-approved tool for assessing children who might require HCBS and might qualify to be participants in this program.

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

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

Medicaid Agency staff do not have the same qualifications as Independent Assessors.
Medicaid Agency staff must pass a background check, and are trained:
(a) On Medicaid and YES program eligibility criteria.
(b) On working with Medicaid programs.
(c) To conduct and document sensitive fact-finding interviews.
(d) To deal with individuals who are in stressful situations from varying cultural/socioeconomic backgrounds.
(e) To de-escalate emotionally charged situations.
(f) To apply written policies and criteria and determining qualifications for services or benefits.

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

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

The independent assessment will include a comprehensive clinical diagnostic assessment, or review of a current CDA, to verify a diagnosis that is consistent with serious emotional disturbance (SED), and the administration of the CANS (Child-Adolescent Needs and Strengths) assessment tool, which will

identify the child's needs, strengths, and initial functional impairment score. (See assessment scoring criteria on the following page.) The initial assessment process also includes:
a. Evaluation of the child's current behavioral health, living situation, relationships, and family functioning;
b. Contacts, as necessary, with significant individuals such as family and teachers; and
c. A review of information regarding the child's clinical, educational, social, behavioral health, and juvenile/criminal justice history.

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

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

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

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

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

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

Substantial Functional Impairment

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

1) Behavioral and Emotional Needs (this subscale contains 12 items on which the child is rated);

2) Life Domain Functioning (8 items);

3) Risk Behaviors (14 items).

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

1) Behavioral and emotional needs—at least one item is rated a "2" or higher (indicating the presence of a psychiatric syndrome requiring treatment); AND

2) Life domain functioning—at least one item is rated a "2" or higher, (indicating substantial functional impairment associated with the psychiatric syndrome); OR

3) Risk behaviors—at least one item rated at least a "2" (indicating danger to self or others associated with the psychiatric syndrome).

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

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
Participants eligible to receive services under this 1915(i) have a substantial functional impairment that is measured by and documented through the use of a standardized instrument conducted or supervised by a qualified independent assessor clinician. **Substantial Functional Impairment** The CANS assessment tool is used to measure substantial functional impairment, which is a condition of participation in this program. Using the CANS, the independent assessor assigns the child a rating from 0 to 3 (where 0 = no evidence of a need, 1 = monitoring for need, 2 = need requiring intervention, and 3 = need requiring immediate or intensive	**[Excerpted/adapted from IDAPA 16.03.10.223]** 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	**[Excerpted/adapted from IDAPA 16.03.10.584]** **01. Diagnosis.** Persons must be financially eligible for Medicaid; must have a primary diagnosis of being intellectually disabled or have a related condition defined in Section 66-402, Idaho Code and IDAPA Sections 500 through 506; and persons must qualify based on functional assessment, maladaptive behavior, a combination of both, or medical condition. **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	**[Excerpted/adapted from IDAPA 16.03.09.701]** Participants must have a DSM-5 diagnosis with substantial impairment in thought, mood, perception or behavior. **01. Medical Necessity Criteria.** Both severity of illness and intensity of services criteria must be met for admission to a psychiatric unit of a general hospital. **a. Severity of illness criteria.** The child must meet one (1) of the following criteria related to the severity of his psychiatric illness: i. Is currently dangerous to self, as defined in IDAPA 16.03.09.701.01.a; ii. Is actively violent or aggressive and exhibits homicidal ideation or other symptoms which indicate he is a probable danger to others, as defined in IDAPA 16.03.09.701.01.a; or iii. Is gravely impaired, as defined in IDAPA 16.03.09.701.01.a., which

intervention) on each item. The following three domains are central to a determination of substantial functional impairment associated with a treatable mental health condition: 1) Behavioral and Emotional Needs (this subscale contains 12 items on which the child is rated); 2) Life Domain Functioning (8 items); 3) Risk Behaviors (14 items). The child is considered to have substantial functional impairment when the following criteria are met: 1) Behavioral and emotional needs—at least one item is rated a "2" or higher (indicating the presence of a psychiatric syndrome requiring treatment); AND 2) Life domain functioning—at least one item is rated a "2" or higher, (indicating substantial functional impairment associated with the psychiatric syndrome); OR 3) Risk behaviors—at least one item rated at least a "2" (indicating danger to self or others associated with the psychiatric syndrome).	potential of a child, even where full recovery or medical improvement is not possible. **03. Specific Needs for Children.** When the plan of care, risk factors, and aggregate of health care needs is such that the assessments, interventions, or supervision of the child necessitate the skills of a licensed nurse or a licensed physical therapist or licensed occupational therapist. In such cases, the specific needs or activities must be documented by the physician's orders, progress notes, plan of care, and nursing and therapy notes. **04. Nursing Facility Level of Care for Children.** Using the above criteria, plus consideration of the developmental milestones, based on the age of the child, the Department will determine nursing facility level of care.	require institutionalization, other than services in an institution for mental disease, in the near future. **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 (SIB-R, or subsequent revisions) would qualify. b. Persons Under Sixteen Years of Age. Persons under sixteen (16) years of age qualify if their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age. **04. Combination Functional and Maladaptive Behaviors.** Persons may qualify for ICF/ID level of care if they display a combination of criteria as described in IDAPA 16.03.10.584 at a level that is significant and it can be determined they are in need of the level of services provided in an ICF/ID, including active treatment services.	specifies that the individual meet at least (1) of the following criteria: (1) The child has such limited functioning that his physical safety and well being are in jeopardy due to his inability for basic self-care, judgment and decision making (details of the functional limitations must be documented); or (2) The acute onset of psychosis or severe thought disorganization or clinical deterioration has rendered the child unmanageable and unable to cooperate in non-hospital treatment (details of the child's behaviors must be documented); or (3) There is a need for treatment, evaluation or complex diagnostic testing where the child's level of functioning or communication precludes assessment and/or treatment in a non-hospital based setting, and may require close supervision of medication or behavior or both. **b. Intensity of service criteria.** The child must meet all of the criteria set forth in IDAPA 16.03.09.701.01.b.: i. It is documented that the child has been unresponsive to treatment at a less intensive level of care; ii. The services provided in the hospital can reasonably be expected to improve the child's condition or prevent further regression so that inpatient services will no longer be needed; and iii. Treatment of the child's psychiatric condition

		05. Medical Condition. Individuals may meet ICF/ID level of care based on their medical condition if the medical condition significantly affects their functional level/capabilities and it can be determined that they are in need of the level of services provided in an ICF/ID, including active treatment services.	requires services on an inpatient basis, including twenty-four (24) hour nursing observation, under the direction of a psychiatrist.

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

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

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

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

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

8. ☒ **Adjustment Authority.** As provided in 42 CFR §441.715(c), the State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

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

monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for State plan HCBS:

i.	**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: At least annual provision of 1915(i) services.

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.)

Description of the settings where individuals will reside: Individuals may reside in the family home, a foster family home, or another private residence. Individuals may not reside in locations that are institutional in nature.

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

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

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

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

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

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

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

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

Person-Centered Planning & Service Delivery

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

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

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

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

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

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

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

The Department assures that independent assessors will not be involved in providing 1915(i) services to participants. Training on assessment tools is provided to assessors.

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

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

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

The goal is for the team to develop the person-centered plan and submit it to the contractor or the designee of the Department for approval within 90 days of eligibility verification; the contractor or designee of the Department will have five business days to review and approve or reject the plan. The review will ensure that all requirements established by Medicaid and CFR, as well as all services needed by the participant, are properly documented on the plan. If the plan does not meet all applicable CFR and Medicaid requirements, the contractor or designee of the Department will send the plan back to the plan facilitator for revision by the person-centered planning team.

Participants will be informed in writing of any denials, and that communication will also include instructions on how to appeal adverse decisions and the opportunities for the participant to request a fair hearing.

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

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

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

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

During the initial assessment process, the independent assessor links applicants with the resources needed to take full advantage of Medicaid services and this program, including lists of community resources and qualified service providers. If the applicant is deemed eligible by the SMA's Division of Self-Reliance, the SMA or its designee will reach out to begin the person-centered planning process. During the person-centered planning process, services and qualified providers will be identified and related documentation will be provided to participants.

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

process by which the person-centered service plan is made subject to the approval of the Medicaid

ultimate oversight for service plan approval through a retrospective review process. Furthermore, as the basis of one of the reporting requirements documented elsewhere in this application (see Service Plans, Sub-requirement (a) in the QIS section), the Department or its designee will

- Plans have been developed in accordance with the policies and procedures set forth in this 1915(i);
- Plans initially approved by the Department or its designee do in fact accurately reflect participant's needs, goals, and risk factors as identified in the assessment;
- Plans meet other required criteria set forth in applicable CFR; and
- Plans comply with all applicable Medicaid requirements.

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

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

☐	Medicaid agency	☐	Operating agency	☑	Case manager
☑	Other (*specify):*	IBHP Contractor, or if applicable for the service being provided, Network Providers			

Services

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

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

Service Title: Respite Care

Service Definition (Scope):

Respite care is short-term or temporary care for a child/youth with SED provided in the least restrictive environment that provides relief for the usual caretaker and is aimed at de-escalation of stressful situations.

Respite may be provided by a credentialed behavioral health agency in the participant's home, another private residence, the credentialed agency, or in community locations that are not institutional in nature, such as parks, malls, stores, and other activity centers.

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

N/A

Specify limits (if any) on the amount, duration, or scope of this service for *(choose each that applies):*

☑ Categorically needy *(specify limits):*

Limitations:

- Maximum of 72 hours of respite care consecutively when respite is not delivered in a community location; maximum of 10 hours consecutively when respite is delivered in a community location; and 300 hours total in a 12-month calendar period.
- Payments for respite services are not made for room and board.
- Respite services shall not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. In addition, as a result of care coordination efforts, a participant who may be receiving services under 1915(c) waiver programs will not receive duplicate services. As part of the reimbursement process, the IBHP contractor will verify that there are not multiple claims for providing respite care to the same participant on the same dates of service. This will preclude potential duplication of respite services.

☐ 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)*:
Respite Care Provider			To provide respite, providers must be affiliated with a Medicaid-enrolled, credentialed behavioral health agency and: 1) Be at least eighteen (18) years of age with a high school diploma or GED;

			2) Have at least six (6) months' full-time (1,040 hours) work or volunteer experience working with children experiencing SED and their families; 3) Have the knowledge and skills to provide the service and effectively address participants' needs; 4) Successfully complete the training for respite care developed by the IBHP contractor; 5) Have received classroom or on-the-job training on the following: a. Characteristics of an SED; b. Behavior management principles and strategies; c. How to de-escalate and prevent, as well as manage, a crisis; d. Confidentiality and mandated reporting requirements; e. Basic First Aid training.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Respite Care Provider	Credentialed behavioral health agency	• 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

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

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

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

Participant-Direction of Services

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

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

◉	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):*

Quality Improvement Strategy

Quality Measures

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

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

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

Requirement	**Service Plans, Sub-requirement (a):** **Plans address assessed needs of 1915(i) participants**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of approved service plans that: • Have been developed in accordance with the policies and procedures specified in this 1915(i); • Accurately reflect the participant's needs, goals, and risk factors as identified in the assessment; • Meet other required criteria set forth in applicable CFR; and • Comply with all applicable Medicaid requirements. **a. Numerator:** Number of approved plans reviewed that meet the requirements specified in the bulleted list above. **b. Denominator:** Number of approved plans reviewed.

Discovery Activity *(Source of Data & sample size)*	Data Source: Analysis of individual service plans by IDHW staff or contractor to ensure the accuracy of plan approvals and determine whether the plan: (1) is accurately aligned with the needs, goals, and risk factors as identified in the independent assessment; (2) is in accordance with the policies and procedures specified in this 1915(i); (3) meets other required criteria set forth in applicable CFR; and (4) complies with all applicable Medicaid requirements. Sampling Approach: 100% review.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Annual
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)*	Annual

Requirement	**Service Plans, Sub-requirement (b):** **Plans are updated annually**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of service plans reviewed and approved by the Department or its designee prior to the expiration of the current plan of service. **a. Numerator:** Number of service plans that were reviewed and approved by the Department or its designee prior to the expiration of the current plan of service. **b. Denominator:** Number of service plans reviewed and authorized by the Department or its designee.
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	Annual
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)*	Annual

Requirement	**Service Plans, Sub-requirement (c):** **Plans document choice of services and providers**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of approved service plans that document, for every service whose need was indicated by the results of the independent assessment, either: • The participant's choice among the available providers qualified to deliver that service; or • In cases where a given service was called for by the results of the independent assessment but was declined, the participant's choice not to receive that service. **a. Numerator:** Number of approved plans reviewed whose content meets the criteria specified in the bulleted list above. **b. Denominator:** Number of approved service plans reviewed.
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: Representative sample of service plans developed for program participants receiving 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	Annual
Remediation	
Remediation Responsibilities *(Who corrects,*	The State Medicaid Agency is responsible for data aggregation and analysis.

analyzes, and aggregates remediation activities; required timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	Annual

Requirement	**Eligibility Requirements: Sub-requirement (a):** **An evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of applicants who are likely in need or qualify for 1915(i) services, scheduled for Independent Assessments with the state's contractor, for whom a completed assessment was obtained. **a. Numerator:** Number of Independent Assessments completed by the state contractor. **b. Denominator:** Number of scheduled Independent Assessments for program services.
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports to State Medicaid Agency from the independent assessor on delegated administrative functions. Sampling Approach: 100% review of remediation issues.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Annual
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)*	Annual

Requirement	**Eligibility Requirements: Sub-requirement (b):** **The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately**
Discovery	

Discovery Evidence *(Performance Measure)*	Number and percent of eligibility determinations for which criteria were evaluated appropriately and in accordance with policy. **a. Numerator:** Number of eligibility determinations that were completed based on the instruments and processes in the approved 1915(i) benefit. **b. Denominator:** Total number of eligibility determinations reviewed.
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: Representative sample of eligibility determinations performed. 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
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	**Eligibility Requirements: Sub-requirement (c):** **The 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of enrolled participants who received an annual redetermination of 1915(i) Benefit eligibility within 364 days of their previous eligibility evaluation. **a. Numerator:** Number of enrolled participants who received an annual redetermination of 1915(i) Benefit eligibility within 364 days of their previous eligibility evaluation. **b. Denominator:** Number of enrolled participants who received an annual redetermination of 1915(i) Benefit eligibility.
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: 100% review of annual redeterminations of eligibility.
Monitoring Responsibilities	The State Medicaid Agency is responsible for data collection/generation.

(Agency or entity that conducts discovery activities)	
Frequency	Annual
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)*	Annual

Requirement	**Providers meet required qualifications**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of enrolled program service providers who meet state and program requirements for certification and have successfully completed state-required training. **a. Numerator:** For a given 1915(i) service, the number of enrolled providers delivering that service who meet required licensure or certification standards and have completed state-required training, and are therefore qualified to be program service providers. **b. Denominator:** For a given 1915(i) service, the number of enrolled providers delivering that service to participants.
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	Annual

(of Analysis and Aggregation)	

Requirement	**Compliance with HCBS Settings Requirements**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of providers whose Department-required self-assessment forms confirm that the provider's settings meet HCBS settings requirements as stated in this SPA and applicable CFR. **a. Numerator:** Number of HCBS providers whose self-assessment forms were approved by the Department or its designee. **b. Denominator:** Number of HCBS providers who submitted self-assessment forms for review and approval.
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports from contractor to the SMA, giving statistics regarding Department-approved self-assessment forms related to setting requirements and qualities, which all current providers of HCBS are required to complete as a condition of becoming a Medicaid provider, in accordance with IDAPA 16.03.10.318. Sampling Approach: 100% review of providers' self-assessment forms by the Department or its designee.
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)*	Annual

Requirement	**Administrative Authority and Program Oversight**
Discovery	

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

Requirement	**Financial Accountability:** **Claims are paid for services that are authorized and are delivered by qualified providers**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of claims denied for 1915(i) services that were not authorized or were furnished by unqualified providers. **a. Numerator:** Number of claims denied because services were not authorized or were furnished by unqualified providers. **b. Denominator:** Total claims submitted for 1915(i) services.
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: Representative sample of child participants receiving SED services. Confidence interval = 95% with -/+ 5% margin of error.

Monitoring Responsibilities *(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)*	Annual

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

Requirement	**Identifying, addressing and preventing incidents of abuse, neglect, and exploitation: Sub-requirement (b)**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of participants and/or family who received information/education about how to report abuse, neglect, exploitation, the use of restraints, and other critical incidents. **a. Numerator:** Number of participants or family who received information/education about how to report critical incidents. **b. Denominator:** Number of participants receiving services.
Discovery Activity *(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	Annual
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)*	Annual

System Improvement

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

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

a. Complaints and incident reports are investigated.

b. Services are delivered in accordance with care plans.

c. How are children and families showing improvement in functioning?

d. Annual QM Report.

e. Are children provided services in the least restrictive environment appropriate for their care?

2. **Roles and Responsibilities**

a. Quality Management, Improvement and Accountability (QMIA): This is a group of dedicated state agency employees who will look at complaints and issues across the continuum of care.

b. Department Analyst: This resource will examine quality management issues across the continuum of care.

c. QMIA: The QMIA team is responsible for steering the quality assessment and improvement process.

d. Medicaid's program manager: The program manager takes overall responsibility for leading team members, finalizing annual QM reports, leading the process of prioritizing needs for system improvements, and implementing approved system improvements.

e. QMIA: The QMIA team is responsible for steering the quality assessment and improvement process.

3. **Frequency**

a. Ongoing.

b. Ongoing.

c. Annual

d. Annual Report.

e. Annual.

4. **Method for Evaluating Effectiveness of System Changes**

a. Annual QM report is submitted to administration.

b. Annual QM report is submitted to administration.

c. Annual QM report is submitted to administration.

d. Annual QM report is submitted to administration.

e. Annual report is submitted to administration.

Methods and Standards for Establishing Payment Rates

(a) 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
☒	HCBS Respite Care
	The state's rates for respite reimbursement—$7.55 per unit of 15 minutes for individual respite, and $3.75 per unit of 15 minutes for group respite—were determined by a comparative analysis of other states' Medicare/Medicaid rates for code S5150, which was conducted by a national pricing consultant retained by the IBHP contractor. Specifically, the rates above were those found to be most closely aligned with the current Medicare/Medicaid rates of other states providing the same service.
For Individuals with Chronic Mental Illness, the following services:	
☐	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)