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State/Territory Name: ID

State Plan Amendment (SPA) #: 22-0022

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

June 16, 2023

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

RE: ID-22-0022 Adult Developmental Disabilities §1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal

Dear Mr. Jeppesen:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's 1915(i) state plan home and community-based services (HCBS) state plan amendment (SPA), transmittal number ID-22-0022. The purpose of this amendment is to renew Idaho's1915(i) State Plan HCBS for Adults with Developmental Disabilities (DD) benefit. The effective date for this renewal is July 1, 2023. 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 expiring June 30, 2023 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.

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.

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.

If you have any questions concerning this information, please contact me at (206) 615-3814. You may also contact Elizabeth Heintzman at elizabeth.heintzman@cms.hhs.gov or (206) 615-2596.

Sincerely,

Wendy Hill Petras, Deputy Director
Division of HCBS Operations and Oversight

Enclosure

cc: Dominique Mathurin, CMS
Courtenay Savage, CMS
Kevin Patterson, CMS
James Moreth, CMS

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: 22-0022

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
07-01-2023

5. FEDERAL STATUTE/REGULATION CITATION
1915(i) of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ $45,547,363.
b. FFY 2024 $ $102,299,441.

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-A: Supplement 2 pages, 1-47
Attachment 4.19-B page 43a

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-A: Supplement 2 pages, 1-66
Attachment 4.19-B page 43a

9. SUBJECT OF AMENDMENT
Amendment to the State Plan to renew the SSA 1915(i) state plan authority for Adults with Developmental Disabilities, under which it delivers Adult Developmental Therapy and Adult Community Crisis Supports services.

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

12. TYPED NAME
JULIET CHARRON

13. TITLE
Administrator

14. DATE SUBMITTED
12/30/2022

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
December 30, 2022

17. DATE APPROVED
June 16, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2023

19 SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL
Wendy Hill Petras

21. TITLE OF APPROVING OFFICIAL
Deputy Director, DHCBSO

22. REMARKS
3/17/2023-State authorized a P&I change to #6, 7, and 8.

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):*

Adult – Developmental Therapy Adult – Community Crisis Supports

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

Select one:

◉	**Not applicable**
○	**Applicable**
Check the applicable authority or authorities:	
☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* *(b) the geographic areas served by these plans;* *(c) the specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
☐	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*
Specify the §1915(b) authorities under which this program operates *(check each that applies)*:	
☐ §1915(b)(1) (mandated enrollment to managed care)	☐ §1915(b)(3) (employ cost savings to furnish additional services)
☐ §1915(b)(2) (central broker)	☐ §1915(b)(4) (selective contracting/limit number of providers)
☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*

☐	**A program authorized under §1115 of the Act.** *Specify the program:*

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

(Select one):

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

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

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

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

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☐	☐

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

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

Eligibility Evaluation: The State Medicaid Agency contracts with an Independent Assessment Contractor (IAC) to collect participant information required to complete needs-based criteria determinations and assign individualized budgets according to specific parameters as established by the single Medicaid agency as described in the contract. The IAC is not a provider of 1915(i) state plan home and community-based services (HCBS), nor does the IAC serve under the authority of a provider of 1915(i) state plan HCBS.

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

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

N/A

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

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

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

Number Served

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

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

Annual Period	From	To	Projected Number of Participants
Year 1	July 1, 2023	June 30, 2024	2,170
Year 2			
Year 3			
Year 4			
Year 5			

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

Financial Eligibility

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

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

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

Evaluation/Reevaluation of Eligibility

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

○	Directly by the Medicaid agency
◉	By Other (*specify State agency or entity under contract with the State Medicaid agency*):
	The State Medicaid Agency's contracted Independent Assessment Contractor.

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

Independent Assessment Contractors who gather information needed to provide needs-based criteria determinations 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:

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

Within three (3) days of receiving the application for services, BDDS verifies if the participant is financially eligible for Medicaid. After verifying a participant's financial eligibility, the application is forwarded to the State Medicaid Agency's Independent Assessment Contractor (IAC) to begin collecting information required to determine if the participant meets Needs-based HCBS Eligibility Criteria for this HCBS benefit.

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

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

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

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

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

e. Eligibility determinations and calculated budgets are communicated to the participant and their decision-making authority (if applicable) through a written Notice of Decision. Participants or their decision-making authority (if applicable) who do not agree with a decision regarding eligibility or the calculated budget may request a fair hearing through the state's Fair Hearing Unit.

f. Care Managers for the State Medicaid Authority (SMA) Bureau of Developmental Disability Services (BDDS) review eligibility determinations during review and authorization of the Individual Support Plan (ISP). BDDS Care Managers request updates or corrections when information collected by the IAC falls outside of the contractor parameters as set by the SMA. Similarly, when a participant does not agree with the eligibility determination and has requested a fair hearing, the BDDS Appeal's Specialist reviews the preliminary eligibility decision and requests updates or corrections from the IAC as needed.

g. The IAC maintains all documentation associated with the initial eligibility assessment process in an electronic participant file in the IAC database including the Eligibility Application, Eligibility Assessments, Eligibility Notices, and any other documentation used to support approval of eligibility.

PROCESS FOR ANNUAL REEVALUATION

Participants of this benefit are reevaluated at least annually.

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

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

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

verify participant eligibility prior to providing services as approved on the annual Individual Service Plan (ISP).

c. Participants are required to complete new functional assessment(s) when it is determined an existing functional assessment(s) does not accurately describe the current status of the participant as recommended by of the publisher of the of the current functional assessment tool, noted in the tool's user manual. The need for a new functional assessment(s) will be determined through a review of participant documentation and information provided by respondent during the annual face-to-face eligibility re-determination meeting. This respondent is someone the participant and their decision-making authority (if applicable) have identified as the person who is most qualified to provide current information regarding the participant's medical, functional, and behavioral needs.

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

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

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

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

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

- The individual requires assistance due to substantial limitations in three (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 has a need for combination and sequence of special interdisciplinary or generic care, treatment or other services which are of life-long or extended duration and individually planned and coordinated due to a delay in developing age appropriate skills occurring before the age of 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 requires assistance due to substantial limitations in three or more of the following major life activities – self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self- sufficiency; and The individual has a need for combination and sequence of special interdisciplinary or generic care, treatment or other services which are of life-long or extended duration and individually planned and coordinated due to a delay in developing age appropriate skills occurring before the age of twenty-two (22). (end)	Idaho has developed a Uniform Assessment Instrument (UAI) as the basis of the nursing facility needs-based criteria instrument. The UAI measures deficits in ADLs, IADLs, Behavioral and Cognitive Functioning. A score of 12 points is needed to demonstrate NF LOC. Idaho administrative code defines this in IDAPA 16.03.10.322.04-.08, "Medicaid Enhanced Plan Benefit." In determining need for nursing facility care an adult must require the level of assistance according to the following formula: **Critical Indicator - 12 Points Each.** a. Total assistance with preparing or eating meals. b. Total or extensive assistance in toileting. c. Total or extensive assistance with medications which require decision making prior to taking, or assessment of efficacy after taking. (con't)	In addition to being part of the Target Group described in this SPA and having substantial limitations outlined in the HCBS Needs-Based Criteria, the individual must be determined to need consistent, intense and frequent services by meeting the following criteria: The individual must meet needs-based criteria for receipt of institutional services. Persons living in the community must meet needs-based criteria for receipt of institutional services provided in an ICF/ID, including active treatment, and in the absence of available intensive alternative services in the community, would require institutionalized, other than services in an institution for mental disease, in the near future; and Persons may qualify based on their functional skills. Persons with an age equivalency composite score of eight (8) years and zero (0) months or less on the State Medicaid Agency-approved assessment tool would qualify; or Persons may qualify based on their Maladaptive Behaviors: a. A minus twenty-two (-22) or below score. Adults will be eligible if their general Maladaptive index on the State Medicaid Agency-approved assessment tool is minus twenty-two (-22) or less (con't)	The State uses criteria defined in 42 C.F.R. §440.10 for inpatient hospital services. (end)

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

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
	High Indicator - 6 Points Each a. Extensive assistance with preparing or eating meals. b. Total or extensive assistance with routine medications. c. Total, extensive or moderate assistance with transferring. d. Total or extensive assistance with mobility. e. Total or extensive assistance with personal hygiene. f. Total assistance with supervision from Section II of the Uniform Assessment Instrument (UAI). **Medium Indicator - 3 Points Each.** a. Moderate assistance with personal hygiene. b. Moderate assistance with preparing or eating meals. c. Moderate assistance with mobility. d. Moderate assistance with medications. e. Moderate assistance with toileting. f. Total, extensive, or moderate assistance with dressing. g. Total, extensive or moderate assistance with bathing. h. Extensive or moderate assistance with supervision from Section II No. 18 of the UAI. (end)	b. Above a Minus twenty-two (-22) score. Individuals who score above minus twenty-two (-22) may qualify for ICF/ID needs-based criteria for receipt of institutional services if they engage in aggressive or self-injurious behaviors of such intensity that the behavior seriously endangers the safety of the individual or others, the behavior is directly related to developmental disability, and the person requires active treatment to control or decrease the behavior; or Persons may qualify based on a combination of functional and maladaptive behaviors. Persons may qualify for ICF/ID needs-based criteria for receipt of institutional services if they display a combination of criteria at a level that is significant. An overall age equivalency up to eight and one-half (8.5) years is significant in the area of functionality when combined with a general maladaptive index on the SIB-R State Medicaid Agency-approved assessment tool from minus seventeen (-17), up to minus twenty-two (-22) inclusive; or Persons may qualify based on their Medical Condition. Individuals may meet ICF/ID needs-based criteria for receipt of institutional services based on their medical conditions if the medical condition significantly affects their functional level/capabilities and if it can be determined that they are in need of the level of services provided in an ICF/ID, including active treatment services. (end)	

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

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

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

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

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

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

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

i.	**Minimum number of services.** The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is: 1	
ii.	**Frequency of services.** The state requires (select one):	
	◉	**The provision of 1915(i) services at least monthly**

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 Medicaid Agency (SMA) has implemented the Home and Community-Based Settings (HCBS) Final Rule standards to establish compliance with HCBS settings requirements. The SMA has also implemented robust ongoing monitoring activities ensuring ongoing compliance. Monitoring is in place to ensure all HCBS settings are following state rules and all HCBS criteria allowing for integration and choice in the setting where individuals access HCBS.

The HCBS Settings Final Rule implementation methods and ongoing monitoring activities for all HCBS settings criteria are described below:

A. Idaho Administrative Code (IDAPA) Rule Promulgation: The SMA codified HCBS setting qualities and person-centered service plan and planning requirements into state administrative code under 16.03.10 "Medicaid Enhanced Plan Benefits", implemented effective July 1, 2017. State rules address a variety of HCBS setting requirements the SMA monitors for ongoing compliance such as HCBS setting qualities, residential provider-owned or controlled settings, and HCBS planning requirements.

B. Internal Policies and Procedures: Internal SMA documents have been updated to include new regulatory criteria. Process manuals for conducting provider audits and supplemental tools have been modified to include a review of setting qualities and person-centered service planning compliance (as applicable to the provider type/service type). Onboarding processes and training materials for new SMA staff have been updated to include orientation to the HCBS regulatory requirements and associated job-specific tasks.

Person-Centered Planning processes have been strengthened to ensure that participants and their decision-making authority have a choice of when and where their services are received. Additional fields have been added to several documents produced by the state, including service plan templates, to ensure that HCBS setting elements are not overlooked.

C. Provider/Settings Enrollment: State administrative code in 16.03.10 "Medicaid Enhanced Plan Benefits" 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. Prior to approval of new enrollment applications, the SMA evaluates HCBS compliance for the following provider types: Adult Day Health, CFHs, DDAs, Supported Living, Supported

Employment, Nursing Services, Respite Services, and Behavioral Consultation/Crisis Management. Documents reviewed for HCBS settings compliance prior to approval as a Medicaid HCBS provider or setting include the provider application, template notices, template intake packets, and policies and procedures.

D. Provider Training Materials: Public-facing materials for provider reference, including new provider onboarding materials, have been updated to include HCBS setting quality and person-centered planning requirements.

E. Licensing and Certification: The SMA Licensing and Certification (L&C) staff assess compliance with all HCBS requirements when completing their routine surveys of HCBS providers. L&C reviews the following HCBS regulations: integration and access, selection of setting, participant rights, autonomy and independence, choice, written agreement, privacy, schedules and activities, access to food, visitors, and physical accessibility. Surveys are completed every six (6) months to three (3) years, depending on provider type and status.

F. Provider Quality Reviews: SMA Quality Assurance Specialists (QA) continue to complete provider quality reviews. Existing Provider Quality Review processes have been modified to include components specific to HCBS compliance. QA Specialists have been trained to offer collaboration to non-compliant providers, in the form of technical assistance, onsite meetings, or other methods as defined by the SMA. Provider reviews are completed every six (6) months to three (3) years, depending on provider type and status.

G. Complaints and Critical Incidents: Complaint and critical incident management systems have been modified to include a category specific to HCBS setting qualities and service plan-related issues. Regular trend monitoring activities have been updated to include oversight of these regulatory criteria.

H. Participant Feedback Mechanisms: Existing participant feedback mechanisms have been modified to include targeted questions about HCBS compliance in the participant's service setting. The Adult Service Outcome Review (ASOR) is used to assess services provided to participants of this benefit. The ASOR Templates and Instruction Manual were revised in 2018 to incorporate HCBS requirements.

I. Service Plan Review: SMA BDDS Care Managers review all service plans prior to authorization and annually thereafter to ensure that only HCBS-compliant settings are selected for identified services. They ensure that all components of the person-centered plan are completed accurately. SMA BDDS Care Managers confirm all services and settings are chosen by the participant or their decision-making authority as evidenced by their signature on the person-centered service plan. Service providers also sign the plan acknowledging they will deliver services according to the authorized plan of service and consistent with HCBS requirements.

Person-Centered Planning & Service Delivery

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

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

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

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

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

At a minimum, individuals conducting the independent assessment must meet the requirements for a Qualified Intellectual Disability Professional (QIDP) in accordance with 42 C.F.R. §483.430 Condition of participation: Facility staffing.

At a minimum, A QIDP must:

a. Having at least one (1) year experience working directly with persons with intellectual disabilities or other developmental disabilities; and

b. Being one of the following:
- Licensed as a doctor of medicine or osteopathy, or as a nurse; or
- Have at least a bachelor's degree in one of the following professional categories: psychology, social work, occupational therapy, speech pathology, professional recreation therapy or other related human services professions; and

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

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

At a minimum, a paid plan developer developing a plan of care must meet service coordination qualifications outlined in Idaho administrative code IDAPA 16.03.10.729. Service Coordination: Provider Qualifications.

a. Neither a provider of direct service to the participant nor the assessor may be chosen to be the paid plan developer.

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

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

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

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

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

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

The plan of service is developed by the participant and their person-centered planning team. This group includes, at a minimum, the participant, their decision-making authority (if applicable) and the service coordinator or plan developer chosen by the participant. With the participant's consent, the person-centered planning team may include family members, or individuals who are significant to the participant. A plan developer's responsibility for developing a service plan using a person-centered planning process is supported by Idaho administrative code IDAPA 16.03.10.730. Service Coordination: Plan Development – Assessment and IDAPA 16.03.10.731. Service Coordination: Plan Development – Written Plan.

If limits for service coordination are reached, additional service coordination hours can be authorized by the State Medicaid Agency in situations where the participant is experiencing a crisis situation. Service coordination consists of services provided to assist individuals in gaining access to needed services. Service coordination includes: Plan Development and Periodic Reassessment, Referral and Related Activities, Monitoring and Follow-Up Activities and Crisis Assistance. The service limitations on service coordination is four and a half hours per month and 6 hours per year for plan development as per IDAPA 16.10.03.727.

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

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

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

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

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

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

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

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

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

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

Each individual support plan must be submitted to the State Medicaid Agency (SMA) at least 45 days prior to the expiration of the current individual support plan in accordance with IDAPA 16.03.10. Medicaid Enhanced Plan Benefits. The SMA has thirty (30) days to review the plan, discuss any issues with the plan developer (service coordinator), and request changes as needed. The plan developer (service coordinator) has the responsibility to discuss identified plan review issues with the participant and their decision-making

authority (if applicable). The SMA has an additional fifteen (15) days to enter the prior authorizations for approved services into the MMIS system.

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

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

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

Services

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

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Adult - Developmental Therapy
Service Definition (Scope):	
Developmental therapy may be delivered in a developmental disabilities agency center-based program, the community, or the home of the participant. Developmental therapy includes individual developmental therapy and group developmental therapy. Developmental therapy services must be delivered by Developmental Specialists or paraprofessionals based on a comprehensive developmental assessment completed prior to the delivery of services. • Areas of service. These services must be directed toward the rehabilitation or habilitation of physical or mental disabilities in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. • Age-appropriate. Developmental therapy includes instruction in daily living skills the participant has not gained at the normal developmental stages in his life, or is not likely to develop without training or therapy. Developmental therapy must be age-appropriate. • Tutorial activities and educational tasks are excluded. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the participant's disability. • Settings for developmental therapy. Developmental therapy, in both individual and group formats, must be available in both community-based and home-based settings, and be based on participant needs, interests, or choices. • Staff-to-participant ratio. When group developmental therapy is center-based, there must be a minimum of one (1) qualified staff, who may be a paraprofessional or a Developmental Specialist, providing direct services for every twelve (12) participants. Additional staff must be added, as necessary, to meet the needs of each individual served. • Community-based services must occur in integrated, inclusive settings and with no more than three (3) participants per qualified staff at each session. The services under the 1915(i) State Plan Option HCBS Benefit for Adults with Developmental Disabilities are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.	
Additional needs-based criteria for receiving the service, if applicable *(specify)*:	
N/A	

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

☑ Categorically needy *(specify limits)*:

Developmental therapy benefits limitation is twenty-two (22) hours per week. The State Medicaid Agency (SMA) ensures that the individual's needs can be met within the service limit by requiring that each service plan be prior authorized by the SMA. The prior authorization process ensures that the provision of services promote participant rights, self-determination and independence. All participants may request an exception review of plans and addendums requesting adult developmental therapy services that exceed established limits. These requests will be authorized when the requested services are necessary for the individual to live and receive services in their home and community.

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

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

A DDA may not hire a relative or legal guardian of a participant to provide services to any adult they are a relative to or the appointed legal guardian.

☐ Medically needy *(specify limits)*:

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

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

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

Provider Type *(Specify):*	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

Developmental Disabilities Agencies	State Medicaid Agency (Idaho Department of Health and Welfare)	• At initial provider agreement or renewal • At least every three (3) years, and as needed based on service monitoring concerns

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

☐	Participant-directed	☑	Provider managed

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

Service Title:	Adult - Community Crisis Support

Service Definition (Scope):

Community crisis supports are interventions for adult participants who are at risk of losing housing, employment or income, or are at risk of incarceration, physical harm, family altercation or other emergencies. If a participant experiences a crisis, community crisis supports can be offered to assist the participant out of the crisis and develop a plan that mitigates risks for future instances.

These individualized interventions are to ensure the health and safety of the participant and may include referral of the participant to community resources to resolve the crisis, direct consultation and clinical evaluation of the participant, training and staff development related to the needs of a participant, emergency back-up involving the direct support of the participant in crisis, and/or other assistance that is appropriate to resolve the crisis and does not duplicate another service that is the same in nature and scope regardless of source, including federal, state, local and private entities. Payments may not be made for room and board, items of comfort or convenience, or items that are for purely diversional/recreational purposes. Any housing support activities that are directly performed by the provider on behalf of the participant, community transition services, and home adaptations are excluded. Any other services and supports that are not permissible for federal financial participation are excluded.

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

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

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

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☑	Categorically needy *(specify limits)*:
	Community crisis support is limited to a maximum of twenty (20) hours during any consecutive five (5) day period. In order to initiate a request for community crisis supports, the service coordinator, in coordination with the person-centered planning team, submits a request for community crisis supports to the State Medicaid Agency (SMA). The SMA case manager will review the request to ensure that the supports requested are not duplicative of other services being delivered to the participant. Community crisis supports will only be approved if all service hours previously prior authorized that may be appropriate to address the crisis have already been exhausted. When Community Crisis Supports has been accessed, the proactive strategy used to address the factors that resulted in a crisis should be incorporated as goals into the participant's person-centered plan of service. Community crisis support may be retroactively authorized within seventy-two (72) hours of providing the service if there is a documented need for immediate intervention, no other means of support are available and the services are appropriate to rectify the crisis. Participants who are not currently receiving developmental disability services may receive community crisis supports after completing an abbreviated person-centered planning process. In these cases, after eligibility for the service is determined, the participant and their planning team will develop a crisis plan to address the immediate crisis. This crisis plan will subsequently be incorporated into the overall person-centered planning process and development of the initial DD plan of service. Legally responsible individuals (e.g., a parent of minor child or a spouse) and relatives may not be paid for the provision of Community Crisis services.
☐	Medically needy *(specify limits)*:

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

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

			IDAPA 16.03.10.729. Service Coordination: Provider Qualifications.
Behavioral Consultation			Behavioral Consultation Providers must meet provider qualifications as outlined in Idaho administrative code IDAPA 16.03.10.705.12. Behavior Consultation or Crisis Management.
Supported Employment Services			Supported Employment Providers must meet provider qualifications as outlined in Idaho administrative code IDAPA 16.03.10.705.05. Supported Employment.
Residential Habilitation Agency		Certificate as described in Idaho administrative code IDAPA 16.04.17 Residential Habilitation Agencies and 16.03.10.705. Adult DD Waiver Services: Provider Qualifications and Duties.	
Certified Family Home		Certified Family Home certificate as described in IDAPA at 16.03.19	

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

Provider Type *(Specify):*	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Service Coordination Agency	State Medicaid Agency (Idaho Department of Health and Welfare)	At least every two (2) years.
Behavioral Consultation	State Medicaid Agency (Idaho Department of Health and Welfare)	At least every two (2) years.
Supported Employment Services	State Medicaid Agency (Idaho Department of Health and Welfare)	At least every two (2) years.
Residential Habilitation Agency	State Medicaid Agency (Idaho Department of Health and Welfare)	Residential habilitation providers are surveyed when they seek

		renewal of their certificate. The State Medicaid Agency issues certificates that are in effect for a period of no longer than three (3) years.
Certified Family Home	Department of Health and Welfare	Certification for Certified Family Homes is required the year after the initial home certification study and at least every twenty-four (24) months thereafter.

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

☐	Participant-directed	☑	Provider managed

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

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

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

Participant-Direction of Services

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

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

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

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

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

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

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

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐

	☐	☐

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

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

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

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

8. **Opportunities for Participant-Direction**

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

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

		employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

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

Quality Improvement Strategy

Quality Measures

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

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

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

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

Requirement 1 ***(Service Plans)***	***Sub-Requirement 1-a*** Service plans address all 1915(i) participants' assessed needs, either by 1915(i) HCBS service or through other means.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 2 (PM2)*** Number and percent of participant records reviewed that indicate services were delivered consistent with the service type, scope, amount, duration and frequency approved on service plans. Numerator: Number of participant records reviewed that indicate services were delivered consistent with the approved service plans. Denominator: Number of participant records reviewed.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Adult Services Outcome Review (record reviews and participant interviews) Sampling Approach: Representative Sample of adult participants receiving 1915(i) HCBS. Confidence Interval = +/- 5% and Confidence Level = 95%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement 1 ***(Service Plans)***	***Sub-Requirement 1-b*** Service plans are updated at least annually.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 3 (PM3)*** Number and percent of service plans reviewed that were updated at least annually. Numerator: Number of service plans reviewed that were updated at least annually. Denominator: Number of participant records reviewed.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Adult Services Outcome Review (record reviews and participant interviews) Sampling Approach: Representative Sample of adult participants receiving 1915(i) HCBS. Confidence Interval = +/- 5% and Confidence Level = 95%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 1 ***(Service Plans)***	***Sub-Requirement 1-c*** 1915(i) HCBS participants are afforded choice: Between/among 1915(i) services and providers.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 4 (PM4)*** Number and percent of participant records reviewed that indicated participants were given a choice when selecting 1915(i) services. Numerator: Number of participant records reviewed that indicated participants were given a choice of 1915(i) services. Denominator: Number of participant records reviewed.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Adult Services Outcome Review (record reviews and participant interviews) Sampling Approach: Representative Sample of adult participants receiving 1915(i) HCBS. Confidence Interval = +/- 5% and Confidence Level = 95%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 1 ***(Service Plans)***	***Sub-Requirement 1-c*** 1915(i) HCBS participants are afforded choice: Between/among 1915(i) services and providers.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 5 (PM5)*** Number and percent of participant records reviewed that indicated participants were given a choice when selecting 1915(i) HCBS providers. Numerator: Number of participant records reviewed that indicated participants were given a choice of 1915(i) HCBS providers. Denominator: Number of participant records reviewed.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Adult Services Outcome Review (record reviews and participant interviews) Sampling Approach: Representative Sample of adult participants receiving 1915(i) HCBS. Confidence Interval = +/- 5% and Confidence Level = 95%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 2 ***(Eligibility)***	***Sub-Requirement 2-a*** An evaluation for 1915(i) Benefit eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 6 (PM6)*** Number and percent of initial applicants for whom an evaluation of the 1915(i) Benefit needs-based eligibility criteria was completed prior to receiving 1915(i) services. Numerator: Number of initial applicants for whom an evaluation of the 1915(i) Benefit needs-based eligibility criteria was completed prior to receiving 1915(i) services. Denominator: Number of initial applicants receiving 1915(i) services.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Continuously and Ongoing, and Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement 2 ***(Eligibility)***	***Sub-Requirement 2-b*** The process and instruments for determining 1915(i) Benefit eligibility as described in the approved state plan are applied appropriately.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 7 (PM7)*** Number and percent of reviewed 1915(i) Benefit eligibility determinations that were made according to the 1915(i) Benefit needs-based eligibility criteria. Numerator: Number reviewed 1915(i) Benefit eligibility determinations that were made according to the 1915(i) Benefit needs-based eligibility criteria. Denominator: Number of reviewed 1915(i) Benefit eligibility determinations in the representative sample.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Reports to State Medicaid Agency on delegated Administrative functions Sampling Approach: Representative Sample. Confidence Interval = +/- 5% and Confidence Level = 95%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement 3 ***(Qualified Providers)***	Providers meet required qualifications
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 8(PM8)*** Number and percent of new 1915(i) Benefit providers, which are required by the State to be certified, that meet the State's certification standards prior to providing services. Numerator: Number of new 1915(i)_Benefit providers, which are required by the State to be certified, that meet the State's certification standards prior to providing services. Denominator: Number of initial 1915(i)_Benefit providers, which are required by the State to be certified.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Record Reviews – Off-Site Sampling Approach: 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Continuously and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 3 ***(Qualified Providers)***	Providers meet required qualifications.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 9(PM9)*** Number and percent of ongoing 1915(i) Benefit providers, which are required by the State to be certified, that meet the State's certification standards. Numerator: Number of ongoing 1915(i) Benefit providers, which are required by the State to be certified, that meet the State's certification standards. Denominator: Number of ongoing 1915(i) Benefit providers, which are required by the State to be certified.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Record Reviews – On-Site Sampling Approach: 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Providers are surveyed when they seek renewal of their certificate. The State Medicaid Agency issues certificates that are in effect for a period of no longer than three (3) years.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 3 ***(Qualified Providers)***	Providers meet required qualifications.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 10 (PM10)*** Number and percent of new 1915(i) Benefit providers, which are not required by the State to be licensed or certified, that received an initial provider quality review within six (6) months of providing 1915(i) services to 1915(i) participants. Numerator: Number of new 1915(i) Benefit providers, which are not required by the State to be licensed or certified, that received an initial provider quality review within six (6) months of providing 1915(i) services to 1915(i) participants. Denominator: Number of new 1915(i) Benefit providers, which are not required by the State to be licensed or certified.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Record Reviews – On-Site and Off-Site Sampling Approach: 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Continuously and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 3 (Qualified Providers)	Providers meet required qualifications.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 11 (PM11)*** Number and percent of ongoing 1915(i) Benefit providers, which are not required by the State to be licensed or certified, that received a quality review every two (2) years. Numerator: Number of ongoing 1915(i) Benefit providers, which are not required by the State to be licensed or certified, that received a quality review every two (2) years. Denominator: Number of ongoing 1915(i) Benefit providers, which are not required by the State, to be licensed or certified.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Record Reviews – On-Site and Off-Site Sampling Approach: 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Every two (2) years.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 4 ***(HCBS Settings)***	Settings meet the home and community-based services (HCBS) setting requirements as specified in this state plan amendment and in accordance with 42 C.F.R. §441.701(a)(1) and (2).
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 12 (PM12)*** Number and percent of HCBS settings reviewed that meet the HCBS setting requirements as specified in this state plan amendment and in accordance with 42 C.F.R. §441.701(a)(1) and (2). Numerator: Number of HCBS providers reviewed who meet compliance standards. Denominator: Number of HCBS providers reviewed in the representative sample.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Record Reviews – On-Site and Off-Site Sampling Approach: 100% of reviewed HCBS providers
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 5 ***(Administrative Authority)***	The State Medicaid Agency retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 13(PM13)*** The number and percent of issues requiring remediation identified in contract monitoring reports that were addressed by the State. Numerator: Number of identified issues requiring remediation that were addressed by the State. Denominator: Number of issues requiring remediation identified in contract monitoring reports.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Reports to State Medicaid Agency on delegated Administrative functions Sampling Approach: 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement 6 ***(Financial Accountability)***	The State Medicaid Agency maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
Discovery	
Discovery Evidence *(Performance Measure)*	***Performance Measure 14(PM14)*** Number and percent of claims paid to 1915(i) service providers that are qualified to furnish 1915(i) services to 1915(i) participants. Numerator: Number of claims paid to 1915(i) service providers that are qualified to furnish 1915(i) services to 1915(i) participants. Denominator: Number of claims paid to all 1915(i) service providers.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: 100% Review of billing for a one-week period on an annual basis
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation
Frequency	Quarterly and Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 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 15(PM15)*** Number and percent of critical incidents (related to abuse, neglect, exploitation, and use of restraints) substantiated by the State that were remediated. Numerator: Number of critical incidents (related to abuse, neglect, exploitation, and use of restraints) substantiated by the State that were remediated. Denominator: Number of critical incidents (related to abuse, neglect, exploitation, and use of restraints) substantiated by the State.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Critical events and incident reports Sampling Approach: 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection.
Frequency	Continuously and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 7 ***(Health and Welfare)***	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 16(PM16)*** Number and percent of reviewed services plans with restrictive interventions (including restraints and seclusion) that were approved according to criteria in the approved state plan. Numerator: Number of reviewed service plans with restrictive interventions that were approved according to criteria in the approved state plan. Denominator: Number of reviewed service plans reviewed with restrictive interventions in the representative sample.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Reports to State Medicaid Agency on delegated Administrative functions Sampling Approach: Representative Sample of adult participants receiving 1915(i) HCBS with restrictive interventions. Confidence Interval = +/- 5% and Confidence Level = 95%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement 7 (Health and Welfare)	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 17 (PM17)*** Number and percent of 1915(i) participants (and/or family or legal guardians) who received information/education about how to report abuse, neglect, exploitation and other critical incidents as specified in the approved state plan.
Discovery Activity *(Source of Data & Sample Size)*	Data Source: Reports to State Medicaid Agency on delegate Administrative functions Sampling Approach: 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection.
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

System Improvement

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

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

The State Medicaid Agency's Division of Medicaid, Bureau of Developmental Disability Services (BDDS) has a Quality Assurance Management Team. This team includes:

- BDDS Bureau Chief
- BDDS Quality Manager
- BDDS Operations Manager
- Medicaid Policy Staff
- Medicaid Contract Monitors
- State Licensing and Certification Staff

This team is responsible for reviewing Quality Improvement Strategy findings and analysis (including trending), formulating remediation recommendations, and identifying and addressing any statewide resource or program issues identified in QA business processes.

Recommended program changes or system improvement processes are then referred to the Central Office Management Team (COMT) for review and approval. The COMT is responsible for reviewing BDDS quality improvement recommendations. The COMT prioritizes recommendations taking into consideration division wide resources, coordination issues and strategies. Based on prioritization, the COMT makes final remediation decisions and implements system wide change.

The BDDS Quality Manager is responsible for leading team members and the Quality Assurance tasks for State Plan HCBS services. The Quality Manager is responsible for finalizing quarterly and yearly Quality Management reports, leading the process of prioritizing needs for system improvements, and implementing approved system improvements.

2. **Roles and Responsibilities**

State Medicaid Agency is Responsible for Remediation Data Aggregation and Analysis

3. **Frequency**

Quarterly

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

When the Central Office Management Team (COMT) identifies system wide changes, the BDDS Quality Assurance Management Team monitors and analyzes the effectiveness of the design change.

The BDDS Quality Assurance Team comprised of BDDS Regional Quality Assurance Staff are responsible for implementation of quality assurance related activities as defined in the quality improvement strategy

All design changes are tracked through a Continuous Quality Improvement task list. This task list identifies:

- the description of a task
- the implementation plan
- monitoring plan
- outcome

Quality improvement tasks are monitored on a quarterly and annual basis and updates are given to the COMT.

The Division of Medicaid's BDDS Quality Manager is responsible for the management and oversight of BDDS's QA system. These duties include:

- implementation and monitoring of quality improvement strategy
- training and oversight of the BDDS Quality Assurance Team
- related data collection
- reporting
- continuous quality improvement and remediation processes and activities

As part of quarterly monitoring activities, the Quality Manager evaluates the quality improvement strategy for effectiveness and recommends changes as needed.

Methods and Standards for Establishing Payment Rates

9. **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)*:

[X] HCBS Habilitation

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

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

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

Code	Description	Rate of Reimbursement
97537	Development Therapy in Home or Community (per 15 minute)	$ 6.26
H2032	Development Therapy in Center (per 15 minute)	$ 4.17
H2011	Community Crisis Support (per 15 minute)	$11.35
H2000	Developmental Therapy Evaluation (per 15 minute)	$16.95