Table of Contents

State/Territory Name: Idaho

State Plan Amendment (SPA) #: 12-007

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
2201 Sixth Avenue, MS/RX -43
Seattle, WA 98121

CENTERS FOR MEDICARE & MEDICAID SERVICES

Centers of Medicaid and CHIP Services

JUL 31 2012

Richard Armstrong, Director
Department of Health and Welfare
Towers Building – Tenth Floor
Post Office Box 83720
Boise, Idaho 83720-0036

RE: Idaho State Plan Amendment (SPA) Transmittal Number 12-007

Dear Mr. Armstrong:

The Centers for Medicare & Medicaid Services (CMS) Seattle Regional Office has completed its review of State Plan Amendment (SPA) Transmittal Number 12-007. This SPA amends Idaho's current 1915(i) State plan benefit by adding clarifying language to the services available to eligible participants. In addition, this SPA adds language to indicate that on June 30, 2013, Intensive Behavioral Intervention (IBI), IBI consultation, Developmental Therapy (DT), and Children's Service Coordination (CSC) will sunset in Idaho's Basic and Enhanced Benchmark Benefit plans. Thus, Idaho will be voluntarily rescinding its OBRA '89 status which has allowed them to provide these "habilitative" services under the Section 1905(a) rehabilitation benefit.

This SPA is approved effective June, 1, 2012, as requested by the State.

If you have any additional questions or require any further assistance, please contact me, or have your staff contact Jan Mertel at (206) 615-2317 or Jan.Mertel@cms.hhs.gov.

Sincerely,

[redacted]

Carol J.C. Peverly
Associate Regional Administrator
Division of Medicaid and Children's
Health Operations

Enclosure

cc:
Leslie Clement, Deputy Director, Department of Health & Welfare
Paul Leary, Medicaid Benefits Administrator, Division of Medicaid

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **12-007**

2. STATE: **IDAHO**

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

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
June 1, 2012

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:
Section 6086 of the Deficit Reduction Act of 2005, and Section 2402(b) through 2402(f) of the Affordable Care Act

7. FEDERAL BUDGET IMPACT:
N/A

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A Supplement 1 – Pages 2, 3, 6, 7, 12-26, ~~32a – 32m (new pages)~~ (remove), 33, 33a, 39, 40, 47
Attachment 3.1-C, Basic Benchmark Plan – Pages 35, 36
Attachment 3.1-C, Enhanced Benchmark Plan – Pages 43, 49 & 49a
~~Removing Attachment 3.1C Enhanced Benchmark Plan – Pages 49b – 49 h~~
Attachment 3.1-C Enhanced Benchmark Plan - Page 52

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

Attachment 3.1-A Supplement 1 – Pages 2, 3, 6, 7, 12-26, 33, 33a, 39, 40, 47
Attachment 3.1-C, Basic Benchmark Plan – Pages 35, 36
Attachment 3.1-C, Enhanced Benchmark Plan – Pages 43, 49, 49a -49 h
Attachment 3.1-C Enhanced Benchmark Plan - Page 52

10. SUBJECT OF AMENDMENT:
1915(i) State Plan HCBS benefit for children with developmental disabilities.

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
LESLIE M. CLEMENT

14. TITLE:
Deputy Director

15. DATE SUBMITTED: 5/3/12

16. RETURN TO:

Paul J. Leary, Administrator
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 83720
Boise ID 83720-0009

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **May 4, 2012**

18. DATE APPROVED: **July 31, 2012**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: **June 1, 2012**

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: **Carol J.C. Peverly**

22. TITLE: **Associate Regional Administrator**
Division of Medicaid and Children's Health Operations

23. REMARKS:
07/23/2012 - Pen and Ink (P&I) changed authorized by State in Blocks 8 and 9

FORM HCFA-179 (07-92)

Supplement 1 to Attachment 3.1-A, Program Description

1915(i) STATE PLAN HOME AND COMMUNITY-BASED SERVICES
A. Children with Developmental Disabilities

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 service title(s) for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Respite
Habilitative Supports
Family Education
Community Support Services
Support Broker
Financial Management Services

2. Statewideness. *(Select one)*:

X	The State implements the 1915(i) State plan HCBS benefit statewide, per §1902(a)(1) of the Act.

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

X	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)*:		
	O	The Medical Assistance Unit *(name of unit)*:	
	X	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.*	Division of Family and Community Services, Department of Health and Welfare
O	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.		

Supplement 1 to Attachment 3.1-A, Program Description

Distribution of State plan HCBS Operational and Administrative Functions.

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

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

State plan enrollment and eligibility evaluation: Independent Assessment Provider
Review of participant service plans: Case management contractor(s)

Supplement 1 to Attachment 3.1-A, Program Description

Financial Eligibility

1. X **Income Limits.** *(By checking this box the State assures that):* Individuals receiving State plan HCBS are in an eligibility group covered under the State's Medicaid State plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL.

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

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

Needs-Based Evaluation/Reevaluation

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

O	Directly by the Medicaid agency
X	By Other (*specify State agency or entity with contract with the State Medicaid agency*):
	Contracted Independent Assessment provider(s) will be determined according to state purchasing requirements.

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

Qualified Intellectual Disabilities Professional (QIDP) in accordance with 42 CFR 483.430a.

Supplement 1 to Attachment 3.1-A, Program Description

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:

Participants applying for 1915(i) state plan option services will be referred to the independent assessment provider (IAP) for initial eligibility determination.

The IAP will evaluate the participant using the Scales of Independent Behavior-Revised (SIB-R) and an inventory of individual needs to determine if the participant meets the needs-based criteria. Reevaluations must be completed annually for current participants. The independent assessor must reassess the participant, or establish and document that the existing assessments reflect the participant's current needs.

4. X **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):*

- Require assistance due to substantial limitations in three or more of the following major life activities - self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self sufficiency; and
- Reflect the need for a combination and sequence of special, interdisciplinary services due to a delay in developing age appropriate skills occurring before the age of 22.

5. X **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits 1915(i) state plan option services to a group or subgroups of individuals:

Children, birth through age seventeen (17), who are determined to have a developmental disability in accordance with Sections 500 through 506 under IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits" and Section 66-402, Idaho Code.

Supplement 1 to Attachment 3.1-A, Program Description

Person-Centered Planning & Service Delivery

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

1. X There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:
   - An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified;
   - Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;
   - An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the plan of care;
   - An examination of the individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
   - If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
   - A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.
2. X Based on the independent assessment, the individualized plan of care:
   - Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
   - Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
   - Prevents the provision of unnecessary or inappropriate care;
   - Identifies the State plan HCBS that the individual is assessed to need;
   - Includes any State plan HCBS in which the individual has the option to self-direct the purchase or control ;
   - Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
   - Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.
3. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. *(Specify qualifications):*

At a minimum, the qualifications of the individuals conducting the independent assessment include: 1. Qualified Intellectual Disabilities Professional (QIDP) in accordance with 42 CFR 483.430 which includes: a. Having at least one (1) year experience working directly with persons with intellectual disabilities or other developmental disabilities or; b. Being licensed as a doctor of medicine or osteopathy, or as a nurse or; c. Having at least a bachelor's degree in one of the following professional categories: psychology, social work, occupational therapy, speech pathology, professional recreation, or other related human services professions. 2. Have training and experience in completing and interpreting assessments.

Supplement 1 to Attachment 3.1-A, Program Description

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

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

Traditional Waiver Services:

The Department and its contractor(s) will be responsible for developing the plan of service in coordination with the participant and their family. Neither a provider of direct services to the participant nor the assessor may be chosen to develop the plan of service.

Case Management Qualifications:

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

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

Family-Directed Waiver Services:

Under the family-directed model, a qualified parent is permitted to act as an unpaid support broker, or the family may choose to hire an approved support broker to purchase specific duties as needed.

The paid support broker may assist the family in developing and maintaining a support and spending plan. The plan must include the supports that the participant needs and wants, related risks identified with the participant's needs and preferences, and a comprehensive risk plan for each potential risk. This plan must be reviewed and prior authorized by the Department prior to implementation.

Specific qualifications are outlined in Idaho Administrative Code - IDAPA 16.03.13. It includes review of education, experience, successful completion of Support Broker training and ongoing education.

5. **Supporting the Participant in Plan of Care Development.** 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 plan of care development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

Participants who select State plan HCBS are given an orientation to developmental disability services by the IAP and their case manager. Participants and their parent/legal guardian may develop their own plan or use a case manager from the Department. If the participant and parent/legal guardian chooses to develop their own plan or use an unpaid natural support, the Department's case manager is available to assist in completing all required components. Family-centered planning must include at a minimum the participant (unless otherwise determined by the family-centered planning team), parent/legal guardian, and the case manager. With the parent/legal guardian's consent, the family-centered planning team may also include additional family members or individuals who are significant to the participant.

Participants and their parent/legal guardian who choose family-direction receive an orientation on family-direction and training from the Department. Families may select a qualified support broker to assist with writing the Support and Spending Plan, or they may choose to become a qualified support broker approved by the Department. As outlined in IDAPA 16.03.13, "Consumer-Directed Services," the participant and parent/legal guardian decides who will participate in the planning sessions in order to ensure the participant's choices are honored and promoted. The family may direct the family-centered planning meetings, or these meetings may be facilitated by a chosen support broker. In addition, the participant and parent/legal guardian selects a circle of support. Members of the circle of support commit to work within the group to help promote and improve the life of the participant in accordance with the participant's choices and preferences, and meet on a regular basis to assist the participant and parent/legal guardian to accomplish their expressed goals.

Supplement 1 to Attachment 3.1-A, Program Description

6. **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 plan of care):*

Once participants are determined eligible for services, they and their families are given an opportunity to participate in orientation training about developmental disability services in Idaho. During family orientation, participants and their families are provided with a list of all approved providers in the state of Idaho, which is organized by geographic area. This provider list includes the website link for the children's DD website at www.redesignforchildren.medicaid.idaho.gov so that participants and families have access to the most current providers in their area and across the state. Both the orientation and the provider list include a statement that the family may choose any willing and available provider in the state. Families are also informed of how to navigate the website to access the list of providers as well as how to access other helpful resources available to them.

Families are also provided with resources on interviewing potential providers and are encouraged to contact multiple providers to identify the provider that can best meet their needs. In addition, families are informed that who they select is their choice and they may change their choice of providers if they want. The case manager is utilized to assist families in selecting service providers at the family's request.

7. **Process for Making Plan of Care Subject to the Approval of the Medicaid Agency.** *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

In both the traditional and family-directed options, the plan is developed by the participant and parent/legal guardian with their support team. The support team is typically comprised of the case manager or a support broker, the parent/legal guardian, at least one involved care giver and any friends, family or support staff that the family wants to invite. The number of people who can be involved is not limited. Besides the parent/legal guardian, the case manager is the only person who is required to be a member of the support team.

In the traditional model, the Department or its contractor develops the plan of service with the family. The contractor submits the plan of service to the Department for review and approval within 10 business days prior to the plan expiration date. Participants and their parents or legal guardians who choose to family-direct their services submit their Support and Spending Plan directly to the Department for review and authorization. The Department has ten (10) business days to review the plan. The participant and parent/legal guardian, and their circle of supports are in charge of how long the plan development process takes. The process may take from a few days to much longer, depending on the needs and wants of the participant, their family and the support team.

The IAP conducts and/or collects a variety of assessments and determines the participant's individual budget at the time of initial application and on an annual basis, for both the traditional and the family-directed option.

The IAP conducts the following assessments at the time of the initial application for children's DD services:

- Scales of Independent Behavior – Revised (SIB-R) functional assessment.
- Medical, Social and Developmental Assessment Summary.

At the time of annual re-determination, the IAP conducts and/or reviews the following:

- The Medical, Social and Developmental Assessment Summary is reviewed and updated.
- The SIB-R results are reviewed and another assessment performed if there are significant changes in the participant's situation or the reassessment criteria are met.

The following assessments are gathered on an as-needed basis or may be used as historical information at the time of both initial and annual re-determinations:

- Psychological evaluations, including evaluations regarding cognitive abilities, mental health issues and issues related to traumatic brain injury.
- Neuropsychological evaluations.
- Physical, occupational and speech-language pathology evaluations.
- Developmental and specific skill assessments.

The results of a physical examination by the participant's primary care physician are provided to the case manager on an annual basis. Participants using traditional State plan HCBS, and their support team, must be assessed for health and safety issues. Participants using the family-directed option, and their support team, must complete safety plans related to any identified health and safety risks and submit them to the Department.

In the traditional option, the participant and parent/legal guardian's needs, goals, preferences and health status are summarized on the plan of service. This document is a result of the family-centered planning meeting listing a review of all assessed needs and participant and parent/legal guardian preferences. In addition, the case manager is responsible to collect data status reviews from all paid providers, synthesize all of the information and include it on the plan of service. The participant's parent/legal guardian sign the plan of service to indicate it is correct, complete, and represents the participant and parent/legal guardian's needs and wants.

Family-directed participant's needs, goals, preferences, health status, and safety risks are summarized on the Support and Spending Plan and in the Family-Direction workbook. The circle of supports, using family-centered planning, develops these documents and submits them to the Department at the time of initial/annual plan review.

Participants and their parent/legal guardian, along with other members of the support team can receive information regarding State plan HCBS through several methods:

- The Department of Health and Welfare web site has a page specific for Children's DD Services that includes FAQ's, provider forms, rules, services, list of available providers, and other important resources. The website is found at www.redesignforchildren.medicaid.idaho.gov.

The Department of Health and Welfare's web site also has a page specific for family-directed services found at www.familydirected.dhw.idaho.gov.

- The IAP provides each new applicant with an informational packet which includes a listing of providers in the local area that provide developmental disabilities services for children, as well as a list of the services available under the children's DD program.

Supplement 1 to Attachment 3.1-A, Program Description

• The case manager is charged with verbally explaining the various programs and options to the participant and parent/legal guardian during the family-centered planning process, under the traditional option.

• The support broker is charged with assisting the participant and parent/legal guardian to assess what services meet their needs, under the family-direction option.

Idaho requires that a family-centered planning process be utilized in plan development to ensure that participant goals, needs and preferences are reflected on the plan of service or on the Support and Spending Plan.

Case managers are trained in family-centered planning, and possess the education and experience needed to assist families in making decisions about their child's course of treatment and Medicaid services. The child's goals, needs, and resources are identified through a comprehensive review process that includes review of assessments and history of services, and family-centered planning.

Parents/legal guardians who choose to family-direct must attend training offered by the Department prior to submitting a Support and Spending Plan. Completion of this training is documented in the family-direction quality assurance database. The training covers participant and parent/legal guardian responsibilities in family-direction and the process of developing a Support and Spending Plan. The family-directed option utilizes a workbook and a support broker to ensure that the participant's individual goals, needs and preferences are thoroughly explored and prioritized during the plan development process.

Children's State plan HCBS participants typically receive a variety of services and other supports to address their needs and wants. The family-centered planning team works to ensure that the plan of service adequately reflects the necessary services. The plan of service is a single plan that includes the goals, objectives and assessment results from all of a child's services and supports in the child's system of care. The plan of service will demonstrate collaboration is taking place among providers and that objectives are directly related to the goals of the family.

Under the traditional option, the responsibility is placed on the case manager, IAP, and Department to complete the plan development process.

- The IAP is responsible to submit the assessment and individual budget to the Department.
- The Department assigns either a contracted case manager or Department staff to deliver case management and is responsible to:
  - Ensure that services are not duplicative, and are complementary and appropriate
  - Work with the members of the family-centered planning team and providers to ensure that the service needs of the participant are reflected on the plan of service
  - Act as the primary contact for the family and providers
  - Link the family to training and education to promote the family's ability to competently choose from existing benefits
  - Complete a comprehensive review of the child's needs, interests, and goals
  - Assist the family to allocate funding from their child's individual budget
  - Monitor the progress of the plan of service
  - Ensure that changes to the plan of service are completed when needed
  - Facilitate communication between the providers in a child's system of care

Supplement 1 to Attachment 3.1-A, Program Description

Under the family-directed option, the responsibility is placed on the participant and parent/legal guardian to coordinate services with assistance from the Department and F/EA as required.

- The IAP is responsible to submit the assessment and individual budget to the Department.
- The family and a support broker use the Family-Direction Workbook and the family-centered planning process to identify the participant's needs and develop a Support and Spending Plan.
- The Department reviews the plan to ensure that all health and safety risks are covered.
- The Fiscal/Employer Agent (F/EA) ensures that duplication of payment does not occur.

Under the traditional model, the family-centered planning team must identify the frequency of monitoring but at a minimum it must occur at least annually. In addition, the plan must be monitored for continuing quality by the participant's case manager. Plan monitoring ensures that the plan of service continues to address the participant's goals, needs and preferences by requiring:

- Contact with the parent/legal guardian at least annually or as needed to identify the current status of the program and changes if needed. Changes may be made to the plan when a service is added or eliminated, when service objectives or goals are changed, when there is a change in provider, or when the child's level of needs change. The plan should be changed to ensure that the services continue to align with the child's individual budget and that the family is up to date on the services their child is receiving.
- Contact with service providers to identify barriers to service provision.
- Discussion about satisfaction regarding quality and quantity of services with the family.
- Review of provider status reports and complete a plan monitor summary after the six month review and for annual plan development.
- Reporting of any suspicion or allegation of abuse, neglect or exploitation to the appropriate authorities.

Participants and their parent/legal guardian who family-direct their services may choose to assume the responsibility of plan monitoring themselves, utilize members of the circle of supports, or require a support broker to perform these duties. This decision is made in the circle of supports during the family-centered planning process and is reflected in the Family-Direction workbook.

Each participant is required to complete a new plan of service annually. The IAP sends written notification 120 days prior to the expiration of the current plan. The notice requests that the family schedule a meeting with the IAP to begin the process of eligibility re-determination and annual budget determination. Families will work closely with the case manager and at any time can determine the need to add, decrease, or change services. Both plans and addendums will be reviewed by the Department.

Participants and their parent/legal guardian who are family-directing their services are required to complete a new Support and Spending Plan annually. Families can request changes be made to their Support and Spending plan at any time during the plan year by completing a plan change form and submitting to the Department for review.

Supplement 1 to Attachment 3.1-A, Program Description

8. **Maintenance of Plan of Care 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):*

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

Supplement 1 to Attachment 3.1-A, Program Description

Services

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

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*			
Service Title:	Respite		
Service Definition (Scope):			
Respite provides supervision to the participant on an intermittent or short-term basis because of the need for relief of the primary unpaid caregiver. Respite is available in response to a family emergency or crisis, or may be used on a regular basis to provide relief to the caregiver. Respite may be provided in the participant's home, the private home of the respite provider, a developmental disabilities agency, or in community settings. Respite may only be offered to participants who have an unpaid primary caregiver living in the home who requires relief. Limitations: •Payment for respite services are not made for room and board. •Respite cannot be provided during the same time other Medicaid services are being provided to a participant. •Respite cannot be provided on a continuous, long-term basis where it is part of daily services that would enable an unpaid caregiver to work. - Respite cannot be provided as group- or center-based respite when delivered by an independent respite provider. •Respite services shall not duplicate other Medicaid reimbursed services.			
Additional needs-based criteria for receiving the service, if applicable *(specify)*:			
N/A			
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies)*:			
X	Categorically needy *(specify limits)*:		
	Subject to individual budget maximums.		
☐	Medically needy *(specify limits)*:		
Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Developmental Disabilities Agency		*Developmental Disabilities Agency (DDA) certificate as described in Idaho Administrative*	Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide respite in a DDA:

Supplement 1 to Attachment 3.1-A, Program Description

		Code.	Providers must be at least 16 years of age when employed by a DDA; meet the qualifications prescribed for the type of services to be rendered or must be an individual selected by the participant and parent/legal guardian; have received care giving instructions in the needs of the participant who will be provided the service; demonstrate the ability to provide services according to a plan of service; and pass a criminal background check.
Respite Care Provider			Individuals must meet the following qualifications to provide respite: Providers must be at least eighteen (18) years of age and be a high school graduate, or have a GED; meet the qualifications prescribed for the type of services to be rendered or must be an individual selected by the participant and parent/legal guardian; have received care giving instructions in the needs of the participant who will be provided the service; demonstrate the ability to provide services according to a plan of service; pass a criminal background check; and must be certified in CPR and first aid prior to delivering services, and must maintain current certification thereafter.
Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):			

Supplement 1 to Attachment 3.1-A, Program Description

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Developmental Disabilities Agencies	Department of Health and Welfare	- At initial provider agreement approval or renewal - At least every three years, and as needed based on service monitoring concerns
Respite Care Provider	Department of Health and Welfare	- At initial provider agreement approval or renewal - At least every three years, and as needed based on service monitoring concerns

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

☐	Participant-directed	X	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: Habilitative Supports

Service Definition (Scope):

Habilitative Supports provides assistance to a participant with a disability by facilitating their independence and integration into the community. This service provides an opportunity for a participant to explore their interests, practice skills learned in other therapeutic environments, and learn through interactions in typical community activities.

Integration into the community enables participants to expand their skills related to activities of daily living and reinforces skills to achieve or maintain mobility, sensory-motor, communication, socialization and relationship building, and participation in leisure and community activities.

This service is only provided in the participant's home or in community settings when integration into the community is an identified goal. These supports may serve to reinforce skills or lessons taught in school, therapy or other settings, but are not intended to supplant services provided in school or therapy, nor are they intended to supplant the role of the primary caregiver.

The supports provider must maintain a log of the habilitative support services in the participant's record documenting the provision of activities outlined in the plan of service. Supports that take place in both the home and community must ensure the participant is actively participating in age appropriate activities and is engaging with typical peers according to the ability of the participant.

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Supplement 1 to Attachment 3.1-A, Program Description

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Supplement 1 to Attachment 3.1-A, Program Description

Limitations:
- Habilitative Supports cannot be provided during the same time other services are being provided to a participant.
- Habilitative Supports shall not duplicate other Medicaid reimbursed services.

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

N/A

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

☐	Categorically needy *(specify limits)*:
X	Subject to individual budget maximums
☐	Medically needy *(specify limits)*:

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

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Developmental Disabilities Agency		Developmental Disabilities Agency (DDA) certificate as described in Idaho Administrative Code.	Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide habilitative supports in a DDA: Must be at least 18 years of age; must be a high school graduate or have a GED; demonstrate the ability to provide services according to a plan of service; have received instructions in the needs of the participant who will be provided the service; pass a criminal background check; complete a competency course approved by the Department related to the support staff job requirements; and have six (6) months supervised experience working with children with developmental disabilities. Experience can be achieved in the following ways: i. Have previous work experience gained through paid employment, university practicum experience, or internship; or ii. Have on-the-job supervised experience gained through employment at a DDA with increased supervision. In addition to the habilitative support qualifications, staff serving infants and toddlers from birth to three (3) years of age must meet the following qualifications: - Have transcripted courses for a minimum of a Child Development Associate degree (CDA) or the equivalent through completion of twelve (12) semester credits from an accredited college or university in child development, special education, or closely-related coursework; or - Have three (3) years of documented experience providing care to infants, toddlers, or children less than five (5) years of age with developmental delays or disabilities under the supervision of a child development professional, certified educator, licensed therapist, or Developmental Specialist.

Supplement 1 to Attachment 3.1-A, Program Description

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Developmental Disabilities Agencies	Department of Health and Welfare	- At initial provider agreement approval or renewal - At least every three years, and as needed based on service monitoring concerns

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

☐	Participant-directed	X	Provider managed

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

Service Title: Family Education

Service Definition (Scope):

Family education is professional assistance to families to help them better meet the needs of the participant. It offers education to the parent/legal guardian that is specific to the individual needs of the family and child as identified on the plan of service. Family education is delivered to families to provide an orientation to developmental disabilities and to educate families on generalized strategies for behavioral modification and intervention techniques specific to their child's diagnoses. Family education may also provide assistance to the parent/legal guardian in educating other unpaid caregivers regarding the needs of the participant.

Family education providers must maintain documentation of the training in the participant's record documenting the provision of activities outlined in the plan of service. When family education is provided in a group setting, the group should consist of no more than five (5) participants' families.

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

N/A

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

X	Categorically needy *(specify limits)*:
	Subject to individual budget maximums.
☐	Medically needy *(specify limits)*:

Supplement 1 to Attachment 3.1-A, Program Description

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.	Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide family education in a DDA: Must hold at least a bachelor's degree in a health, human services, educational, behavioral science or counseling field from a nationally accredited university or college; must have one year experience providing care to children with developmental disabilities; must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide family education; and must complete a criminal history and background check.

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

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

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

Supplement 1 to Attachment 3.1-A, Program Description

Community Support Services provide goods and supports that are medically necessary and/or minimize the participant's need for institutionalization and address the participant's preferences for: - Personal support to help the participant maintain health, safety, and basic quality of life. - Relationship support to help the participant establish and maintain positive relationships with immediate family members, friends, or others in order to build a natural support network and community. - Emotional support to help the participant learn and practice behaviors consistent with their goals and wishes while minimizing interfering behaviors. - Adaptive support to help a child to learn new adaptive skills or expand their existing skills. - Transportation support to help the participant accomplish their identified goals. - Adaptive equipment identified in the participant's plan that meets a medical or accessibility need and promotes their increased independence. - Skilled Nursing.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
N/A	
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
X	Categorically needy *(specify limits):*
	Subject to the individual budget amount.
☐	Medically needy *(specify limits):*

Supplement 1 to Attachment 3.1-A, Program Description

2. Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians: 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) how the State ensures that the provision of services by such persons is in the best interest of the individual; (c) the State's strategies for ongoing monitoring of services provided by such persons; (d) the controls to ensure that payments are made only for services rendered; and (e) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

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

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

Individual Budget Amount: There is a limit on the maximum dollar amount of HCBS State Plan services authorized for each specific participant.

(a) All HCBS services are included in the budget: Respite, habilitative supports, and family education. If the family chooses to family-direct their services, community support worker, paid support broker, and FEA services are included in the budget.

b) The state utilizes an individual budget model for children's developmental disabilities services that provides each child with an individual budget amount based on evidence-based research and level of care needs. The budget methodology includes a tiered approach using budget categories that range from addressing basic needs to intense early intervention needs.

The intent of the Children's Redesign Budget Methodology is to maximize budget distribution based upon the variable service needs of children with developmental disabilities. The budget methodology is based on a random sample analysis with a 95% confidence level. An 'Inventory of Individual Needs' assessment was completed on a random sample of eligible children with developmental disabilities to identify trends in the population that could be used for budget setting purposes. This methodology was determined to be the most effective way to manage budgets, whereas historical utilization was found to be unreliable and not a true reflection of appropriate utilization. The inappropriate utilization patterns were a result of a system driven by provider and family needs rather than the child's needs.

The sample findings were applied to the general Children's DD population, and the budgets were distributed based upon the service level needs of the participants and funds available. The children's budget methodology is driven by evidence-based research and is reflective of the children's continuum of services developed under the Redesign. The continuum of services creates a system based on needs – as children's needs become more involved they are able to access a wider array of services and the budget levels are increased accordingly.

The Department monitors the budgets on an ongoing basis to ensure that children's needs are accurately being reflected. The budget setting methodology will be evaluated on an annual basis using tracking reports established by the Department, and once sufficient data is collected on the population the findings may help the state identify improvements.

Initially, the state has identified that children who meet developmental disabilities criteria defined in IDAPA 16.03.10.501 qualify for a $4,900 budget for 1915i HCBS state plan services. Children who meet ICF/ID level of care will qualify for additional budget dollars when enrolled in a waiver program.

The IAP contractor makes the final determination of a child's eligibility, based upon the assessments administered by the

Supplement 1 to Attachment 3.1-A, Program Description

IAP. The purpose of the eligibility assessment is to determine a child's eligibility for the DD program including if the child qualifies for ICF/ID level of care, and assigning a budget amount based on the funding level criteria.

Eligibility determination must be completed initially and on an annual basis for participants, and includes a functional assessment to reflect the child's current level of functioning. Once eligibility is completed, the IAP must provide the results of the determination to the family by sending a notice with appeal rights.

c) Ongoing monitoring of the budget model, complaints, appeals, and participant outcomes will be conducted by the Department to ensure that assigned budgets are sufficient to assure health and safety of participants in the community. When the Department determines that a change needs to be made to the budget methodology, participants will be sent notification of the change prior to implementation. The budget methodology is available on the children's redesign website for families and providers, and is included in administrative code. Changes to administrative code regarding the budget methodology will be subject to public feedback as part of the rulemaking process.

d) Families who believe that their child's assigned budget does not accurately reflect their needs may appeal the decision and request a fair hearing.

e) A child's individual budgets will be re-evaluated at least annually. At the request of the family, the Department will also re-evaluate the set budget amount when there are documented changes that may support placement in a waiver or other program.

Families may request a re-evaluation at any point during the planning year by submitting the request to their case manager. The case manager will forward the request to the IAP, and a written notification will be sent to the family of the decision and the right to appeal.

f) Participants are notified of their eligibility for services and given an annual individual budget at the time of their initial determination or annual re-determination. Each participant receives written notification of the set budget amount. The notification includes how the participant may appeal the set budget amount decision. Individual budgets are re-evaluated annually by the IAP and written notifications of the set budget amount are sent annually.

Supplement 1 to Attachment 3.1-A, Program Description

b. Participant–Budget Authority (individual directs a budget). *(Select one):*

O	The State does not offer opportunity for participants to direct a budget.
X	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 how the method makes use of reliable cost estimating information, 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 plan of care):*
	The same budget methodology used for the traditional option is applied for the family-directed services option. See page 33 of this Supplement 1 to Attachment 3.1-A for the complete description.
	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):*

Supplement 1 to Attachment 3.1-A, Program Description

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

Supplement 1 to Attachment 3.1-A, Program Description

Methods and Standards for Establishing Payment Rates

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

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
X	HCBS Habilitation
	Refer to attachment 4.19-B
X	HCBS Respite Care
	Refer to attachment 4.19-B
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
Other Services:	
X	Family Education
	Refer to attachment 4.19-B
Supports for Participant Direction:	
X	Community Support Services
	Refer to attachment 4.19-B
X	Support Broker
	Refer to attachment 4.19-B
X	Financial Management Services
	Refer to attachment 4.19-B

3.R ESSENTIAL PROVIDERS

The Basic Benchmark Benefit Package includes **Clinic Services and Rehabilitative Services** furnished by certain essential providers permitted under sections 1905(a)(9), 1905(a)(13) and 2110(a)(5) of the Social Security Act.

Services from essential providers are preventative, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician and which may include those services provided by community health centers.

3.R.1 Rural Health Clinic Services

Rural Health Clinic services and other ambulatory services furnished by a rural health clinic, which are otherwise included in the State plan.

3.R.2 Federally Qualified Health Center Services

Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the State plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Federally qualified health centers are provided within the scope, amount, and duration of the State's Medical Assistance Program as described under applicable Department rules.

3.R.3 Indian Health Services Facility Services

Indian Health Service Facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

3.R.4 Independent Schools District Services

Independent School Districts that have entered into a provider agreement with the Department may bill for the following Basic and Enhanced Plan Services when they are identified on the student's Individual Education Plan (IEP). Medically necessary behavioral health services are designed to restore a participant to his or her best possible level of functioning (per 42 CFR 440.130) and must be documented in an IEP. All provider qualification and prior authorization requirements as specified in IDAPA 16.03.09 for these services apply.

Covered Services:

Developmental Therapy and Evaluation - Instruction in daily living skills the student has not gained at the normal developmental stages in his life, or is not likely to develop without training and therapy beyond age-appropriate learning situations. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the student's disability.

Coverage for Developmental Therapy and Evaluation will end on June 30, 2013.

Medical Equipment and Supplies - Medical equipment and supplies as allowed under 440.70 that are covered by Medicaid and are needed for use at school but are too large or unsanitary to transport from home to school. They must be for the student's exclusive use and transfer with the student if the student changes schools.

Nursing Services - Skilled nursing services that must be provided by a licensed nurse. Emergency, first aide or assistance with non-routine medications not identified on the IEP as health related services are not reimbursable

Occupational Therapy and Evaluation - Occupational therapy and evaluation services for vocational assessment, training or vocational rehabilitation is not covered.

Personal Care Services - School based personal care services include medically oriented tasks having to do with the student's physical or functional requirements while at school.

Physical Therapy and Evaluation

Psychological Evaluation

Psychotherapy

Psychosocial Rehabilitation and Evaluation - Services to assist the student in gaining and utilizing skills necessary to participate in school such as training in behavior control, social skills, and coping skills.

Intensive Behavioral Intervention - Short term, one-on-one comprehensive interventions that produce measurable outcomes which diminish behaviors that interfere with the development and use of language and appropriate social interaction skills.

Coverage for Intensive Behavioral Intervention will end on June 30, 2013.

Speech/Audiological Therapy and Evaluation

Social History and Evaluation

Transportation - Student must require special transportation that is ordered by a physician and included on the IEP, and receive another Medicaid reimbursable service on the same day.

Interpretive Services - May only be billed when the student needs the services of an interpreter to receive a Medicaid reimbursable service. Not covered if the person providing the service is able to communicate in the student's primary language.

Limitations:

The amount for each service is determined by the interdisciplinary team through the Individualized Education Plan (IEP) process.

Excluded Services: Vocational, Educational and Recreational services are not reimbursable under the Benchmark Plans.

3.S MEDICAL TRANSPORTATION SERVICES

The Basic Benchmark Benefit Package includes **Medical Transportation Services** permitted under sections 1905(a)(26), 1905(a)(6) and 2110(a)(17) of the Social Security Act.

These services include transportation services and assistance for eligible persons to medical facilities.
Payment for meals and lodging may be authorized where appropriate. Ambulance services will be covered in emergency situations or when prior authorized by the Department or its designee.

qualified providers.

3.R.4 Independent Schools District Services

Independent School Districts which have entered into a provider agreement with the Department may bill for the following Basic and Enhanced Plan Services when they are identified on the student's Individual Education Plan (IEP). Medically necessary behavioral health services are designed to restore a participant to his or her best possible level of functioning (per 42 CFR 440.130) and must be documented in an IEP. All provider qualification and prior authorization requirements as specified in IDAPA 16.03.09 for these services apply.

Covered Services.

Medical Equipment and Supplies - Medical equipment and supplies as allowed under 440.70 that are covered by Medicaid and are needed for use at school but are too large or unsanitary to transport from home to school. They must be for the student's exclusive use and transfer with the student if the student changes schools.

Nursing Services - Skilled nursing services that must be provided by a licensed nurse. Emergency, first aide or assistance with non-routine medications not identified on the IEP as a health related service are not reimbursable.

Occupational Therapy and Evaluation - Occupational therapy and evaluation services for vocational assessment, training or vocational rehabilitation is not covered.

Personal Care Services - School based personal care services include medically orientated tasks having to do with the student's physical or functional requirements while at school.

Physical Therapy and Evaluation

Psychotherapy

Psychosocial Rehabilitation and Evaluation - Services to assist the student in gaining and utilizing skills necessary to participate in school such as training in behavior control, social skills and coping skills.

Intensive Behavioral Intervention - Short term, one on one comprehensive interventions that produce measurable outcomes which diminish behaviors that interfere with the development and use of language and appropriate social interaction skills.
Coverage for Intensive Behavioral Intervention will end on June 30, 2013.

Speech/Audiological Therapy and Evaluation

Social History and Evaluation

Transportation - Student must require special transportation that is ordered by a physician and included on the IEP, and receive another Medicaid reimbursable service on the same day.

Interpretative Services - may only be billed when a student needs the service of an interpreter to receive a Medicaid reimbursable service. Not covered if the person providing the service is able to communicate in the student's primary language.

Limitations.

The amount for each service is determined by the interdisciplinary team through the Individualized Education Plan (IEP) process.

Excluded Services: Vocational, Education and Recreational services are not reimbursable under the Benchmark Plans.

3.S MEDICAL TRANSPORTATION SERVICES

The Enhanced Benchmark Benefit Package includes **Medical**

there of) for the mentally retarded or persons with related conditions.

3.V.2 Developmental Disability Agency Services

The Enhanced Benchmark Benefit Package also includes rehabilitation services permitted under section 1905(a) of the Social Security Act which are the core medical rehabilitative services to be provided on a statewide basis by facilities which have entered into a provider agreement with the Department and are licensed as Developmental Disability Agencies (DDAs) by the Department. Services provided by DDAs are outlined in the applicable Department rules.

A Developmental Disability Agency (DDA) is an agency that is a developmental disabilities facility, certified by the Department to provide services to people with developmental disabilities, and primarily organized and operated to provide therapy to individuals with developmental disabilities. An individual receiving service in a DDA must be determined to have developmental disabilities. Through qualified staff or contractors, a development disabilities agency provides the following services called developmental disabilities agency services: Developmental Therapy, Intensive Behavioral Intervention (IBI), IBI consultation, collateral contact, psychotherapy, supportive counseling, speech language pathology, physical therapy, occupational therapy, and pharmacological management.

Coverage for Developmental Disability Agency (DDA) services defined in Section 3.V.2 will end on June 30, 2013.

Intensive Behavioral Interventions (IBI).
EPSDT Rehabilitation Intensive Behavioral Interventions (IBI).
Pursuant to 42 CFR 440.230, Idaho has defined the amount, scope and duration of the EPSDT benefit of Intensive Behavioral Intervention (IBI) as follows: IBI is an individualized comprehensive, proven intervention used on a short term, one-to-one basis that produces measurable outcomes which diminish behaviors interfering with the development and use of language and appropriate social interaction skills or broaden an otherwise severely restricted range of interest. It is available only to children birth through age twenty-one (21) who have demonstrated self injurious, aggressive, or severely maladaptive behavior and severe deficits in the areas of verbal and non-verbal communication; or social interaction; or leisure
and play skills.

IBI is available Statewide through developmental disabilities agencies, Idaho public school districts, charter schools, and Idaho Infant toddler programs. IBI services cannot exceed twenty-two (22) hours per week in combination with developmental therapy and occupational therapy in a DDA. IBI services are designed to be provided for up to a three (3) year duration by Developmental Disabilities Agencies.

- After three (3) years the expectation is that these participants will be reassessed, and transitioned into appropriate services.
- Individuals under twenty-one (21) years of age qualifying under EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

IBI Professional Provider Qualifications.

A professional qualified to provide or direct the provision of Intensive Behavioral Intervention must have Department approved training and certification which addresses course work, experience, ethical standards, continuing education and demonstrated competencies and:

- Must be employed by a DDA certified by the State of Idaho.
- Hold a bachelor's degree in health, human service, educational behavioral science or counseling from a nationally accredited university or college.
- Have one (1) year of supervised experience working with children with developmental disabilities gained through paid employment of practicum, and include at least 1000 hours of direct contact or care of children with developmental disabilities in a behavioral context.
- Complete and pass Department approved training course and examination for IBI certification including the following curriculum: Assessment, behavioral management, treatment, supervised practicum, and completion of student project.
- Must complete a minimum of twelve (12) hours per year of formal training, six (6) hours of which must cover behavior methodology or interventions shown to be effective.
- Participate and complete fire and safety training yearly.
- Must be certified in CPR and First Aid within ninety (90) days of hire, and maintain such certification.

Must be trained to meet special health or medical requirements of the participants they serve.

IBI Paraprofessional Qualifications, participants ages 3-21

- Must be employed by a DDA certified by the State of Idaho.
- Must be supervised by a certified IBI professional.
- Must be at least eighteen (18) years of age.
- Must provide documentation of one (1) year paid supervised experience working with children with developmental disabilities either through paid employment, or university practicum experience or internship or documented to include 1000 hours of direct contact or care of children with developmental disability in a behavioral context.
- Complete and pass Department approved training course and examination for IBI certification including the following curriculum: Assessment, behavioral management, treatment, supervised practicum, and completion of student project.
- Must complete a minimum of twelve (12) hours per year of formal training, six (6) hours of which must cover behavior methodology or interventions shown to be effective.

Participate and complete fire and safety training yearly.

provided under EPSDT. Needs for services discovered during an EPSDT screening which are outside the coverage provided by applicable Department rules must be shown to be medically necessary and the least costly means of meeting the recipient's medical needs to correct or improve the physical or mental illness discovered by the screening and ordered by the physician, nurse practitioner or physician's assistant. The Department will not cover services for cosmetic, convenience or comfort reasons. Any service requested which is covered under Title XIX of the Social Security Act that is not identified in applicable Department rules specifically as a covered benefit or service will require preauthorization for medical necessity prior to payment for that service. Any service required as a result of an EPSDT screen and which is currently covered under the scope of the Enhanced Benchmark Benefit Package will not be subject to amount, scope, and duration limitations, but will be subject to prior-authorization. The additional service must be documented by the attending physician as medically necessary and that the service requested is the least costly means of meeting the recipient's medical needs. Preauthorization from the Department or its authorized agent will be required prior to payment.

The Enhanced Benchmark Benefit Package includes **Case Management Services** permitted under sections 1905(a)(19) and 2110(a)(20) of the Social Security Act.

Target Group:

- Children up to age 21 with a developmental delay or disability; or
- Children up to age 21 who have special health care needs requiring medical and multidisciplinary rehabilitation services; or
- Children up to age 21 with a serious emotional disturbance (SED) with an expected duration of at least one year; and
- Who require and choose assistance to access services and supports necessary to maintain independence in the community.

Coverage for Children's Service Coordination for children with a developmental delay or disability will end on June 30, 2013.

For case management services provided to individuals in medical institutions: [Olmstead letter #3]

☒ Target group is comprised of individuals transitioning to a community setting and case management services will be made available for up to the last 60 consecutive days of the covered stay in the medical institution.

Areas of State in which services will be provided:

☒ Entire State

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)