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State/Territory Name: Idaho

State Plan Amendment (SPA) #: 16-0003

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, WA 98104

Division of Medicaid & Children's Health Operations

June 29, 2016

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

RE: Idaho State Plan Amendment (SPA) Transmittal Number 16-0003

Dear Mr. Armstrong:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of State Plan Amendment (SPA) Transmittal Number 16-0003. This SPA renew's Idaho's 1915(i) State Plan Home and Community-Based Services (HCBS) benefit for children with developmental disabilities.

The SPA is approved with an effective date of July 1, 2016, and an expiration date of June 30, 2021. Since the state has elected to target the population who can receive these Section 1915(i) State Plan HCBS, CMS approves this SPA for a five-year period, in accordance with Section 1915(i)(7) of the Act. To renew the 1915(i) State Plan HCBS benefit for an additional five-year period, the state must provide a written request for renewal to CMS at least 180 days prior to the end of the approval period. CMS approval of a renewal request is contingent upon state adherence to federal requirements and the state meeting its objectives with respect to quality improvement and beneficiary outcomes.

Per 42 CFR §441.745(a)(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 Children's 1915(i) state plan HCBS in the previous year. Additionally, at least 18 months prior to the end of the five-year approval period, the state must submit to CMS a report with the results of the state's quality monitoring, including an analysis of state data, findings, any remediation, and systems improvement for each of the 1915(i) requirements in accordance with the Quality Improvement Strategy in their approved SPA. Submission of the report 18 months in advance of the end of the approval period will allow time for CMS to review, respond, and for the state to make any necessary changes as a result prior to the state's submission of a renewal request to CMS.

Thank you for the cooperation of your staff in the approval process of this amendment. If you have any additional questions related to this matter, please contact me, or have your staff contact Kendra Sippel-Theodore at kendra.sippel-theodore@cms.hhs.gov or (206) 615-2065.

Sincerely,

Digitally signed by David L. Meacham -S

[redacted]

Date: 2016.06.29 12:36:32 -07'00'

David L. Meacham
Associate Regional Administrator

cc:
Lisa Hettinger, Idaho Department of Health and Welfare
Matt Wimmer, Idaho Department of Health and Welfare
Cathy Libby, Idaho Department of Health and Welfare
Carolyn Burt, Idaho Department of Health and Welfare

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: **16-0003**

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
July 1, 2016

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR §441.745

7. FEDERAL BUDGET IMPACT:
None

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
~~**Supplement 1 to Attachment 3.1-A, Program Description; Pages 2-3, 5-7, 11-17, 19-21, 23-25, 28-36, 38, and 40.**~~ (P&I)
Supplement 1 to Attachment 3.1-A, Program Description Pages 1-47 (P&I)
Supplement 1 to Attachment 3.1-A, 11a-11e, 13a, 14a, 33b-33e, and 46a (P&I)
Attachment 2.2A, pages 23f and 23g (P&I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Supplement 1 to Attachment 3.1-A, Program Description; Pages 1-47 (P&I)
Attachment 2.2A, page 23f (P&I)

10. SUBJECT OF AMENDMENT:
1915(i) 5-year renewal and updates in accordance with HCBS regulations and the Idaho Statewide Transition Plan (STP) submitted to CMS on March 13, 2015.

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 [redacted]

13. TYPED NAME:
LISA HETTINGER

14. TITLE:
Medicaid Director

15. DATE SUBMITTED:
3/2/16

16. RETURN TO:

Lisa Hettinger, 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:
3/2/16

18. DATE APPROVED:
6/29/2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
7/1/16

20. SIGNATURE OF [redacted]
Digitally signed by David L. Meacham -S
DN: c=US, o=U.S. Government, ou=HHS
Date: 2016.06.29 12:44:28 -07'00'

21. TYPED NAME:
David L. Meacham

22. TITLE:
Associate Regional Administrator

23. REMARKS:
6/28/16 - State Authorized P&I changes to Box 8 and 9.

FORM HCFA-179 (07-92)

Groups Covered

Optional Groups other than the Medically Needy

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

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

X Yes. State covers the following optional categorically needy groups.

(Select all that apply):

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

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

X OTHER (*describe*):

Among the 1905(a) groups covered in this category, the state selects only children as a covered group.

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

Income limit: (*Select one):*

X 300% of the SSI/FBR

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

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

Children's 1915(i) State Plan HCBS, Children's DD Waiver – ID 0859, and Act Early Waiver – ID 0887, and Idaho Developmental Disabilities Waiver - ID 0076

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

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

Supplement 1 to Attachment 3.1-A, Program Description

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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
Family-Directed Community Support Services
Financial Management Services
Support Broker

2. 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)*:		
	○	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
○	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 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: Contracted Independent Assessment Provider
Review of participant service plans: Case management contractor(s)

Supplement 1 to Attachment 3.1-A, Program Description

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

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

   N/A

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

Supplement 1 to Attachment 3.1-A, Program Description

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of
Year 1	July 1,2016	June 30, 2017	203
Year 2	July 1, 2017	June 30, 2018	244
Year 3	July 1, 2018	June 30, 2019	293
Year 4	July 1, 2019	June 30, 2020	352
Year 5	July 1, 2020	June 30, 2021	422
Please Note: The original 1915(i) application used 1915(c) waiver participants in the projected number calculations in error. This corrected chart reflects the appropriate approximated numbers of participants eligible for this 1915(i) State plan option.			

2. X **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.

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. 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):*

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):*

Per contract requirements, contractor staff must comply, at a minimum, with Qualified Intellectual Disabilities Professional (QIDP) requirements 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 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 services options. The IAP will evaluate the participant through face-to-face consultation with the participant, and if applicable, the participant's decision-making authority. Functional assessment evaluations are conducted using the Scales of Independent Behavior-Revised (SIB-R) and a Department-developed inventory of individual needs to determine if the participant meets the needs-based criteria. The inventory of individual needs includes a summary of medical, social and developmental status and helps to determine categorical eligibility. This summary process includes an evaluation of existing participant documentation of medical assessments, diagnostic assessment, and psychometric testing. If there is no current testing, diagnostic testing may be completed by the IAP if necessary.
Eligibility determinations must be completed within thirty (30) days of the new referral.
Reevaluations of eligibility must be completed annually and require either a full reassessment or a focused review. A full assessment is required at least every three (3) calendar years.
An independent needs-based inventory must be conducted at least every twelve (12) months to assess a participant's support needs and determine the participant's eligibility for HCBS State plan services. Eligibility determination is made by using the needs-based eligibility criteria that has been established by the State.

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):*

An eligible participant must:

Require assistance due to substantial limitations in three (3) or more of the following major life activities - self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self sufficiency; and

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 twenty-two (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

6. X **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):*

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
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.	The participant requires nursing facility level of care when a child meets one (1) or more of the following criteria: **01. Supervision Required for Children**. Where the inherent complexity of a service prescribed by the physician is such that it can be safely and effectively performed only by or under the supervision of a licensed nurse or licensed physical or occupational therapist. **02. Preventing Deterioration for Children**. Skilled care is needed to prevent, to the extent possible, deterioration of the child's condition or to sustain current capacities, regardless of the restoration potential of a child, even where full recovery or medical improvement is not possible. **03. Specific Needs for Children**. When the plan of care, risk factors, and aggregate of health care needs is such that the assessments, interventions, or	**01. Diagnosis**. Persons must be financially eligible for Medicaid; must have a primary diagnosis of being intellectually disabled or have a related condition defined in Section 66-402, Idaho Code and Section 500 through 506 of these rules; and persons must qualify based on functional assessment, maladaptive behavior, a combination of both, or medical condition; and **02. Must Require Certain Level of Care**. Persons living in the community must require the level of care provided in an ICF/ID, including active treatment, and in the absence of available intensive alternative services in the community, would require institutionalization, other than services in an institution for mental disease, in the near future; and **03. Functional Limitations**. **a.** Persons Sixteen Years of Age or Older. Persons (sixteen (16) years of age or older) may qualify	The state uses criteria defined in 42 CFR 440.10 for inpatient hospital services.

	supervision of the child necessitates the skills of a licensed nurse or a licensed physical therapist or licensed occupational therapist. In such cases, the specific needs or activities must be documented by the physician's orders, progress notes, plan of care, and nursing and therapy notes. **04. Nursing Facility Level of Care for Children**. Using the above criteria, plus consideration of the developmental milestones, based on the age of the child, the Department's will determine nursing facility level of care.	based on their functional skills. Persons with an age equivalency composite score of eight (8) years and zero (0) months or less on a full scale functional assessment (Woodcock Johnson Scales of Independent Behavior, or SIB-R, or subsequent revisions) would qualify; or **b.** Persons Under Sixteen Years of Age. Persons (under sixteen (16) years of age) qualify if their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; or **04. Maladaptive Behavior**. **a.** A Minus Twenty-Two (-22) or Below Score. Individuals may qualify for ICF/ID level of care based on maladaptive behavior. Persons will be eligible if their General Maladaptive Index on the Woodcock Johnson Scales of Independent Behavior (SIB-R) or subsequent revision is minus twenty-two (-22) or less; or **b.** Above a Minus Twenty-Two (-22) Score. Individuals who score above minus twenty-two (-22) may qualify for ICF/ID level of care if they engage in aggressive or self injurious behaviors of such intensity that the behavior seriously endangers the safety of the individual or others, the behavior is directly related to developmental disability, and the person requires active treatment	

		to control or decrease the behavior; or **05. Combination Functional and Maladaptive Behaviors**. Persons may qualify for ICF/ID level of care if they display a combination of criteria as described in Subsections 585.05 and 585.06 of these rules at a level that is significant and it can been determined they are in need of the level of services provided in an ICF/ID, including active treatment services. Significance would be defined as: (3-19-07) **a.** Persons Sixteen Years of Age or Older. For persons sixteen (16) years of age or older, an overall age equivalency up to eight and one-half (8 1/2) years is significant in the area of functionality when combined with a General Maladaptive Index on the Woodcock Johnson SIB-R up to minus seventeen (-17), minus twenty-two (-22) inclusive; or **b.** Persons Under Sixteen Years of Age. For persons under sixteen (16) years of age, an overall age equivalency up to fifty-three percent (53%) of their chronological age is considered significant when combined with a General Maladaptive Index on the Woodcock Johnson SIB-R between minus seventeen (-17), and minus twenty-one (-21) inclusive; or **06. Medical Condition**. Individuals may meet ICF/ID level of care based	

		on their medical condition if the medical condition significantly affects their functional level/capabilities and it can be determined that they are in need of the level of services provided in an ICF/ID, including active treatment services.	

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

7. X **Reevaluation Schedule**. Needs-based eligibility reevaluations are conducted at least every twelve months.

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

9. X **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):	
	X	**The provision of 1915(i) services at least monthly**
	O	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

10. X **Residence in home or community**. The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State plan HCBS:

(i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or

(ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State. *(If applicable, specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):*

Supplement 1 to Attachment 3.1-A, Program Description

Idaho assures that the setting transition plan included with this 1915(i) State Plan Amendment will be subject to any provisions or requirements in the State's approved Statewide Transition Plan. The State will implement any applicable required changes upon approval of the Statewide Transition Plan and will make conforming changes to its 1915(i) State Plan Amendment, as needed, when it submits the next amendment or renewal. The most recent version of the Statewide Transition Plan can be found here:
http://healthandwelfare.idaho.gov/Medical/Medicaid/HomeandCommunityBasedSettingsFinalRule/tabid/2710/Default.aspx

The intention of the home and community-based services (HCBS) rule is to ensure individuals receiving HCBS long-term services and supports have full access to the benefits of community living and the opportunity to receive services in the most integrated settings appropriate. In addition, the new regulations aim to enhance the quality of HCBS and provide protections to participants. Idaho Medicaid administers several HCBS programs that fall under the scope of the new regulations, including the 1915(i) program for children with developmental disabilities.

The Children's 1915(i) only serves participants in non-residential settings. As part of Idaho's Statewide Transition Plan, a preliminary gap analysis of its non-residential HCBS settings was completed in December 2014. The gap analysis included an in-depth review of state administrative rule and statute, Medicaid waiver and state plan language, licensing and certification requirements, Medicaid provider agreements, service definitions, administrative and operational processes, provider qualifications and training, quality assurance and monitoring activities, reimbursement methodologies, and person-centered planning processes and documentation. This analysis identified areas where the new regulations are supported in Idaho as well as areas that will need to be strengthened in order to align Idaho's HCBS programs with the regulations.

Below is an exhaustive list of the HCBS administered to participants in the children's 1915(i) program, the corresponding category for each service, and the settings in which the service can occur. Settings that are listed as "in-home" are presumed to meet HCBS compliance, as these are furnished in a participant's private residence. Settings indicated as "community" are also presumed to meet the HCBS qualities, as they are furnished in the community in which the participant resides. Quality reviews of services and participant service outcome reviews will ensure that providers do not impose restrictions on HCBS setting qualities in a participant's own home or in the community without a supportive strategy that has been agreed to through the person-centered planning process.

Service	**Applicable HCBS Qualities**	**Setting(s)**
Respite	Non-residential	• Home • Community • DDA Center
Habilitative supports	Non-residential	• Home • Community • DDA Center
Family education	Non-residential	• Home • Community • DDA Center

Supports for Family - Directed Services		
Community Support Services	Non-residential	• Home • Community • DDA Center
Financial Management Services	Non-residential	• Home
Support Broker	Non-residential	• Home

Systemic Assessment and Systemic Remediation: Non-Residential Settings

As part of its systemic assessment, Idaho completed a preliminary gap analysis of its non-residential service settings in December 2014. The results of Idaho's analysis of its non-residential settings are summarized below, including an overview of existing support for each regulation. The state has included, where applicable, the full IDAPA rule citation(s) to identify where IDAPA supports the HCBS requirement, in addition to indicating if IDAPA is silent. The state did not identify any IDAPA rule that conflicts with the HCBS requirements. Additionally the chart includes preliminary recommendations to transition these settings into full compliance with the new regulations. Please note that the analysis of existing support for each new regulation is only the first step in the assessment process. It has been used to identify where Idaho lacks documented support for the setting quality requirements. Idaho understands that more work is necessary to complete a full assessment of settings.

Of the 6 services listed in the table above, only the habilitative support service was included in the systemic assessment's non-residential service settings gap analysis. The state determined that the other services did not have gaps related to HCBS setting requirements as they are highly medical/clinical in nature, self-directed, for the purchase of goods/adaptations, provided by providers who have no capacity to influence setting qualities, or occur in settings which are analyzed elsewhere in the Transition Plan. Therefore, for those services, a detailed analysis was not necessary. The gap analysis conducted for habilitative supports is provided below:

Federal Requirement	Habilitative Supports	
The setting is integrated in, and facilitates the individual's full access to the greater community to the same degree of access as individuals not receiving Medicaid HCBS.	Support	Idaho rule (IDAPA 16.03.10.521.18, 16.03.10.683.04.b, and 16.03.10.683.04.c.ii.) allows habilitative supports to be provided in three different settings. Idaho rule supports that service settings are integrated and facilitate community access when provided in the home and community.
	Gap	The state lacks quality assurance/monitoring activities to ensure this requirement is met. The state lacks standards for integration for services provided in a congregate setting. The state lacks standards for "the same degree of access as individuals not receiving Medicaid HCBS."
	Remediation	Enhance and expand existing quality assurance/monitoring activities and data collection for monitoring. Strengthened IDAPA 16.03.10.313 to support this requirement. Develop best practice to support

		provider compliance with this HCBS requirement. Include it in the HCBS toolkit.
The setting includes opportunities to seek employment and work in competitive, integrated settings to the same degree of access as individuals not receiving Medicaid HCBS.	Support	None
	Gap	IDAPA is silent
	Remediation	This service benefit is for children who would not be seeking employment due to their age
The setting includes opportunities to engage in community life to the same degree of access as individuals not receiving Medicaid HCBS.	Support	Idaho rule (IDAPA 16.03.10.521.18, 16.03.10.683.04.b, and 16.03.10.683.04.c.ii.) supports that service settings include opportunities to engage in community life when services are provided in the home and community.
	Gap	The state lacks quality assurance/monitoring activities to ensure this requirement is met. The state lacks best practices for integration for services provided in a congregate setting. The state lacks best practices for "the same degree of access as individuals not receiving Medicaid HCBS."
	Remediation	Enhance existing quality assurance/monitoring activities and data collection for monitoring. Strengthened IDAPA 16.03.10.313 to support this requirement. Develop best practices to support provider compliance with this HCBS requirement. Include it in the HCBS toolkit.
The setting includes opportunities to control personal resources to the same degree of access as individuals not receiving Medicaid HCBS.	Support	Providers have no authority to control participant resources.
	Gap	The state lacks quality assurance/monitoring activities to ensure this requirement is met. The state lacks rule support for this requirement. IDAPA is silent. The state lacks best practices for "the same degree of access as individuals not receiving Medicaid HCBS."
	Remediation	Enhance existing quality assurance/monitoring activities and data collection for monitoring. Incorporate HCBS requirement into IDAPA 16.03.10.313. Develop best practices to support provider compliance with this HCBS requirement. Include it in the HCBS toolkit.
The setting includes opportunities to receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.	Support	Idaho rule (IDAPA 16.03.10.521.18, 16.03.10.683.04.b, and 16.03.10.683.04.c.ii.) supports that service settings include opportunities to receive services in the community when services are provided in the home and community.
	Gap	The state lacks quality assurance/monitoring activities to ensure this requirement is met. The state lacks best practices for integration for services provided in a congregate setting. The state lacks best practices for "the same degree of access as individuals not receiving

		Medicaid HCBS."
	Remediation	Enhance existing quality assurance/monitoring activities and data collection for monitoring. Strengthened IDAPA 16.03.10.313 to support this requirement. Develop best practices to support provider compliance with this HCBS requirement. Include it in the HCBS toolkit.
The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and based on the individual's needs, preferences, and resources available for room and board (for residential settings).	Support	Providers have no capacity to control the participant's selection of the residential setting.
	Gap	IDAPA is silent
	Remediation	It is assumed that children are residing at home with their parents (or legal guardian) rather than in residential settings.
An individual's essential personal rights of privacy, dignity, respect, and freedom from coercion and restraint are protected.	Support	Idaho rule (IDAPA 16.03.21.905.01, 16.03.21.905.02, 16.03.21.905.03. a-d) supports that an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint are protected (licensing and certification rules). IDAPA 16.03.21.915 describes the process used to implement authorized restraints. These rules are monitored and remediated by L&C.
	Gap	None
	Remediation	None
Optimizes, but does not regiment individual initiative, autonomy, and independence in making life choices. This includes, but is not limited to, daily activities, physical environment, and with whom to interact.	Support	Idaho rule (IDAPA 16.03.10.526.06) supports that an individual's initiative, autonomy, and independence in making life choices is facilitated in the community.
	Gap	The state lacks quality assurance/monitoring activities to ensure this requirement is met.
	Remediation	Enhance quality assurance/monitoring activities and data collection for monitoring. Incorporated HCBS requirement into IDAPA 16.03.10.313.
Individual choice regarding services and supports, and who provides them, is facilitated.	Support	Idaho rule (IDAPA 16.03.10.526.06) supports that an individual has the choice of services. The state lacks regulation that supports choice of who provides them. This requirement is monitored through the Family and Community Services Quality Assurance assessment.
	Gap	The state lacks regulation that supports choice of who

		provides chosen services.
	Remediation	Incorporated HCBS requirement into IDAPA 16.03.10.313.

Analysis of Non-Residential Settings for Characteristics of an Institution

In addition to the systemic assessment described above, Idaho conducted an analysis of non-residential settings for characteristics of an institution. The Centers for Medicare and Medicaid Services has identified three characteristics of settings that are presumed to be institutional. Those characteristics are:

1). The setting is in a publicly or privately owned facility providing inpatient treatment.
2). The setting is on the grounds of, or immediately adjacent to, a public institution
3). The setting has the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS.

Idaho completed an initial assessment of all settings against the first two characteristics of an institution in early 2015. At that time there were no settings where an HCBS participant lived or received services that were located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment. Further, there were no settings on the grounds of or immediately adjacent to a public institution. Idaho has initiated its assessment of all settings for the third characteristic on an institutional setting: the setting has the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS. Any setting identified as potentially institutional will receive a site visit by Department staff who will examine each site for all the characteristics of an institution. If the state determines a setting is HCBS compliant and likely to overcome the presumption of being an institution, those sites will be moved forward to CMS for heightened scrutiny. Any site unable to overcome this assumption will move into the provider remediation process.

Idaho's children's 1915(i) HCB services by definition must occur in a participant's private residence, the community, or in developmental disabilities agencies (DDAs). A setting in a participant's private residence or the community is presumed to be compliant with all HCBS requirements. DDAs were examined for this non-residential service setting analysis.

In 2015 Medicaid solicited the help of Department of Health and Welfare staff responsible for completing the licensing and certification of DDA settings to assess those settings for the first two characteristics of an institution. Those characteristics are that they are in a publicly or privately owned facility providing inpatient treatment or on the grounds of, or immediately adjacent to, a public institution. A list of all DDAs was created with two questions tied to the two above mentioned characteristics of an institutional setting. Licensing and certification staff who routinely visits those settings then answered the two questions about each specific DDA. No DDAs were found to be in a publicly or privately owned facility providing inpatient treatment or on the grounds of, or immediately adjacent to, a public institution.

In January, 2017, Idaho will begin a site-specific assessment and site-specific remediation process to assess and monitor HCBS settings for compliance with the HCBS setting requirements. DDAs will be included in this process.

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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 meets federal requirements at 42 CFR §441.720.

2. X 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. X 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 physical and mental needs 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 CFR 483.430. QIDP requirements include:

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 recreational therapy, or other related human services professions.
d. Have training and experience in completing and interpreting assessments.

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):*

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

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

Traditional Services:

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

Paid plan developers are called case managers. Case Management Qualifications:

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

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

Family-Directed Services:

Non-paid plan development is allowed under the family-directed services option and may be provided by the family, or a person of their choosing, in accordance with the stated HCBS rules, when this person is not a paid provider of services identified on the child's plan of service. Alternatively, the family may choose to hire a Department approved support broker to assist with plan development and purchase specific duties as needed. Plan developers under the Family-Directed Services option are called Support Brokers.

Specific qualifications for support brokers are outlined in Idaho Administrative Code - IDAPA 16.03.13. The qualification requirements include review of the individual's education and experience. Support brokers must demonstrate successful completion of the Department's Support Broker training and of the required ongoing education.

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 are eligible for and select State plan HCBS are given an orientation to the available developmental disability services by the Independent Assessment Provider (IAP) and their case manager or support broker. Participants and their decision making authority that chose traditional services may develop their own plan or use a case manager from the Department. If the participant and the participant's decision making authority choose 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. The family-centered planning team must include people chosen by the participant the family and the participant's decision making authority, if applicable.

Participants and their decision- making authority that choose family-directed services receive an orientation on family-direction and program training from the Department. Families may select a qualified support broker to assist with writing of 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 the participant's decision –making authority decide who will participate in the planning sessions in order to ensure the participant's choices are honored and promoted. The family may direct the family-centered planning meetings, or

these meetings may be facilitated by a chosen support broker. In addition, the participant and the participant's decision- making authority select a circle of support. Members of the circle of support attend the family-centered planning meetings and commit to work within the group to help promote and improve the life of the participant in accordance with the participant's choices and preferences. They also agree to meet on a regular basis to assist the participant and participant's decision-making authority to accomplish their expressed goals. In developing the plan of service, the family-centered planning team must identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals.

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

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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. The printed materials provided to families include the website link for the Idaho State children's DD website at www.redesignforchildren.medicaid.idaho.gov where electronic versions of documents are available. Both the orientation materials and the provider list include a statement that the family may choose any willing and available provider in the state. Families are also informed of how to navigate the website to access the list of providers as well as how to access other helpful resources available to them.

Families are also provided with resources on interviewing potential providers and are encouraged to contact multiple providers to identify the provider that can best meet their needs. In addition, families are informed that who they select is their choice and they may change their choice of providers if they want. Families are encouraged to access the Department case manager if needed to assist families in selecting or changing service providers. at the participant's or the participant's decision making authority'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, the participant's decision-making authority and the family-centered planning team as selected by the participant and family. The plan of service must identify all services and supports that were determined through a family-centered planning process. This plan development is required in order to provide DD services to children from birth through seventeen (17) years of age. A plan of service must identify, at a minimum, the type of service to be delivered, goals and desired outcomes to be addressed within the plan year, strengths and preferences of the participant, including the participant's safety and the safety of those around the participant, target dates, and methods of collaboration. The independent assessment meets the federal requirements at 42 CFR §441.720 and is used to develop the individual plan of service. Additionally, 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).

The plan of service must be developed in accordance with the Home and Community-Based Services (HCBS) regulations as stated in IDAPA 16.03.10. The plan developer is responsible for the documentation of the developed plan and any subsequent plan changes as determined by the family-centered planning team. In the traditional services model, the plan developer submits the plan of service to the Department. The Department has 10 business days to review and authorize the plan.

When the family-directed service model is chosen, the participant and the participant's decision making authority, 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 decision-making authority and the participant's family-centered planning team. Once the family-planning process has been completed, the support broker is responsible to submit the participant's Support and Spending Plan directly to the Department for review and authorization. The Department has ten (10) business days to review and authorize the plan.

The participant and parent/decision-making authority 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 determined 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 is performed if there are significant changes in the participant's situation or the reassessment criteria are met.

All service plans must be finalized and agreed to, by the participant, or the participant's decision making authority, in writing, indicating informed consent. Plans must also be signed by all individuals and providers responsible for its implementation indicating they will deliver services according to the authorized plan of service and consistent with home and community based requirements as described in IDAPA 16.03.10.

Individual service plans are distributed to the participant and the participant's decision-making authority, if applicable, and other people involved in the family-centered planning and implementation of the plan.

Medicaid has operational processes that optimize participant independence, community integration and choices in daily living. These processes include the requirement for HCBS benefits to be requested through a participant's plan. Once plans are developed through the family-centered planning process, the plans are submitted to Medicaid for prior authorization. The prior authorization process is used to ensure the provision of services that enhance health and safety, promote participant rights, self-determination and independence according to IDAPA 16.03.10.526.

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/decision-making authority 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/decision-making authority sign the plan of service to indicate it is correct, complete, and represents the participant and parent/decision-making authority's needs and wants.

Family-directed participant 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/decision-making authority, 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.

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• The case manager is charged with verbally explaining the various programs and options to the participant and parent/decision-making authority during the family-centered planning process, under the traditional option.
• The support broker is charged with assisting the participant and parent/decision-making authority 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/decision-making authorities 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/decision-making authority 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 may 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

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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):*				

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: • The amount of respite services available are based on an individual's approved support and spending plan that is subject to the individual budget maximum allowed for 1915(i) services. •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:

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		Code.	Providers must be at least 16 years of age when employed by a DDA or Infant Toddler Program; 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 .
Independent Respite Care Provider			Individuals must meet the following qualifications to provide respite: Independent respite care providers must enroll as an Idaho Medicaid provider and meet the following: 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.
Early Intervention Provider			Providers must be at least 16 years of age when employed by a DDA or Infant Toddler Program; meet the qualifications prescribed for the type of services to be rendered; 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.

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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
Respite Care Provider And Early Intervention Provider	Department of Health and Welfare	- At initial provider agreement approval or renewal - At least every two years, and as needed based on service monitoring concerns

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

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Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Early Intervention Provider			Providers 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: -Have previous work experience gained through paid employment, university practicum experience, or internship; or -Have on-the-job supervised experience gained through employment at a DDA with increased supervision. Staff serving infants and toddlers from birth to three (3) years of age must: - 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.

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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
Early Intervention Provider	Department of Health and Welfare	- At initial provider agreement approval or renewal - At least every two years, and as needed based on service monitoring concerns

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

☐	Participant-directed	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/ participant's decision making authority 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/participant's decision making authority 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 human services 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. Additionally, each professional providing family education services must complete at least twelve (12) hours of yearly training, six (6) hours of which must cover behavior methodology or interventions shown to be effective.
Early Intervention Provider			Provider must hold at least a bachelor's degree in ahuman services 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. Additionally, each professional providing family education services must complete at least twelve (12) hours of yearly training, six (6) hours of which must cover behavior methodology or interventions shown to be effective. Providers of family education servicing infants and toddlers from birth to three (3) years of age must have a minimum of 240 hours of professionally-supervised experience with young children who have developmental disabilities and at least one (1) of the following: - An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education - A Blended Early Childhood/Early Childhood Special Education (EC/ECSE) Certificate or - A bachelor's or master's degree in special

			education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, or nursing plus a minimum of twenty-four (24) semester credits in Early Childhood/Early Childhood Special Education (EC/ ECSE) from an accredited college or university.

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
Early Intervention Provider	Department of Health and Welfare	- At initial provider agreement approval or renewal - At least every two years, and as needed based on service monitoring concerns

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

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

Family-Directed 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.

- Learning support to help a child to learn new adaptive skills or improve and expand their existing skills that relate to his identified goals

- Non-Medical Transportation support to help the participant accomplish their identified goals.

- Adaptive and therapeutic equipment address an identified medical or accessibility need in the service plan (improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements:

  - A safe and effective treatment that meets acceptable standards of medical practice
  - Items needed to optimize the health, safety and welfare of the participant
  - The least costly alternative that reasonably meets the participant's need
  - For the sole benefit of the participant
  - The participant does not have the funds to purchase the item or the item is not available through another source.

Adaptive and therapeutic equipment must also meet at least one of the following:

- maintain the ability of the participant to remain in the community,
- enhance community inclusion and family involvement,
- decrease dependency on formal support services and thus increase independence of the participant OR
- provide unpaid family members and friends training in the use of the equipment to provide support to the participant.

Adaptive and therapeutic equipment are not otherwise covered under Durable Medical Equipment (DME). Services and equipment that are available through the Medicaid State plan as 1905(a) services for children per Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements are not allowed as payable under family-directed community support services. Experimental or prohibited treatments are excluded.

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):*

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Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Community Support Agency	If required to identify goods or supports. For example, a Community Support providing speech-language pathology must have a current speech-language pathology licensure.	If required to identify goods or supports.	Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and statement of qualification to provide identified supports.
Community Support Provider	If required for identified goods or supports. For example, a Community Support providing speech-language pathology must have current speech-language pathology license.	If required for identified goods and supports.	Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and statement of qualification to provide identified supports.

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Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Community Support Agency	Participant and parent/decision-making authority Paid Support Broker (if applicable) Department of Health and Welfare (during retrospective quality assurance reviews)	Initially and annually, with review of employment/vendor agreement
Community Support Provider	Participant and parent/ decision-making authority Paid Support Broker (if applicable) Department of Health and Welfare (during retrospective quality assurance reviews)	Initially and annually, with review of employment/vendor agreement

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

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

Service Definition (Scope):

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

A. Payroll and Accounting. Provides payroll and accounting supports to the participant that has chosen the family-directed community supports option;

B. Financial Reporting. Performfinancial reporting for employees of the participant;

C. Financial Information Packet. Prepare and distribute a packet of information, including department approved forms for agreements, in order for the participant and family to hire their own staff;

D. Time Sheets and Invoices. Processand pay timesheets for community support workers and support brokers, as authorized by the participant and parent/decision-making authority according to the participant's Department authorized support and spending plan;

E. Taxes. Manages and processes payment of required state and federal employment taxes for the participant's community support worker and support broker;

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F. Payments for goods and services. Processes and pay invoices for goods and services, as authorized by the participant and parent/decision- making authority according to the participant's support and spending plan;

G. Spending information. Provides participant and parent/decision-making authority with reporting information and data that will assist the participant and parent/decision-making authority with managing the individual budget;

H. Quality assurance and improvement. Participate in department quality assurance activities.

FEA qualifications and requirements and responsibilities as well as allowable activities are described in Idaho Administrative Rules.

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):*

Only participants who select the family-directed option may access this service.

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

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

☐ Medically needy *(specify limits):*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Fiscal Employer/Agent			Agencies that provide financial management services as a FEA must be qualified to provide such services as indicated in section 3504 of the Internal Revenue Code and in accordance with the requirements outlined in the signed provider agreement with the Department

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

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Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Fiscal Employer/Agent	Department of Health and Welfare	At the time of application, as indicated by a readiness review to be conducted by the Department for all FEA providers and thereafter at least every three years by Department review.
Fiscal Employer/Agent	Department of Health and Welfare	At the time of application, as indicated by a readiness review to be conducted by the Department for all FEA providers and thereafter at least every three years by Department review.

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

X	Participant-directed	☐	Provider managed

Service Title: Support Broker

Service Definition (Scope)*:*

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

- Participate in the family-centered planning process.

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- Develop a written support and spending plan with the participant and family that includes the supports the participant needs and wants, related risks identified with the participant's wants and preferences, and a comprehensive risk plan for each potential risk that includes at least three backup plans should a support fall out. - Assist the participant and family to monitor and review their budget through data and financial information provided by the FEA. - Submit documentation regarding the participant and parent/decision-making authority's satisfaction with identified supports as requested by the Department. - Participate with Department quality assurance measures, as requested. - Assist the participant and parent/decision-making authority with scheduling required assessments to complete the Department's annual re-determination process as needed, including assisting the participant and parent/decision-making authority to update the support and spending plan and submit it to the Department for authorization. In addition to the required minimum support broker duties, the support broker must be able to provide the following services when requested by the participant and parent/decision-making authority: - Assist the participant and parent/decision-making authority to develop and maintain a circle of support. - Help the participant and family learn and implement the skills needed to recruit, hire, and monitor community supports. - Assist the participant and parent/decision-making authority to negotiate rates for paid Community Support Workers. - Maintain documentation of supports provided by each Community Support Worker and participant and parent/ decision-making authority's satisfaction with these supports. - Assist the participant and parent/decision-making authority to monitor community supports. - Assist the participant and parent/decision-making authority to resolve employment-related problems. - Assist the participant and parent/ decision-making authority to identify and develop community resources to meet specific needs.
Additional needs-based criteria for receiving the service, if applicable *(specify):*
N/A
Specify limits (if any) on the amount, duration, or scope of this service for *(choose each that applies):*

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X	Categorically needy *(specify limits):*
	Only participants who select the Family-Directed Option may access this service. Support brokers may not act as a fiscal employer agent, instead support brokers work together with the participant and parent/decision-making authority to review participant financial information that is produced and maintained by the fiscal employer agent.
☐	Medically needy *(specify limits):*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Support Broker			Specific requirements outlined in Idaho Administrative Code - IDAPA 16.03.13 include review of education, experience, successful completion of Support Broker training and ongoing education. The parent/decision-making authority can be an unpaid support broker for the participant and are subject to the same qualification requirements as paid support brokers.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Support Broker	Department of Health and Welfare	At the time of application, annual review of ongoing education requirement, and by participant and parent/decision-making authority when entering into employment agreement.

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

X	Participant-directed	☐	Provider managed

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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/decision-making authority cannot furnish State plan HCBS, but other relatives may be paid to provide respite services whenever the relative is qualified to provide respite as defined in this application. There are numerous safeguards in place to ensure that payments are only made for services rendered including oversight by provider agencies, 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/decision-making authority's decision making and benefit financially from these decisions. Payments for family-directed services rendered are made only after review and approval by the participant and parent/decision-making authority and review by the Fiscal Employer Agent. Additionally, the participant's Support Broker and Circle of Supports are available to address any conflicts of interest.

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3. Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** *Indicate whether the waiver employs any of the following additional limits on the amount of waiver services* (*select one*).

☐ Not selected

☐ Not applicable- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

☒ Applicable - The State imposes additional limits on the amount of waiver services. When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above*.

☐ Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above.*

☑ Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above.*

a) 1915(i) State Plan HCBS services included in the budget amount are respite, habilitative supports, family education, OR community support services under the family-directed services option. Therapeutic consultation and crisis intervention services are excluded from the budgets.

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 developmental disabilities budget methodology is to maximize ☐

budget distribution based upon the variable service needs of children with developmental disabilities. The Medicaid fee for service rates and estimated utilization of each service are used to develop the individual's budget. 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 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 waiver services. The continuum of services creates a system based on needs. When children's needs become more involved they are able to access a wide 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 is evaluated on an annual basis using tracking reports established by the Department. This information is used to help the state identify improvements if needed. The state has identified the following criteria for the 1915(i)State Plan HCBS benefit:

- *$4,900 budget*
- *Children meeting developmental disabilities criteria who do not meet ICF/ID level of care*

The IAP contractor makes the final determination of a child's eligibility, based upon the assessments administered by the 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 waiver participants. This determination includes a functional assessment or review of the prior 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 are conducted by the Department to ensure that assigned budgets are sufficient to assure health and safety of participants in the community. If 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 developmental disabilities services 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. Families may also submit an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services request if they feel the amount of services are not sufficient to meet the medical needs of their child. Services available under EPSDT are not subject to the child's budget.

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 different budget category.

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.

The Department has also built safeguards into the 1915(i) benefit for outlier cases, where children who have complex conditions may require more specialized services or increased supports beyond what is accounted for in the budget. For this reason the waiver offers services that are not subject to a child's budget that are available for families where it is found the budgeted services may be insufficient to meet their child's needs.

Therapeutic consultation is a service that provides advanced assessments and planning for children who are not demonstrating outcomes with their current treatment. The case manager will work with the family to determine if this specialized service could benefit the child, and the cost of the service is excluded from the budget. The case manager may identify that additional services are needed for any number of reasons, some including recommendations from the family or service providers, changes in the child's condition, or during plan monitoring as part of progress review.

Crisis intervention services are also available outside of the child's budgets to act as a safeguard for children requiring additional support. The Department has a crisis network team that is utilized to case manage crisis situations. Crisis intervention can be provided by a developmental disability agency and assists the family when their child's behaviors are escalating. Crisis services under the waiver provide immediate remediation and up to 24 hours of support for children in crisis, and may be provided in the child's home or in a short term out of home placement. The case manager is informed of the need for these services in a number of ways, some including recommendations from the family or service providers, changes in the child's condition, a critical incident, or during plan monitoring as part of progress review.

f) Participants are notified of their eligibility for waiver 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 from the IAP. 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.

☐ Other Type of Limit. The State employs another type of limit.

Describe the limit and furnish the information specified above.

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Participant-Direction of Services

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

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

O	The State does not offer opportunity for participant-direction of State plan HCBS.
X	Every participant in State plan HCBS (or the participant's decision-making authority) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
O	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):*

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

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

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

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

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The family may choose to hire an approved support broker to perform specific duties as needed, or the parent/decision-making authority may choose to act as an unpaid support broker with the ability to perform the full range of support broker duties. If a parent/decision-making authority wishes to act as an unpaid support broker for the participant, they must complete the support broker training and be approved by the Department. Paid support broker services are included as part of the community support services that participants and their parent/decision-making authority may purchase out of their allotted budget dollars.

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

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

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

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

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

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

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

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

My Learning Needs - identifies activities that support an individual in acquiring new skills or improving established skills that relate to a goal that the person has identified.

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

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

X	Participant direction is available in all geographic areas in which State plan HCBS are available.
O	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)*:

4. **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
Community Support Services	X	X
Support Broker Services	X	X
Financial Management Services	X	X

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

O	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
O	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.
X	Financial Services are furnished through a third party entity. *Specify whether governmental and/or private entities furnish these services.* ☐ Governmental entities X Private entities

6. X **Participant–Directed Plan of Care.** *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans, that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

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

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

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

7. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff). *(Select one):*

O	The State does not offer opportunity for participant-employer authority.	
X	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 State plan HCBS. 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.
	X	**Participant/Common Law Employer**. The participant (or the participant's decision-making authority) is the common law employer of workers who provide State plan HCBS. 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.

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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):*

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	The participant and parent/decision-making authority's selected Fiscal Employer Agent will have the individual budget and the approved supports and services from the support and spending plan. They will send monthly statements to participants and their parent/decision-making authority 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 describe what is expected and how the support worker will be paid. As part of the QA process, Medicaid staff monitors FEAs to assure that processes are in place to monitor these expenditures. Each fiscal agent is required to: 1) Have a system in place to perform a quarterly quality management (QM) analysis activity on a statistically significant sample of overall participant records; 2) Have documented, approved policies and procedures with stated timeframes for 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).

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Quality Improvement Strategy

(Describe the State's quality improvement strategy in the tables below):

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** ***(Source of Data & sample size)***	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes,and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of Analysis and Aggregation*
Administrative Authority						
The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the program by exercising oversight of the performance of State Plan HCBS functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.	The number and percent of remediation issues that the state followed up on that were identified in the contract monitoring reports **a. Numerator**: number of remediation issues followed up on identified in the contract monitoring reports. **b. Denominator**: number of remediation issues identified in the contract monitoring reports.	Data Source: Reports to State Medicaid Agency on delegated administrative functions Provider performance monitoring Sampling Approach: 100% Review of remediation issues	The State Medicaid Agency is responsible for data collection/generation	Quarterly Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly Annual
1915(i) Eligibility						
An evaluation for state plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that services may be needed in the future.	Number and percent of applicants for HCBS services who receive an eligibility assessment. **a.Numerator**: Number of applicants for HCBS services who received an eligibility assessment **b.Denominator**: Number of applicants for HCBS services	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection/generation	Quarterly Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly Annual

	Number and percent of participants who received an annual redetermination of eligibility within 364 days of their previous eligibility assessment. **a. Numerator**: Number of participants who received an annual redetermination within 364 days of their previous eligibility assessment. **b. Denominator**: Number of participants who received an annual redetermination.	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: 100% Review of annual redetermination of eligibility	The State Medicaid Agency is responsible for data collection/generation	Quarterly Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly Annual
The processes and instruments described in the approved state plan for determining eligibility are applied appropriately	Number and percent of eligibility determinations criteria was determined according to policy **a. Numerator:** number of eligibility determinations that were determined according to policy **b. Denominator**: number of eligibility determinations	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: Representative sample of child participants receiving HCBS services. Confidence interval = 95% with -/+ 5% margin of error	The State Medicaid Agency is responsible for data collection/generation	Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Annual
Qualified Providers						
The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to the approved State Plan standards prior to furnishing services.	Number and percent of initial certified HCBS providers who meet certification standards prior to providing services **a. Numerator**: number of initial providers who meet required licensure or certification standards prior to providing services. **b. Denominator**: number of initial providers	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection/generation	Quarterly Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly Annual

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	Number and percent of certified providers who continue to meet certification standards **a. Numerator**: number of providers who continue to meet certification standards **b. Denominator**: number of ongoing providers surveyed.	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: 100% Review of providers who are surveyed in the year	The State Medicaid Agency is responsible for data collection/generation	Quarterly Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly Annual
The State monitors non-licensed/non-certified providers to assure adherence to provider standards.	Number and percent of new providers that have an initial provider review within 6 months of providing services to participants. **a. Numerator**: number of initial providers who have a review within 6 months of providing services to participants. **b. Denominator:** number of initial providers providing services	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection/generation	Quarterly Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly Annual
	Number and percent of HCBS providers who received a review every two years. **a. Numerator**: number of providers reviewed in the year **b. Denominator**: number of providers who were required to receive a review in the year	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: 100% Review of providers required to receive a review in the year	The State Medicaid Agency is responsible for data collection/generation	Quarterly Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly Annual
The state implements its policies and procedures for verifying that training is conducted in accordance with state requirements and the approved State Plan	Number and percent of HCBS providers that meet state requirements for training. **a. Numerator**: number of HCBS providers reviewed that meet state requirements for training. **b. Denominator**: number of HCBS providers reviewed.	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: 100% Review of providers who were reviewed within the year	The State Medicaid Agency is responsible for data collection/generation	Quarterly Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly Annual

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Service Plan						
Service plans address all members' assessed needs (including health and safety risk factors) and personal goals either by the State Plan HCBS service or through other means	Number and percent of service plans that document participant's needs, goals, and risk factors as identified in the individual's assessment **a. Numerator**: number of plans reviewed that document participant's needs, goals, and risk factors as identified in the assessment **b. Denominator:** number of plans reviewed	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: Representative sample of child participants receiving HCBS services. Confidence interval = 95% with -/+ 5% margin of error	The State Medicaid Agency is responsible for data collection/generation	Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Annual
The state monitors service plan development in accordance with its policies and procedures	Number and percent of service plans reviewed and authorized by the Department prior to the expiration of the current plan of service. **a. Numerator**: number of service plans that were reviewed and authorized by the Department prior to the expiration of the current plan of service. **b. Denominator:** number of service plans reviewed and authorized by the Department.	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: Representative sample of child participants receiving HCBS services. Confidence interval = 95% with -/+ 5% margin of error	The State Medicaid Agency is responsible for data collection/generation	Quarterly Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly Annual
Service plans are updated or revised at least annually or when warranted by changes in the HCBS participant's needs.	Number and percent of service plans that are updated/ revised when requested and warranted by changes in the participant's needs/goals. **a. Numerator:** number of service plans that are updated/ revised when requested and warranted by changes in the participant's needs/ goals. **b. Denominator:** number of service plans reviewed that identified the need for changes.	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: Representative sample of child participants receiving HCBS services. Confidence interval = 95% with -/+ 5% margin of error	The State Medicaid Agency is responsible for data collection/generation	Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Annual
Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.	Number and percent of service plans that indicate services were delivered consistent with the service type, scope, amount, duration and frequency approved on service plans. **a. Numerator:** number of plans reviewed that indicate services were delivered consistent with the approved plans. **b. Denominator:** number of plans reviewed.	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: Representative sample of child participants receiving HCBS services. Confidence interval = 95% with -/+ 5% margin of error	The State Medicaid Agency is responsible for data collection/generation	Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Annual

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Participants are afforded choice Between/among services and providers.	Number and percent of participants reviewed who reported they were given a choice when selecting service providers. **a. Numerator:** number of participants reviewed who reported they were given a choice when selecting service providers. **b. Denominator**: number of participants reviewed.	Data Source: Analyzed collected data Sampling Approach: Representative sample of child participants receiving HCBS services. Confidence interval = 95% with -/+ 5% margin of error	The State Medicaid Agency is responsible for data collection	Quarterly	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly
	Number and percent of participants who reported they were given a choice when selecting services. **a. Numerator**: Number of participants who indicated they were given a choice between services **b. Denominator**: Number of participants reviewed.	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: Representative sample of child participants receiving HCBS services. Confidence interval = 95% with -/+ 5% margin of error	The State Medicaid Agency is responsible for data collection/generation	Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Annual
Health and Welfare						
The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	Number and percent of reported incidents of abuse, neglect or exploitation that follow up was completed within policy timelines **a .Numerator**: Number of reported incidents related to abuse, neglect or exploitation where action/resolution was completed within policy **b. Denominator:** Number of reported incidents related to abuse, neglect or exploitation	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: 100% Review of critical reports	The State Medicaid Agency is responsible for data collection/generation	Monthly Quarterly Annual Continuously and ongoing	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly
	Number and percent of participant and/or family who received information/education about how to report abuse, neglect, exploitation and other critical incidents. **a. Numerator:** Number of participants or family who received information/education about how to report **b. Denominator**: Number of participants receiving services	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: 100% review	The State Medicaid Agency is responsible for data collection/generation	Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Annual

	Number and percent of service plans with restrictive interventions (including restraints and seclusion) that were approved according to criteria. **a. Numerator:** Number of service plans with restrictive interventions that were approved according to criteria. **b. Denominator:** Number of service plans reviewed with restrictive interventions.	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: 100% of service plans reviewed with restrictive interventions.	The State Medicaid Agency is responsible for data collection/generation	Quarterly Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly Annual
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.	Number and percent of claims paid according to the posted fee schedule **a.Numerator**: Number of claims paid according to the posted fee schedule **b. Denominator:** Paid claims (by procedure code) for one week of each calendar quarter	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: Representative sample of child participants receiving HCBS services. Confidence interval = 95% with +/- 5% margin of error.	The State Medicaid Agency is responsible for data collection/generation	Quarterly Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly Annual
	Number and percent of posted rates that are compared to the rate methodology **a. Numerator**: Posted rates compared to the rate methodology **b. Denominator**: Approved rate methodology	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: 100% review of billing for a week period on an annual basis	The State Medicaid Agency is responsible for data collection/generation	Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Annual
	Number and percent of claims paid to providers of Children's 1915(i) services **a. Numerator:** Paid claims to providers enrolled to furnish Children's 1915(i) services **b. Denominator**: Paid claims to providers of 1915(i) services	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: 100% review of billing for a week period on an annual basis	The State Medicaid Agency is responsible for data collection/generation	Quarterly Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly Annual
	Number and percent of unduplicated participants utilizing Children's 1915(i) services **a. Numerator:** Number of unduplicated participants with a paid claim for 1915(i) services **b. Denominator:** Number of unduplicated participants eligible for 1915(i) services	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: Representative sample of child participants receiving HCBS services. Confidence interval = 95% with +/- 5% margin of error.	The State Medicaid Agency is responsible for data collection/generation	Quarterly Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly Annual
HCBS Settings						
Settings meet the home and community-based setting requirements as specified in accordance with 42 CFR 441.701(a) (1) and (2).	Number and percent of HCBS settings who are in compliance with HCBS regulations **a. Numerator:** Number of HCBS providers who meet compliance standards **b. Denominator:** Number of HCBS providers sampled to determine compliance	Data Source: Reports to the State Medicaid Agency on delegated administrative functions. Sampling Approach: 100% of reviewed HCBS providers.	The State Medicaid Agency is responsible for data collection/generation	Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Annual

System Improvement: *(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)*				
Methods for Analyzing Data and Prioritizing Need for System Improvement	**Roles**	**Responsibilities**	**Frequency**	**Method for Evaluating Effectiveness of System Changes**
□ CSOR results are gathered; □ Regional complaints and incident reports are investigated □ Individual plans of service are reviewed by the Department	**Quality Management Staff**	This is a group of staff across seven regions of Idaho, with knowledge of quality improvement interventions, and who are responsible for collecting and reporting data to the Department.	Ongoing	Data is gathered and submitted to the Department's analyst.
□ Results of CSOR are reviewed and analyzed, and tabulated; □ Complaints and Critical Incidents are reviewed analyzed, and tabulated □ Plan of service information is analyzed	**Department Analyst**	This is department staff identified that lead statewide data collection activities, analysis, and reporting activities related to quality management. This staff is responsible for creating and implementing data collection tools.	Ongoing	The analyzed data is presented to the QA team for review and prioritization.
□ Quarterly meetings: Quarterly the committee reviews analyzed data to develop recommendations for program improvements, and reviews actions taken and progress made toward implementing previous approved system improvements. □ Annual meeting: Meets annually to prioritize findings and develop recommendations for specific system improvements for the coming year. This recommendation will be submitted to administration for approval and assignment.	**Quality Management Team**	The QM team is responsible for steering the quality assessment and improvement process, and issues related to parallel data collection. It is responsible for formally recommending specific program improvements to Department administration.	Quarterly	Annual QM report is submitted to administration.
□ Quarterly QM Report □ Annual QM Report	**FACS DD Policy Program Manager**	FACS DD policy program manager takes overall responsibility for leading team members, finalizing quarterly and yearly QM reports, leading the process of prioritizing needs for system improvements, and implementing approved system improvements.	Quarterly and Yearly Report	Overall data findings and recommendations are submitted to the QM Team for review prior to finalization.

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