Table of Contents

Home and Community-Based Services (HCBS) and Long-Term Support Services (LTSS)

This Idaho Medicaid Provider Handbook describes Medicaid-covered options and health related services for participants with disabilities. This handbook does not represent all available services. It is not applicable to services received under consumer directed community supports (CDCS). It addresses the following areas:

- Aged and Disabled (A&D) Waiver Services
- Children's Support Services
- Developmental Disability (DD) State Plan Services
- Developmental Disability (DD) Waiver Services
- Personal Care Services (PCS)
- Service Coordination
- Transition Management and Services

Standards of practice require the coordination of care with other agencies operating within the same service area and are not expected to replace or substitute services already provided by other agencies.

Should the handbook ever appear to contradict relevant provisions of Idaho or federal statute or regulations, the statute and regulations prevail. Any paper or digital copy of these documents is considered out of date except the version appearing on the Gainwell Technologies' Idaho Medicaid website. Sections of the Idaho Medicaid Provider Handbook applicable in specific situations are listed throughout the handbook for provider convenience. Idaho Medicaid Provider Handbooks that always apply include the following:

- General Billing Instructions;
- General Information and Requirements for Providers; and
- Glossary.

Handbooks can only be used properly in context. Providers must be familiar with the handbooks that affect them and their services. The numbering in handbooks is also important to make note of as subsections rely on the content of the sections above them.

Example

Section 1.2.3.a The Answer requires the reader to have also read Section 1, Section 1.2 and Section 1.2.3 to be able to properly apply Section 1.2.3.a.

References are included throughout the handbook for provider and staff convenience. Not all applicable references have been incorporated into the handbook. Not all references provided are equal in weight.

- **Case Law:** Includes references to court cases that established interpretations of law that states and providers are required to follow.
- **CMS Guidance:** These references reflect various Centers for Medicare and Medicaid Services (CMS) publications that Idaho Medicaid reviewed in the formulation of policies. The publications themselves are not required to be followed for Idaho Medicaid services unless otherwise specified.
- **Federal Regulations:** These references are regulations from the federal level that affected policy development. Usually these include the Code of Federal Regulations, the Social Security Act and other statutes. Providers are required to follow these.
- **Idaho Medicaid Publications:** These are communications from Idaho Medicaid to providers that were required to be followed when published. These are included in the

handbook for historical reference. The provider handbook supersedes other communications unless the documents are listed in the Rules, Policies, Procedures, and Waivers webpage under Medicaid Policies in the Policies & Standards Library.

- **Idaho State Plan:** The State Plan is the agreement between the State of Idaho and the Centers for Medicare and Medicaid Services (CMS) on how the State will administer its medical assistance program. Unless otherwise stated, services can only be reimbursed when in compliance with the agreement.
- **Idaho Waivers:** A waiver is a deviation, or an expansion of benefits, of federal requirements approved by the Centers for Medicare and Medicaid Services (CMS). Waiver services can only be reimbursed as detailed in an approved waiver.
- **Professional Organizations:** These references reflect various publications of professional organizations that Idaho Medicaid reviewed in the formulation of policies. Providers may or may not be required to follow these references, depending on the individual reference and its application to a provider's certification, licensure or scope of practice.
- **Scholarly Work:** These references are publications that Idaho Medicaid reviewed in the formulation of policies. The publications themselves are not required to be followed for Idaho Medicaid services.
- **State Regulations:** These references are regulations from the state level that affected policy development. They usually include statute and IDAPA. They are required to be followed.

Some citations may not be available on the internet. Copies of the documents may be requested with a public records request. Guidance for public records requests is available on the department's website.

1. Important Contacts

The Directory, Idaho Medicaid Provider Handbook contains a comprehensive list of contacts. The following contacts are presented here for provider convenience.

1.1. Gainwell Technologies

Gainwell Technologies is Idaho Medicaid's fiscal agent that handles all claims processing and customer service issues for participants not receiving services through a managed care plan.

Gainwell Technologies Contact Information
Gainwell Technologies Provider Services P.O. Box 70082 Boise, ID 83707 Phone: 1 (866) 686-4272 Fax: 1 (877) 661-0974 E-mail: IDProviderServices@gainwelltechnologies.com The Medicaid Automated Call Service (MACS) is available 24 hours a day, seven days a week. Provider service representatives are available Monday through Friday, 7:00 A.M.-7:00 P.M. MT.
Provider Enrollment P.O. Box 70082 Boise, ID 83707 Phone: 1 (866) 686-4272 Fax: 1 (877) 517-2041 E-mail: IDProviderEnrollment@gainwelltechnologies.com
Technical Services Phone: 1 (866) 686-4272 Fax: 1 (877) 517-2040 E-mail: IDEDISupport@gainwelltechnologies.com

1.2. Provider Relations Consultants

Gainwell Technologies Provider Relations Consultants help keep providers up to date on billing changes required by policy updates implemented by the Division of Medicaid. Provider Relations Consultants accomplish this by:

- Conducting provider workshops;
- Conducting live meetings for training;
- Visiting a provider's site to conduct training; and
- Assisting providers with electronic claims submission.

Region 1 and the state of Washington
1 (208) 202-5735
Region.1@gainwelltechnologies.com

Region 2 and the state of Montana
1 (208) 202-5736
Region.2@gainwelltechnologies.com

Region 3 and the state of Oregon
1 (208) 202-5816
Region.3@gainwelltechnologies.com

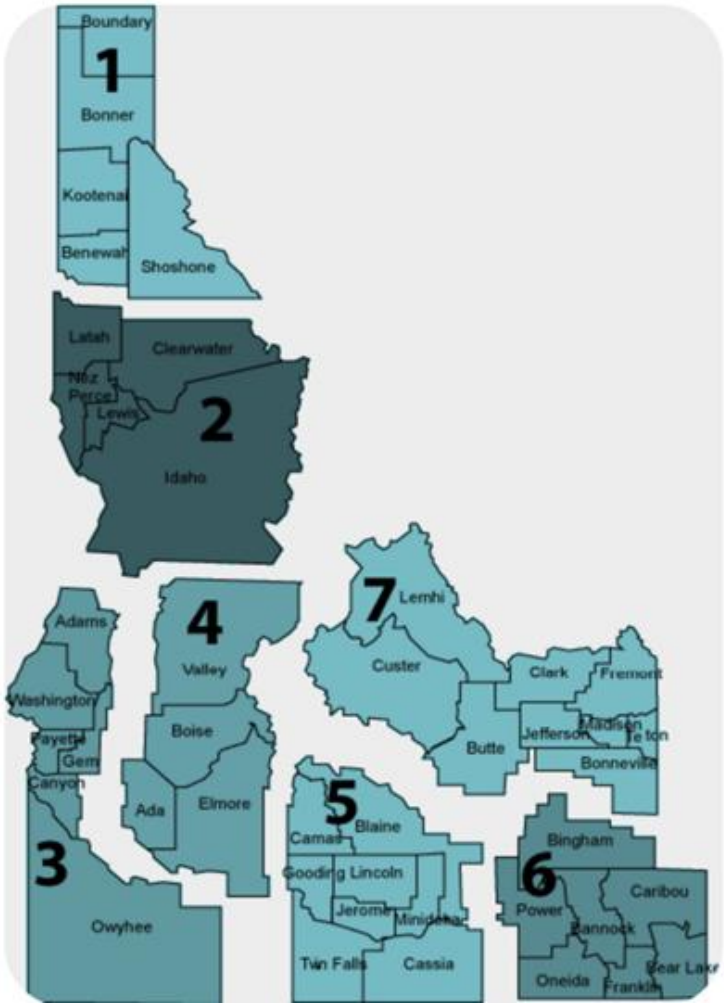
Region 4
1 (208) 202-5843
Region.4@gainwelltechnologies.com

Region 5 and the state of Nevada
1 (208) 202-5963
Region.5@gainwelltechnologies.com

Region 6 and the state of Utah
1 (208) 593-7759
Region.6@gainwelltechnologies.com

Region 7 and the state of Wyoming
1 (208) 609-5062
Region.7@gainwelltechnologies.com

Region 9 and other states (not bordering Idaho)
1 (208) 609-5115
Region.9@gainwelltechnologies.com



1.3. Medicaid

1.3.1. Bureau of Developmental Disability Services

Local offices help with developmental disability service applications, home and community-based waivers, and children's services. Case Management is available through the Bureau of Developmental Disability Services (BDDS) – Children's Program at the Idaho Department of Health and Welfare to assist participants in accessing Children's Developmental Disability supports and Children's Habilitative Intervention Services.

Region 1 – Coeur d'Alene
1120 Ironwood Dr.
Coeur d'Alene, Idaho 83814
208-769-1567
BDDSQA1@dhw.idaho.gov

Region 2 – Lewiston
1118 F St.
Lewiston, Idaho 83501
208-799-4430
BDDSQA2@dhw.idaho.gov

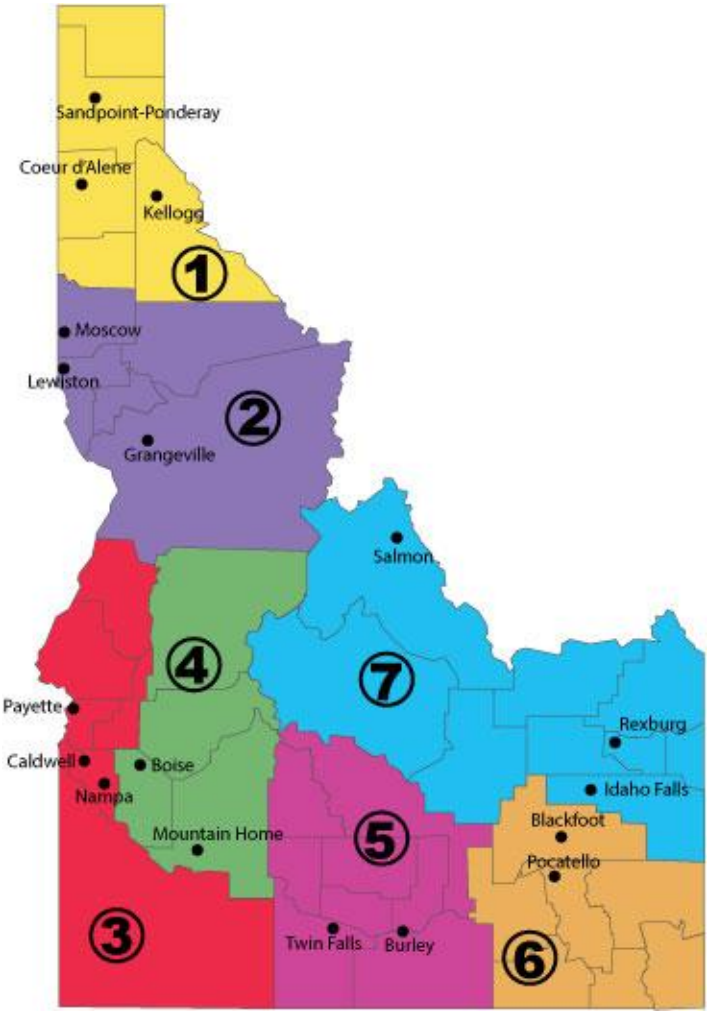
Region 3 – Caldwell
3402 Franklin Rd.
Caldwell, Idaho 83605
208-455-7150
BDDSQA3@dhw.idaho.gov

Region 4 – Boise
1720 Westgate Dr.
Boise, Idaho 83704
208-334-0940
BDDSQA4@dhw.idaho.gov

Region 5 – Twin Falls
601 Pole Line Rd., Suite 3
Twin Falls, Idaho 83301
208-736-3024
BDDSQA5@dhw.idaho.gov

Region 6 – Pocatello
1070 Hiline Rd.
Pocatello, Idaho 83201
208-239-6260
BDDSQA6@dhw.idaho.gov

Region 7 – Idaho Falls
150 Shoup Ave., Suite 4
Idaho Falls, Idaho 83402
208-528-5750
BDDSQA7@dhw.idaho.gov



BDDS – Children's Program
3402 Franklin Rd
Caldwell, ID 83605
Phone: 208-334-6500
E-mail: Children'sDDIntake@dhw.idaho.gov

1.3.2. Bureau of Long Term Care

The Bureau of Long Term Care (BLTC) provides eligibility assessments for the Aged and Disabled (A&D) Waiver. BLTC also authorizes long-term care services for children and adults. BLTC can be contacted at:

Bureau of Long Term Care
PO Box 83720
Boise, ID 83720-0009
Phone: 1 (877) 799-4430
E-mail: BLTCCentral@dhw.idaho.gov

2. Provider Qualifications

2.1. General Provider Qualifications

When applicable, providers must be licensed or certified in the state where services are performed or be under an interstate compact that accepts the provider's license or certification. Services must be within the scope of practice, certification/licensure, and training of the provider rendering them. The provider must have a National Provider Identifier (NPI) to be eligible for enrollment. Enrollment as an Idaho Medicaid provider and entering into a provider agreement must be completed prior to providing services for Idaho Medicaid participants.

All provider handbook and applicable state and federal regulations must be followed to maintain eligibility for Reimbursement. See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

2.1.1. *References: General Provider Qualifications*

(a) State Regulations

"Conditions for Payment." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 025. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individual Provider Requirements." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider Agreements." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 022. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider Application Process." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 021. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

2.2. Developmental Disability Agency

Developmental disability agency (DDA) providers must be certified as a DDA prior to submitting claims for services. A DDA must be comprised of an administrator and their employees. Individuals cannot be enrolled as an agency. Agency employees providing direct care and services must receive a clearance from an Idaho Department of Health and Welfare background check and meet the qualifications for a developmental specialist or a paraprofessional. DDAs providing Adult Day Health, Supported Employment or Behavior Consultation/Crisis Management must sign the appropriate additional terms of the Idaho Medicaid Provider Agreement.

DDAs must follow the requirements of the General Provider Qualifications section in addition to the ones presented here.

2.2.1. References: Developmental Disability Agency

(a) Idaho State Plan

"Services," *ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal*. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

(b) State Regulations

"Background Checks," Idaho Code Title 56, Chapter 27 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH27/SECT56-27.

"*Developmental Disabilities Agencies (DDA), Residential Habilitation Agencies, and Adult Residential Care Facilities*," IDAPA 16.03.21. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160321.pdf.

"Individuals Subject to a Background Check." IDAPA 16.05.06, "*Criminal History and Background Checks*," Sec. 100. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

2.2.2. DDA Administrators

Each developmental disability agency (DDA) must employ an administrator on a continuous, regularly scheduled basis. The administrator is accountable for the overall operations of the DDA including ensuring compliance with rules, overseeing and managing staff, developing and implementing written policies and procedures, overseeing the agency's quality assurance program, and training. The administrator must have two years of supervisory or management experience providing developmental disability services to individuals with developmental disabilities on a continuous, regularly scheduled basis who is responsible for the service elements of the agency. When the administrator is not a developmental specialist, the DDA must employ a developmental specialist to fulfill the supervisory role. The developmental specialist must have the supervisory qualifications to fill in for the administrator.

(a) References: DDA Administrators

(i) Idaho State Plan

ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

(ii) State Regulations

"Agency Staffing Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 607.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"General Staffing Requirements." IDAPA 16.03.21, "*Developmental Disabilities Agencies (DDA), Residential Habilitation Agencies, and Adult Residential Care Facilities*," Sec. 300. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160321.pdf.

"Training Requirements." IDAPA 16.03.21, "*Developmental Disabilities Agencies (DDA), Residential Habilitation Agencies, and Adult Residential Care Facilities*," Sec. 302. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160321.pdf.

2.2.3. DDA Developmental Specialists

Developmental specialists for adults must have a minimum of 240 hours of professionally supervised experience working with individuals who have developmental disabilities. Additionally, they must either have a bachelor's or master's degree in special education, early childhood special education, speech and language pathology, applied behavioral analysis, psychology, physical therapy, occupational therapy, social work, or therapeutic recreation. Individuals with a bachelor's or master's degree in an area not listed may complete a competency course and pass an exam jointly approved by the department and Idaho Association of Community Providers – Developmental Disabilities Agencies that relates to the job requirements of a developmental specialist to meet this requirement. Developmental specialists employed in Idaho prior to May 30, 1997, will be allowed to continue providing services as a developmental specialist as long as there is not a gap of more than three years of employment as a developmental specialist. Developmental specialists can be supervisors.

(a) References: DDA Developmental Specialists

(i) Idaho State Plan

ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

(ii) State Regulations

"Developmental Specialists." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 606.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Training Requirements." IDAPA 16.03.21, "*Developmental Disabilities Agencies (DDA), Residential Habilitation Agencies, and Adult Residential Care Facilities*," Sec. 302. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160321.pdf.

2.2.4. DDA Developmental Therapy Paraprofessionals

Developmental therapy paraprofessionals such as aides or therapy technicians must be employed by a developmental disability agency (DDA) and under the supervision of a developmental specialist during service hours. Paraprofessionals must be at least 17 years old and meet all DDA training requirements. On at least a weekly basis, DDAs must ensure a developmental specialist is available for all paraprofessionals under their supervision to give instructions, review progress, and provide training on the programs and procedures. On at least a monthly basis, a developmental specialist must observe and review the work performed by paraprofessionals under their supervision to ensure they are trained on the program and demonstrate necessary skills to correctly implement them. The DDA must ensure paraprofessionals do not conduct assessments, establish service plans, or develop Program Implementation Plans (PIP). These activities are conducted by a developmental specialist.

Developmental therapy paraprofessionals must meet all training requirements including initial, annual, and ongoing training, participant-sufficient training, and certification training.

(a) References: DDA Developmental Therapy Paraprofessionals

(i) Idaho State Plan

ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

(ii) State Regulations

"Developmental Therapy Paraprofessionals." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 606.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Paraprofessional Standards." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 607.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Training Requirements." IDAPA 16.03.21, "*Developmental Disability Agencies, Residential Habilitation Agencies, and Adult Residential Care Facilities*," Sec. 302. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160321.pdf.

2.2.1. Fiscal Employer Agent

Fiscal Employer Agents (FEA) must meet the requirements outlined in the provider agreement with the department and Section 3504 of the Internal Revenue Code. Additionally, FEAs must not provide other direct services to the participant or employ the guardian, parent, spouse, payee, or conservator of the participant or have direct control over the participant's choice.

(a) References: Fiscal Employer Agent

(i) Federal Regulations

Acts to be performed by agents, IRC 26 USC 3504, (1976). United States Code, http://uscode.house.gov/browse/prelim@title26&edition=prelim.

(ii) Idaho State Plan

ID-20-0020 1915(i) Home and Community-Based Services (HCBS) State Plan Children Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-20-0020.pdf.

(iii) State Regulations

"Fiscal Employer Agent (FEA): Requirements and Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 831. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individual Provider Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

2.3. Personal Assistance Agency

Personal Assistance Agencies (PAA) providers must be enrolled as a Medicaid provider with a signed Medicaid Provider Agreement and a signed Additional Terms – Aged and Disabled Waiver, Personal Care Services on file prior to submitting claims for services. PAAs can provide any of the services listed on the Personal Assistance Agency Fee Schedule.

A PAA must be comprised of an owner and their employees. Individuals cannot be enrolled as an agency. Providers, including direct care workers, licensed registered nurse (RN) supervisors, and qualified intellectual disability professionals (QIDP), must receive a clearance from a Department of Health and Welfare (DHW) background check. PAAs must direct, control, and monitor the work of each of its direct care staff. PAAs are responsible for the following:

- Recruitment, hiring, firing, training, supervision, scheduling and payroll for direct care workers;
- Assuring all providers are qualified to provide quality service;
- Provision of worker's compensation, unemployment compensation, and all other state and federal tax withholdings;
- Maintenance of liability insurance coverage;
- Provision of a licensed registered nurse (RN) supervisor or, where applicable, a QIDP supervisor to develop and complete service plans and provide ongoing supervision of a participant's care;
- Assignment of qualified direct care workers to eligible participants after consultation with and approval by the participants;
- Billing Medicaid for services approved and authorized by Bureau of Long Term Care (BLTC);
- Collecting any participant share of cost due; and
- Conducting annual participant satisfaction or quality control reviews that are available to the department and the public.

Termination of either worker's compensation or professional liability insurance by the provider is cause for termination of the PAA's provider agreement.

The department will identify the need for supervision. All services are overseen by an RN or QIDP. Oversight must include assistance in development of the written service plan, review of treatment by the provider through review of the participant's record, re-evaluation of the service plan as necessary, and immediate notification of the guardian, emergency contact, or family members of any significant changes in the participant's physical condition or response to services delivered.

A QIDP must supervise all participants who are developmentally disabled, other than those with only a physical disability. This oversight must include development of the service plan for those aspects of active treatment that are provided in the participant's personal residence, review of care or training programs through a review of the participant's record and on-site interviews with the participant, re-evaluation of the plan annually or more often as needed, and an on-site visit to the participant to evaluate any change of condition when requested by the direct care worker, the PAA, the RN supervisor, the A&D case manager (or managed care care coordinator), or the participant.

Employees of a PAA must be an RN, a licensed practical nurse (LPN), or meet the qualifications of a direct care worker. To meet the qualifications of a direct care worker, providers must be at least 18 years of age and meet the training requirements in the Provider Training Matrix. These requirements are met by successfully completing a BLTC approved, agency-developed curriculum and written examination or by completing an approved online training program.

The Department's online training platform, Idaho Direct Care Professional Online Training, is available to providers at no cost. The online training courses satisfy certain training requirements that would otherwise be conducted by the agency RN or administrative staff. However, Participant-Specific Endorsement training is not included in the online courses. All Participant-Specific Endorsement training must be completed in accordance with the Provider Training Matrix. PAAs are responsible for maintaining documentation of each employee's training certificate in their personnel record. The department may require a direct care worker to be a certified nursing assistant (CNA) if the participant's medical condition warrants the need for a CNA.

When a participant has a developmental disability, providers must have experience providing direct services to people with developmental disabilities and complete one of the department-approved developmental disabilities training courses. Providers who are qualified as a QIDP are exempt from this training course. The department may temporarily approve a provider who meets all the qualifications except for the required training if they verify there are no other qualified providers available, the provider is enrolled in the next available training course with a graduation no later than six months from the date of the request for temporary provider status, and the supervising QIDP makes monthly visits until the provider graduates from the training program.

All providers must complete a health questionnaire. PAAs must retain the health questionnaire in their personnel files. If the provider indicates on the questionnaire that they have a medical problem, they are required to submit a statement from a healthcare provider that their medical condition does not prevent them from performing all the duties required. Misrepresentation of information submitted on the health questionnaire may be cause for termination of employment for the provider and would disqualify the employee to provide services to Medicaid participants.

Providers must obtain a separate provider number to provide non-medical transportation services. When providing NMT, PAAs may not also bill for other direct care services.

All providers are responsible for providing quality services in compliance state and federal regulations and must comply with all department quality assurance activities. The department will conduct and transmit the results of quality assurance reviews within 45 days after the review is completed. The provider must respond within 45 days after the results are received. If problems are identified, the provider must implement a quality improvement plan and report the results to the department upon request.

Quality assurance reviews for participants on the A&D waiver for personal care services will include service delivery for all Medicaid members receiving services authorized by BLTC. As part of the review progress notes, service plans and staff training records will be reviewed. Providers will be notified when their review is scheduled and will have three weeks to submit the required documentation.

PAAs must follow the requirements of the General Provider Qualifications section in addition to the ones presented here.

2.3.1. References: Personal Assistance Agency

(a) Federal Regulations

Personal Care Services, 42 CFR §440.167 (1997), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-A/section-440.167.

(b) Idaho State Plan

Enhanced Alternative Benefit Plan. Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/Browse.aspx?id=32402&dbid=0&repo=PUBLIC-DOCUMENTS.

(c) Idaho Waivers

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(d) State Regulations

"A&D Waiver Services: Definitions." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 540. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"A&D Waiver Services: Provider Qualifications and Duties." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Background Checks," Idaho Code Title 56, Chapter 27 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH27/SECT56-27.

"Individual Provider Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individuals Subject to a Background Check." IDAPA 16.05.06, "*Criminal History and Background Checks*," Sec. 100. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"PCS: Provider Qualifications and Duties." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 554. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"PCS: Quality Improvement (QI)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 556. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Supervision." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 553.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

2.3.2. Personal Assistance Agency as a Fiscal Intermediary

Participants on the Aged and Disabled (A&D) Waiver may choose to use a self-direction model. Self-direction gives participants greater control over their services by allowing them to recruit, interview, hire, train, supervise, schedule, and, if need be, dismiss the direct care worker of their choice.

Self-direct is supported through a Personal Assistance Agency (PAA) acting as a Fiscal Intermediary (FI). FI agencies assist eligible participants with self-direction of Companion Services, Skilled Nursing, Consultation, Personal Care Services, Attendant Care, Homemaker, Chore Services, and Transition Services.

The FI is responsible for all payroll, administrative tasks, and compliance-related duties that enable participants to self-direct their services. While FI agencies are focused towards supporting self-direction, they must meet all requirements applicable to a PAA.

Unless otherwise specified, each individual service provider must be an employee of record or an employer fact through a PAA. An employer of fact is a participant or representative of a participant, who hires, fires, and directs the services delivered by a waiver provider. This individual may be a family member. An employer of record is an entity that bills for services, withholds required taxes, and conducts other administrative activities on behalf of the waiver participant. In this context, the employer of record is the PAA functioning as the FI.

A FI has the following responsibilities:

- Directly assure compliance with legal requirements related to employment of waiver service providers;
- Offer supportive services to enable participants or their families to perform the required employer tasks themselves;
- Bill the Medicaid program for services approved and authorized by the department;
- Collect any participant share of cost due;
- Pay direct care workers and other A&D waiver service providers for service;
- Perform all necessary withholding as required by state and federal labor and tax laws, rules, and regulations;
- Assure that direct care workers providing services meet the standards and qualifications under this rule;
- Maintain liability insurance coverage;
- Conduct, at least annually, participant satisfaction or quality control reviews that are available to the department and the public; and
- Obtain such background checks and health questionnaires on new and existing employees of record and fact as required.

Providers cannot be a spouse of the participant, or parent of a participant that is a minor. This does not prohibit other family members from providing these services. A participant's spouse, legal representative, or designee can assist with self-direction when they are able to demonstrate that they are willing and able to support the participant fulfilling their responsibilities as a self-directing entity. The spouse, legal representative, or designee only assists the participant with directing services. They cannot provide any A&D case management, companion, homemaker, chore services, skilled nursing, consultation, attendant care, or transition services.

The department may enter into provider agreements with individuals in situations in which no agency exists, or no FI agency is willing to provide services. Such agreements will be reviewed annually to verify whether coverage by a PAA or FI agency is still not available.

All providers are responsible for providing quality services in compliance state and federal regulations and must comply with all department quality assurance activities. The department will conduct and transmit the results of quality assurance reviews within 45 days after the review is completed. The provider must respond within 45 days after the results are received. If problems are identified, the provider must implement a quality improvement plan and report the results to the department upon request.

(a) References: Personal Assistance Agency as a Fiscal Intermediary

(i) Idaho Waivers

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(ii) State Regulations

"A&D Waiver Services: Definitions." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 540. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"A&D Waiver Services: Provider Qualifications and Duties." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Background Checks," Idaho Code Title 56, Chapter 27 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH27/SECT56-27.

"Individual Provider Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individuals Subject to a Background Check." IDAPA 16.05.06, "*Criminal History and Background Checks*," Sec. 100. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"PCS: Provider Qualifications and Duties." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 554. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"PCS: Quality Improvement (QI)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 556. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Supervision." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 553.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

2.4. Residential Habilitation Agency

Residential habilitation agencies must be certified by the department, and compliant with all requirements. Residential habilitation agencies providing residential habilitation services, adult day health, supported employment and behavior consultation/crisis management must sign the appropriate additional terms of the Idaho Medicaid Provider Agreement.

Agencies must supervise the direct services provided. Residential habilitation services must be provided by an employee of a residential habilitation agency.

Residential habilitation agencies providing supported living services may do so only for participants who own their home or have a lease agreement in their name. Any provider who performs residential habilitation services in their home must be a certified family home (CFH) and receive residential habilitation program coordination services from the department or its contractor. The CFH cannot provide supported living services. Information for CFHs providing in-home services can be found in the Certified Family Homes, Idaho Medicaid Provider Handbook.

Residential habilitation agencies must also review the Supported Living: Provider Qualifications section. Residential habilitations agencies must also follow the requirements of the General Provider Qualifications section in addition to the ones presented here.

2.4.1. References: Residential Habilitation Agency

(a) Idaho Medicaid Publications

"Residential Habilitation Services." *MedicAide Newsletter*, March 2025, https://www.idmedicaid.com/MedicAide%20Newsletters/March%202025%20MedicAide.pdf.

(b) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(c) State Regulations

"Certified Family Homes." IDAPA 16.03.19, Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160319.pdf.

"*Developmental Disabilities Agencies (DDA), Residential Habilitation Agencies, and Adult Residential Care Facilities*," IDAPA 16.03.21. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160321.pdf.

"Individual Provider Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

2.4.2. Residential Habilitation Agency: Developmental Disability Waiver Requirements

All skill training provided to agency direct service staff serving participants on the Developmental Disabilities (DD) Waiver must be delivered by a qualified intellectual disabilities professional (QIDP) with demonstrated experience in developing skill training programs. In addition, prior to providing services, direct service staff must complete an orientation specific to working with individuals with DD when supporting participants enrolled in the DD Waiver.

(a) References: Residential Habilitation Agency: Developmental Disability Waiver Requirements

(i) Federal Regulations

"Condition of participation" Facility staffing." 42 CFR §483.430 (2023), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-I/section-483.430.

(ii) Idaho Medicaid Publications

"Residential Habilitation Services." *MedicAide Newsletter*, March 2025, https://www.idmedicaid.com/MedicAide%20Newsletters/March%202025%20MedicAide.pdf.

(iii) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

(iv) State Regulations

"Residential Habilitation – Supported Living." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 614.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

2.4.3. Residential Habilitation Agency: Aged & Disabled Waiver Requirements

Agencies providing services to participants enrolled in the Aged and Disabled (A&D) Waiver must comply with all A&D Waiver Service requirements in addition to Home and Community-Based Services (HCBS) requirements.

All Individual Service Plans must be overseen by a registered nurse or qualified intellectual disability professional (QIDP), including the development, implementation, and annual approval of a service plan. Refer to the Aged and Disabled Waiver - Individual Service Plan section for detailed information on requirements.

Providers are required to document all services in the participant's record and must immediately notify the department, medical provider, case manager, and family of any significant changes in the participant's physical condition. See Aged and Disabled Waiver – Additional Documentation for guidance.

Direct care staff must meet the training requirements outlined in the Idaho Provider Training Matrix. These requirements are met by successfully completing a Bureau of Long Term Care (BLTC) approved, agency-developed curriculum and written examination or by completing an approved online training program. The Department's online training platform, Idaho Direct Care Professional Online Training, is available to providers at no cost. The online training courses satisfy certain training requirements that would otherwise be conducted by the agency RN or administrative staff. However, Participant-Specific Endorsement training is not included in the online courses. All Participant-Specific Endorsement training must be completed in accordance with the Provider Training Matrix. Agencies are responsible for maintaining documentation of each employee's training certificate in their personnel record.

The agency must maintain a signed statement for each direct care worker confirming that the individual is free from communicable disease, understands universal precautions, and complies with agency policies related to communicable disease. These statements must be kept in personnel files. Any misrepresentation of this information may result in termination of employment and disqualification from providing services to Medicaid participants.
Providers may not be the spouse of the participant or the parent of a minor participant; however, other family members may provide services when they meet applicable requirements.

All providers are responsible for providing quality services in compliance state and federal regulations and must comply with all department quality assurance activities. Reviews will include service delivery for all Medicaid members receiving services authorized by BLTC. As part of the review progress notes, service plans and staff training records will be reviewed. Providers will be notified when their review is scheduled and will have three weeks to submit the required documentation. The department will conduct and transmit the results of quality assurance reviews within 45 days after the review is completed. The provider must respond within 45 days after the results are received. If problems are identified, the provider must implement a quality improvement plan and report the results to the department upon request.

(a) References: Residential Habilitation Agency: Aged and Disabled Waiver Requirements

(i) Federal Regulations

"Contents of Request for a Waiver." 42 CFR §441.301 (2024), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-G/section-441.301.

(ii) Idaho Medicaid Publications

"Expanded Quality Assurance Reviews for ResHab Providers for A&D Waiver Members." MedicAide Newsletter, May and June 2026, https://www.idmedicaid.com/MedicAide%20Newsletters/May%20and%20June%202026%20MedicAide.pdf.

(iii) Idaho Waivers

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(iv) State Regulations

"Employment Status." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider Qualifications." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Residential Habilitation." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

2.5. Service Coordination

The human services field for the purposes of these qualifications refers to an area of academic study in healthcare, social services, education, behavioral science, or counseling including, but not limited to:

- Anthropology
- Education
- Gerontology
- Human development
- Psychology
- Rehabilitation counseling
- Social work
- Sociology
- Special education
- Speech communication

Providers must follow the requirements of the General Provider Qualifications section in addition to the ones presented here.

2.5.1. References: Service Coordination – Provider Qualifications

(a) State Regulations

"Human Services Field." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 005.27. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individual Provider Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

2.5.2. Service Coordination: Agency

Service coordination agencies must provide management, supervision, and quality assurance for the service. It must consist of at least a supervisor and a service coordinator. These cannot be the same person. A supervisor cannot oversee their own supervisor. This constitutes a conflict of interest. An administrator can provide supervision, and carry a caseload. They are not exempt from supervision requirements. Supervisors are not restricted from carrying a caseload. If the supervisor meets the requirements to provide supervision, an agency employee can provide supervision to another employee, regardless of whether they carry a caseload or not. If the employee supervising the administrator carries a caseload, they would need to be supervised by another employee they do not supervise.

A participant must have freedom of choice when selecting a service coordinator from an agency. The service coordinator cannot restrict the participant's choice of other healthcare or home and community-based (HCBS) providers.

The provider must be enrolled with Idaho Medicaid prior to submitting claims for services. Providers must follow the provider handbook and all applicable state, and federal regulations. See General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

(a) References: Service Coordination – Agency

(i) State Regulations

"Agency." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 005.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Conflict of Interest." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 633.06. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Freedom of Choice." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 633.04. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Human Services Field." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 005.27. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Service Coordination: Provider Qualifications and Duties." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 634. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

2.5.3. Service Coordination: Agency Supervisors

Agencies must provide supervision to service coordinators and paraprofessionals including documentation that supervisors can address concerns about services provided by employees and contractors under their supervision. A paraprofessional cannot be a supervisor. Supervisors must have one of the following:

- A master's degree in a human services field from a nationally accredited university or college with 12 months of supervised work experience with the population being served; or
- A bachelor's degree in a human services field from a nationally accredited university or college or be a licensed registered nurse with 24 months of supervised work experience with the population being served.

(a) References: Service Coordination – Agency Supervisors

(i) State Regulations

"Human Services Field." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 005.27. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Supervisor Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 634.03 Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

2.5.4. Service Coordinators

Service coordinators must be employees or contractors of a service coordinator agency. They must have a minimum of a bachelor's degree in a human services field from a nationally accredited university or college; or be a licensed registered nurse (RN). Also, required is 12 months of supervised work experience with the population they will be serving or be supervised by a qualified service coordinator until they have gained the experience. They must also have a current clearance from the Idaho Department of Health and Welfare's background check.

(a) References: Service Coordinators

(i) State Regulations

"Background Checks," Idaho Code Title 56, Chapter 27 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH27/SECT56-27.

"Human Services Field." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 005.27. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individuals Subject to a Background Check." IDAPA 16.05.06, "*Criminal History and Background Checks*," Sec. 100. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Service Coordinator Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 634.04 Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

2.5.5. Service Coordination: Paraprofessionals

Paraprofessionals must be under the supervision of a qualified service coordinator. Paraprofessionals may be used to assist in the implementation of a service coordination plan. Paraprofessionals must be at least 18 years of age and have a minimum of a high school diploma or equivalency. They must be able to read and write at an appropriate level to process the required paperwork and forms involved in the provision of service. 12 months of supervised work experience with the population they will be serving is required at the point of hire. They must also have a current clearance from the Idaho Department of Health and Welfare's background check.

(a) References: Service Coordination – Paraprofessionals

(i) State Regulations

"Background Checks," Idaho Code Title 56, Chapter 27 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH27/SECT56-27.

"Individuals Subject to a Background Check." IDAPA 16.05.06, "*Criminal History and Background Checks*," Sec. 100. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Paraprofessional Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 634.05. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

3. Home and Community-Based Services (HCBS)

Home and Community Based Services (HCBS) are services and supports to assist eligible participants to remain in their home and community. HCBS must be delivered in accordance with federal HCBS requirements. HCBS include the following services:

- Aged and Disabled (A&D) Waiver Services
- Consumer-Directed Services
- Developmental Disabilities (DD) Services
- Personal Care Services (PCS)
- Youth Empowerment Services (YES) for Children with Serious Emotional Disturbance (SED).

Developmental Disability Services include Adult DD State Plan Services, Adult DD Waiver Services, and Children's HCBS State Plan Services. It does not include Children's Habilitation Intervention Services (CHIS).

3.1. References: Home and Community-Based Services (HCBS)

3.1.1. Idaho State Plan

ID-20-0020 1915(i) Home and Community-Based Services (HCBS) State Plan Children Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-20-0020.pdf.

ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

3.1.2. Idaho Waivers

1915(i) ID Benefit 22-0009 & 1915(b) Waiver (0002.R02) Concurrent Renewal Approval. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0009.pdf.

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

3.1.3. State Regulations

"HCBS." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

3.2. HCBS Decision-Making Authority

Participants have the right to participate as fully as possible in all decisions affecting them. HCBS requirements do not supersede decision-making authority legally assigned to another individual or entity on the participant's behalf. This includes payees appointed by the Social Security Administration (SSA), court-imposed restrictions related to probation or parole or when committed to the Director of the Department of Health and Welfare, and legal guardians with full decision-making authority. Parents of a participant under the age of 18 are presumed to have full decision-making authority unless the minor has another legally assigned decision-making authority. This decision-making authority does not override the participant's choice where required by the HCBS setting. A request for restrictive intervention for health or safety concerns must still be submitted to the department by the HCBS provider, or by the plan developer in coordination with the HCBS provider through the person-centered planning process.

3.2.1. References: HCBS Decision-Making Authority

(a) State Regulations

"HCBS Exceptions." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 531. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Procedure for Court Appointment of a Guardian of an Incapacitated Person." Idaho Code 15-5-303 (2017). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title15/T15CH5/SECT15-5-303.

3.3. Home and Community-Based Setting Requirements

Home and community-based services (HCBS) settings include all locations where participants who receive HCBS live or receive their services. Home and Community-Based settings do not include a nursing facility, institution for mental diseases, intermediate care facility for individuals with intellectual disabilities (ICF/IID), hospital, or other location that has the qualities of an institutional setting. Qualities of an institutional setting includes any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, a building on the grounds of or immediately adjacent to a state or federally operated inpatient treatment facility, or any other setting that has the effect of isolating participants receiving HCBS from the broader community of individuals not receiving HCBS.

Home and community-based settings must support participants to have the same opportunities for integration, independence, choice, and rights as individuals who do not require supports or services to remain in their home or community. If a setting requirement presents a health or safety risk to the participant or those around the participant, goals must be identified with strategies to mitigate the risk. These goals and strategies must be documented in the person-centered plan. Providers must develop and implement policies and procedures to address the following HCBS setting requirements:

- **Integration and Access.** The setting is integrated in and supports full access to the greater community for participants receiving HCBS. Typical, age-appropriate activities include opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community in the same manner as individuals who do not require supports or services to remain in their home or community.
- **Selection of Setting.** Home and community-based settings are selected by the participant or the participant's decision-making authority from among disability-specific and non-disability-specific settings and are based on the participant's needs and preferences including consideration of the participant's safety and the safety of those around the participant.
- **Participant Rights.** The setting ensures a participant's rights of privacy, dignity, and respect, and freedom from coercion and unauthorized restraint are honored.
- **Autonomy and Independence.** The setting optimizes, but does not regiment, an individual's initiative, autonomy, and independence in making life choices, including daily activities, physical environment, and with whom to interact.
- **Choice.** The setting promotes opportunities for participant choice regarding the services and supports provided in the setting.

It is presumed that services delivered in the participant's own home, that is not a provider-owned or controlled residence, meet the HCBS setting requirements. Providers may not impose restrictions on HCBS setting qualities in a participant's own home without goals and strategies to mitigate risk described in this handbook that have been agreed to through the person-centered planning process.

3.3.1. References: Home and Community-Based Setting Requirements

(a) Federal Regulations

"Contents of Request for a Waiver." 42 CFR §441.301 (2024), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-G/section-441.301.

"State Plan Home and Community-Based Services Under Section 1915(i)(1) of the Act." 42 CFR §441.710 (2014), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-M/section-441.710.

(b) State Regulations

"HCBS: Provider Qualifications and Duties." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 533. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

3.3.2. Residential Provider-Owned or Controlled Setting Quality Requirements

In addition to the Home and Community Based Setting Requirements, provider-owned or controlled settings must meet additional setting requirements. Residential assisted living facilities (RALFs) and certified family homes (CFHs) are examples of provider-owned or controlled settings. There are no state or federal regulations preventing a Residential Habilitation agency from owning or controlling a house or apartment being rented, leased, or sublet to participants for whom the agency is providing services. Rules governing home and community-based services (HCBS) are clear on the setting requirements in general and provider owned or controlled settings specifically. Residential Habilitation agencies choosing to use provider-owned or controlled settings need to make sure their policies and procedures address how residential provider-owned and controlled setting quality requirements will be implemented.

In addition to any applicable state or federal landlord tenant laws, residential provider-owned or controlled settings must meet the following conditions:

- **Written Agreement.** A lease, residency agreement, admission agreement, or other form of written agreement must be in place for each HCBS participant at the time of occupancy. The lease or residency agreement provides protections that address eviction processes and appeals comparable to those provided under Idaho landlord tenant law.
- **Privacy.** Participants have the right to privacy within their residence. Each participant has privacy in their sleeping or living unit including the right to entrance doors that are lockable by the individual with only appropriate staff having keys. Additionally, participants sharing units have a choice of roommates in that setting.
- **Décor.** Participants have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- **Schedules and Activities.** Participants have the freedom and support to control their own schedules and activities.
- **Access To Food.** Participants have access to food at any time.
- **Visitors.** Participants can have visitors of their choice at any time.
- **Accessibility.** The setting is physically accessible to the participant.

Exceptions to residential provider-owned or controlled setting requirements must be made based on the needs of the participant which are identified through person-centered planning. Service plans with exceptions to these requirements must be submitted to the department or its designee for review and approval. When an exception is made, the following information must be documented in the person-centered service plan:

- **Assessed Needs.** Specific and individualized assessed needs that are related to the exception. An assessed need is a need that has been identified through a department-approved assessment.
- **Interventions and Supports.** Positive interventions and supports used prior to any exceptions to the person-centered service plan.
- **Prior Methods.** List less intrusive methods previously implemented that were unsuccessful in addressing the needs of the participant.
- **Description of Intervention.** A clear description of the intervention for the exception that is directly proportionate to the specific assessed needs.
- **Data Collection.** Regular collection and review of data to measure the ongoing effectiveness of the exception.
- **Time Limits.** Established time limits for periodic reviews to determine if the exception is still necessary, if a transition plan can be developed, or if the exception can be terminated.

- **Informed Consent.** Informed consent of the participant or legal guardian for the exception.
- **Assurance of No Harm.** An assurance that interventions and supports will cause no harm to the participant.

When an individual imposes supports on themselves, such as choosing not to have access to food at all hours of the day, this is not a setting exception. Individuals should receive support to ensure that they make responsible decisions that align with their personal goals. These strategies should be clearly outlined and monitored in the person-centered service plan. Parents, guardians, or individuals with parental power of attorney cannot waive the settings requirements in any HCBS setting as a matter of personal preference. If the assessed need is based on a probation/parole requirement upon which an individual's ability to live in the community is contingent, the department's restrictive intervention review and approval process must be followed and agreed to by the individual. The provider is not responsible for enforcing the provisions of probation, parole or guardianship order but should inform the participant of the potential violation and possible consequence of such action.

(a) References: Residential Provider-Owned or Controlled Setting Quality Requirements

(i) Federal Regulations

"Contents of request for a waiver." 42 CFR §441.301 (2025), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-G/section-441.301.

"State Plan Home and Community-Based Services Under Section 1915(i)(1) of the Act." 42 CFR §441.710 (2025), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-M/section-441.710.

(ii) Idaho Medicaid Publications

"Attention Residential Rehabilitation Providers: Information of Provider Owned or Controlled Settings." *MedicAide Newsletter*, January 2020, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202020%20MedicAide.pdf.

(iii) State Regulations

"Exceptions to Residential Provider-Owned or Controlled Setting Qualities." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 535. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

3.4. Home and Community-Based Person-Centered Planning Requirements

All participants or their decision-making authority must direct the development of their home and community-based services (HCBS) service plan through a person-centered planning process. Information and support must be given to the participant to maximize their ability to make informed choices and decisions. Individuals invited to participate in the person-centered planning process should be identified by the participant or the participant's decision-making authority. Legal guardians who do not have full decision-making authority will have a participatory role as needed and defined by the participant. The person-centered planning process must be conducted timely and occur at convenient times and locations to the participant and the participant's decision-making authority. Person-centered planning must reflect cultural considerations of the participant and be conducted by providing information in plain language and in a manner that is accessible to participants with disabilities and persons who are limited English proficient. Additionally, person-centered planning process must utilize strategies for solving conflict or disagreement within the process and follow clear conflict-of-interest guidelines for all planning participants.

The person-centered service plan must reflect the following components:

- **Services And Supports.** Clinical services and supports that are important for the participant's behavioral, functional, and medical needs as identified through an assessment.
- **Service Delivery Preferences.** Indication of what is important to the participant about the service provider and preferences for the delivery of such services and supports.
- **Setting Selection.** HCBS settings selected by the participant or the participant's decision-making authority are chosen from among a variety of setting options. The person-centered service plan must identify and document the alternative home and community setting options that were considered by the participant, or the participant's decision-making authority.
- **Participant Strengths and Preferences.** Individually identified goals and desired outcomes.
- **Paid and Unpaid Services and Supports.** Assist the participant to achieve identified goals, and the providers of those services and supports, including natural supports.
- **Risk Factors.** Risk factors to the participant as well as people around the participant and measures in place to minimize them, including individualized back-up plans and strategies when needed.
- **Understandable Language.** Be understandable to the participant receiving services and supports, and the individuals important in supporting them. The written plan must be written in plain language that is accessible to participants with disabilities and who have limited English proficiency.
- **Plan Monitor.** Identify the name of the individual or entity responsible for monitoring the plan.
- **Plan Signatures.** Be finalized and agreed to, by the participant, or the participant's decision-making authority, in writing, indicating informed consent. The plan must also be signed by the plan developer and 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. Providers responsible for implementation of the plan include all Children's Developmental Disabilities (DD), Personal Care Services (PCS), and Aged and Disabled (A&D) Waiver service providers. For consumer-directed services, this includes the support broker and fiscal employment agency.

- **Plan Distribution.** Be distributed to the participant and the participant's decision-making authority, if applicable, and other people involved in the implementation of the plan. The following providers must receive a copy of the plan:
    - *Children's DD services*. Providers identified on the service plan developed by the family-centered planning team.
    - *Adult DD services*. Providers responsible to develop a provider implementation plan identified in the Implementation Plans and Provider Status Reviews section of this handbook. Additionally, the participant will determine during the person-centered planning process whether the service plan, in whole or in part, will be distributed to any other DD service provider.
    - *Consumer-directed services*. The support broker and fiscal employment agency. Additionally, the participant, or the participant's decision-making authority when the participant is a minor, will determine during the person-centered planning process whether the service plan, in whole or in part, will be distributed to any other community support worker or vendors.
    - *PCS and A&D Waiver services*. All State Plan PCS and A&D Waiver service providers identified on the service plan.
- **Residential Requirements.** For participants living in residential provider-owned or controlled settings, the service plan must include a residential setting option that allows for private units. Selection of residential settings will be based on the participant's needs, preferences, and resources available for room and board. Additionally, any exception to residential provider-owned or controlled setting qualities must be documented in the person-centered plan.

3.4.1. References: Home and Community-Based Person-Centered Planning Requirements

(a) Federal Regulations

"Contents of request for a waiver." 42 CFR §441.301 (2025), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-G/section-441.301.

"Person-centered service plan." 42 CFR §441.725 (2025), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-M/section-441.725.

"State plan home and community-based services under section 1915(i)(1) of the Act." 42 CFR §441.710 (2025), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-M/section-441.710.

(b) Idaho Medicaid Publications

"Expanded Quality Assurance Reviews for ResHab Providers for A&D Waiver Members." MedicAide Newsletter, May and June 2026, https://www.idmedicaid.com/MedicAide%20Newsletters/May%20and%20June%202026%20MedicAide.pdf.

(c) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(d) State Regulations

"HCBS Person-Centered Plan Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 536. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

3.5. HCBS Participant Eligibility

To be enrolled in a home and community-based services (HCBS) waiver or State Plan option program, a participant must meet the eligibility requirements that include an independent assessment, a state-approved person-centered plan, at least an annual redetermination of eligibility, and other state-established criteria for determining Medicaid eligibility. A participant who does not meet eligibility criteria is subject to termination of enrollment. The department will terminate the enrollment of a participant who is enrolled or has accessed services through an HCBS waiver or State Plan option and does not have an identified need for the Waiver or State Plan option service, or who elects not to use services offered under the waiver or State Plan option. Participants who are unable to find a qualified provider for their services will not be disenrolled for non-use of services. Participant enrollment will also be terminated if the participant declines to engage in person-centered planning, does not meet HCBS eligibility requirements, or is non-responsive to three or more attempts by the department or its designee to engage the participant in fulfilling these requirements.

Continuous health care assistance eligibility for children under age 19 does not apply for a participant under the age of 19 who is enrolled in an HCBS waiver or State Plan option program or who has accessed Medicaid coverage through an HCBS waiver or State Plan option program.

3.5.1. References: HCBS Participant Eligibility

(a) State Regulations

"HCBS: Participant Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 539. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

4. Children's Support Services

This section of the Idaho Medicaid Provider Handbook covers Medicaid Support services provided by 1915(i) Children's Developmental Disabilities (DD) Home and Community Based Services (HCBS) State Plan Option. Traditional support services include:

- Respite
- Community-Based Supports
- Family Education

Support services can also be accessed through the Family-Directed Supports (FDS) option.

Those seeking support services must choose either Traditional or FDS. Additionally, Case Management is available through the Bureau of Developmental Disability Services (BDDS) – Children's Program to assist participants in accessing Children's DD HCBS. Contact the BDDS Children's Program central intake at 208-334-6500 or toll free at 877-333-9681 for information.

Visit the Children's Developmental Disability website for forms, processes, contact information, and ongoing updates. Visit the Family Directed Support Services website for information of Family Directed Supports.

4.1. Children's Support Services: Provider Qualifications

Providers of independent respite or community-based supports must have a separate provider agreement, including those who are providers of Family Education as Children's Habilitation Intervention Services (CHIS). The following is a list of providers able to enter into a Medicaid provider agreement and deliver Children's DD HCBS:

- Developmental Disabilities Agencies (DDAs);
- Independent respite providers;
- Independent community-based supports (CBS) providers; and
- Independent Children's Habilitation Intervention Service (CHIS) Providers.

All children's support service providers must receive a clearance from an Idaho Department of Health and Welfare background check. Services provided by a DDA provider must be supervised. The supervisor must meet the intervention specialist or professional qualifications. The observation and review of the services must be performed at least monthly to ensure staff demonstrate the necessary skills to provide services. Independent respite and CBS providers are supervised by the department through the provider agreement.

Providers must follow the requirements of the General Provider Qualifications section in addition to the ones presented here.

4.1.1. References: Children's Support Services – Provider Qualifications

(a) Federal Regulations

Provider Qualifications, 42 CFR §441.730 (2021), Government Printing Office https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-M/section-441.730.

(b) Idaho State Plan

ID-20-0020 1915(i) Home and Community-Based Services (HCBS) State Plan Children Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-20-0020.pdf.

(c) State Regulations

"Children's DD HCBS State Plan Option: Provider Qualifications and Duties." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 585. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"CHIS: Provider Qualifications and Duties." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 184. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individual Provider Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individuals Subject to a Background Check." IDAPA 16.05.06, "*Criminal History and Background Checks*," Sec. 100. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Provider." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Supervision." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 584.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Training Requirements." IDAPA 16.03.21, "*Developmental Disability Agencies, Residential Habilitation Agencies, and Adult Residential Care Facilities*," Sec. 302. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160321.pdf.

4.1.2. Children's Support Services: Respite

Providers of respite services must be at least 16 years of age when employed by a Developmental Disability Agency (DDA), or if providing independent respite services, the provider must be at least 18 years of age. Additionally, providers must meet the following qualifications:

- Have received instructions on the needs of the participant and demonstrate the ability to provide services according to a participant's plan of service;
- Receive a clearance from DHW's background check process; and
- Be certified in CPR and First Aid.

(a) References: Children's Support Services – Respite

(i) Idaho State Plan

ID-20-0020 1915(i) Home and Community-Based Services (HCBS) State Plan Children Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-20-0020.pdf.

(ii) State Regulations

"Background Checks," Idaho Code Title 56, Chapter 27 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH27/SECT56-27.

"Individual Provider Requirements." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individuals Subject to a Background Check." IDAPA 16.05.06, "*Criminal History and Background Checks*," Sec. 100. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Provider." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Respite." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 585.01 Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Training Requirements." IDAPA 16.03.21, "*Developmental Disability Agencies, Residential Habilitation Agencies, and Adult Residential Care Facilities*," Sec. 302. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160321.pdf.

4.1.3. Community-Based Supports

Providers of community-based supports (CBS) must meet the following minimum qualifications:

- Be at least 18 years of age;
- Have received instructions on the needs of the participant and demonstrate the ability to provide services according to a plan of service;
- Must have documentation of at least six months of supervised experience working with children with developmental disabilities (DD). This can be achieved the following ways:
    - Have previous work experience gained through paid employment, university practicum experience, or internship; or
    - On-the-job supervised experience through employment at a developmental disability agency (DDA) with increased supervision. Experience is gained by completing at least six hours of job shadowing before delivering direct supports services, and a minimum of weekly face-to-face supervision with the supervisor for six months while delivering services.
- Complete department approved coursework. The coursework is an online competency training consisting of four modules at the Idaho Center on Disabilities and Human Development website;
    - Intervention providers also providing CBS are not required to take the online CBS course, as their qualifications already exceed those required to provide CBS. However, independent intervention providers must separately enroll as independent CBS providers.
- Receive a clearance from an Idaho Department of Health and Welfare background check; and
- Certified in CPR and First Aid.

Individuals providing CBS to participants birth to age three must have six months of documented experience with DD participants in that age range.

(a) References: Community-Based Supports

(i) Idaho State Plan

ID-20-0020 1915(i) Home and Community-Based Services (HCBS) State Plan Children Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-20-0020.pdf.

(ii) State Regulations

"Background Checks," Idaho Code Title 56, Chapter 27 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH27/SECT56-27.

"Community-Based Support." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 585.02 Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individual Provider Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individuals Subject to a Background Check." IDAPA 16.05.06, "*Criminal History and Background Checks*," Sec. 100. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Provider." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Training Requirements." IDAPA 16.03.21, "*Developmental Disability Agencies, Residential Habilitation Agencies, and Adult Residential Care Facilities*," Sec. 302. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160321.pdf.

4.1.4. Family Education

Family education can be provided by a certified Developmental Disability Agency (DDA) or by an individual with an independent habilitation intervention provider agreement who meets qualifications as an intervention specialist or intervention professional. Additionally, providers of family education services must meet ongoing intervention training requirements. Refer to the Children's Habilitation Intervention Services, Idaho Medicaid Provider Handbook for more information.

(a) References: Family Education

(i) Idaho State Plan

ID-20-0020 1915(i) Home and Community-Based Services (HCBS) State Plan Children Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-20-0020.pdf.

(ii) State Regulations

"Family Education." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 585.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individual Provider Requirements." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

4.2. Children's Support Services: Participant Eligibility

Children's support services are a benefit of Idaho Medicaid. Not all participants are eligible for all services. Services are available based on the participant's enrollment eligibility. Incarcerated individuals or otherwise ineligible non-citizens with Medicaid coverage are not eligible for these services.

The department must determine whether a participant is eligible for services. Eligibility requires the following criteria to be met:

- Birth through age 17;
- Documented Developmental Disability (DD) diagnosis;
- Medicaid eligible; and
- Meets needs-based criteria of the 1915(i) Children's DD Home and Community Based Services (HCBS) State Plan Option benefit.

The table below outlines the DD determination standards used to determine if a participant has a DD diagnosis.

Developmental Disability Determination Standards	
Definition	**Standards**
"Developmental Disability" means a chronic disability of a person that appears before the age of 22 years and:	Age of 22 means through the day before the individual's 22nd birthday. AND
(a) is attributable to an impairment, such as an intellectual disability;	"Is attributable to an impairment" means that there is a causal relationship between the presence of an impairing condition and the developmental disability. **Age five through Adult:** There is a presumption that an intellectual disability exists when a full-scale IQ score up to 75 exists. (IQ of 70 with a standard error of measurement of five points.) **Birth to Age five:** An IQ test score is not required below the age of five. In these cases, it may be necessary to rely on the results of a functional assessment. There is a presumption that an intellectual disability exists when there is a standard score of 75 or below or a delay of 30% overall.
cerebral palsy;	Medical Diagnosis that requires documentation.
epilepsy;	Medical Diagnosis that requires documentation. On medication controlled or uncontrolled. Does not include a person who is seizure-free and not on medication for three years.
autism;	Includes the diagnosis of pervasive developmental disorder.
or other condition found to be closely related to or similar to one (1) of these impairments that requires similar treatment or services;	For related or similar conditions, documentation must be present to show the causal relationship between the impairing condition and the developmental disability. (Does not include mental illness)

Developmental Disability Determination Standards	
Definition	**Standards**
	Intellectual Disability: A full-scale IQ score above 75 can in some circumstances be considered a related or similar condition to an intellectual disability when additional supporting documentation exists showing how the individual's functional limitations make their condition similar to an intellectual disability. **Cerebral Palsy:** Conditions related or similar to cerebral palsy include disorders that cause a similar disruption in motor function. **Epilepsy:** Conditions related or similar to epilepsy include disorders that interrupt consciousness.
or is attributable to dyslexia resulting from such impairments; and	AND
(b) results in substantial functional limitations in three (3) or more of the following major life activities:	"Results in" means that the substantial limitation must be because of the impairment. A "substantial" limitation is one in which the total effect of the limitation results in the need for a "combination and sequence of special interdisciplinary, or generic care, treatment or other services that need to be individually planned and coordinated." Listed below are standards for substantial functional limitations in each major life area. **Age three through Adult:** A score of two standard deviations below the mean creates a presumption of a functional limitation. **Birth to Age three:** The following criteria must be utilized to determine substantial functional limitations for children under three: The child scores 30% below age norm; or The child exhibits a six month delay; or The child scores two standard deviations below the mean.
self-care;	**Adult:** A substantial functional limitation is manifest when the person requires physical or non-physical assistance in performing eating, hygiene, grooming, or health care skills, or when the time required for a person to perform these skills him/herself is so substantial as to impair their ability to conduct other activities of daily living or retain employment. **Birth to Age 21:** A functional limitation is manifest when the child's skills are limited according to age-appropriate responses such that the parent, caregiver, or school personnel is required to provide care that is substantially

Developmental Disability Determination Standards	
Definition	**Standards**
	beyond that typically required for a child of the same age (such as excessive time lifting, diapering, supervision).
receptive and expressive language;	**Age three through Adult:** A substantial functional limitation is manifest when a person is unable to communicate effectively without the aid of a third person, a person with special skills, or without an assistive device (such as sign language). **Birth to Age Three:** A substantial functional limitation is manifest when they have been diagnosed by a qualified professional who determines that the child performs 30% below age norm (adjusted for prematurity up to two years) or demonstrates at least two standard deviations below the mean in either area or one and one-half below in both areas of language development.
learning;	**Birth through Adult:** A substantial functional limitation is manifest when cognition, retention, reasoning, visual or aural communications, or other learning processes or mechanisms are impaired to the extent that special (interventions that are beyond those that an individual normally needs to learn) intervention is required for the development of social, self-care, language, academic, or vocational skills.
mobility;	**Adult:** A substantial functional limitation is manifest when fine or gross motor skills are impaired to the extent that the assistance of another person or an assistive device is required for movement from place to place. **Birth to Age 21:** A substantial limitation would be measured by an age-appropriate instrument that compares the child's skills for postural control and movement and coordinated use of the small muscles with those skills expected of children of the same age.
self-direction;	**Adult:** A substantial functional limitation is manifest when a person requires assistance in managing their personal finances, protecting their self-interest, or making decisions that may affect their well-being. **Birth to Age 21:** A substantial limitation is manifest when the child is unable to help themself or cooperate with others age-appropriate assistance to meet personal

Developmental Disability Determination Standards	
Definition	**Standards**
	needs, learn new skills, follow rules, and adapt to environments.
capacity for independent living; or	**Adult:** A substantial functional limitation is manifest when, for a person's own safety or well-being, supervision or assistance is required, at least on a daily basis, in the performance of health maintenance, housekeeping, budgeting, or leisure time activities and in the utilization of community resources. **Birth to Age 21:** A substantial limitation would be measured by an age-appropriate instrument that compares the child's personal independence and social responsibility expected of children of comparable age and cultural group.
economic self-sufficiency; and	**Adult:** A substantial functional limitation is manifest when a person is unable to perform the tasks necessary for regular employment or is limited in productive capacity to the extent that their earned annual income, after extraordinary expenses occasioned by the disability, is insufficient for self-support. **Age five to Age 21:** Use the pre-vocational area of a standardized functional assessment to document a limitation in this area. **Birth to Age Five:** A substantial limitation in this area is evidenced by the child's eligibility for SSI, early intervention, or early childhood special education under the Individuals with Disabilities Education Act (IDEA). AND
(c) reflects the needs for a combination and sequence of special, interdisciplinary or generic care, treatment or other services that are of life-long or extended duration and individually planned and coordinated.	**Age Five through Adult:** Life-long or extended duration means the developmental disability is one that has the reasonable likelihood of continuing for a protracted period of time, including a reasonable likelihood that it will continue throughout life. **Birth to Age Five:** The expected duration may be frequently unclear. Therefore, determination of eligibility by a multi-disciplinary team for early intervention services through SSI, an IFSP, child study team or early childhood special education services through an IEP will be an indicator of this criteria.

Initial and annual eligibility assessments must be performed by the Independent Assessment Contractor (IAC) under contract with the department. Assessments include documentation of a DD, a medical, social, and developmental assessment (MSDA), and a functional assessment. Evaluations must be performed by qualified personnel with experience and expertise with children using age-appropriate evaluation tools and practices, considering the child's language

and motor skills. Participants must be determined eligible before receiving Children's DD HCBS. When a participant is determined eligible, the IAC assigns the participant an annual budget that will be used for their Children's DD HCBS. Budgets are re-evaluated annually or at the request of the participant, or the department when there are documented changes that may support placement in a different budget category. For participants re-applying for services, the assessor evaluates whether assessments are current and accurately describe the status of the participant.

The following categories are used to determine individualized budgets for children with DD.

- Level I. Children meeting DD criteria.
- Level II. Children who qualify based on functional limitations when their Vineland Adaptive Behavior Scales, Third Edition (Vineland-3) composite full-scale standard score of less than 60 or have an overall standard score up to 63 when combined with an internalizing or externalizing maladaptive v-Scale score of 19 or 20.
- Level III. Children who qualify based on functional limitations with a Vineland-3 composite full-scale standard score less than 60 with an autism spectrum disorder diagnosis.
- Level IV. Children who qualify based on maladaptive behaviors when their Vineland-3 internalizing or externalizing maladaptive v-Scale score is greater than or equal to 21, or they score one Critical Item as a "2" or two or more items scored as a "1".

The participant can choose to use their budget for Traditional or Family-Directed Services.

Before delivery of services, providers must check eligibility on the date of the service to validate coverage. Providers must maintain documentation of the eligibility check. Eligibility can be checked by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website.

See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more detail on eligibility checks.

4.2.1. References: Children's Support Services – Participant Eligibility

(a) Federal Regulations

Persons to Whom Services will be Provided, 42 CFR §136.12 (1999). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-I/subchapter-M/part-136/subpart-B/section-136.12.

(b) Idaho State Plan

ID-20-0020 1915(i) Home and Community-Based Services (HCBS) State Plan Children Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-20-0020.pdf.

(c) State Regulations

"Children's DD HCBS State Plan Option: Eligibility Determination." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 581. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"DD Determination Standards: Participant Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 561. Department of Administration, State of Idaho,

https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"DD Determination Standards: Test Instruments." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 563. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

4.3. Children's Support Services: Covered Services and Limitations

Idaho Medicaid covers the following children's development disabilities (DD) home and community-based services (HCBS) for eligible Medicaid participants:

- Respite;
- Community-based supports; or
- Family education.

Children's DD HCBS involve the collaboration of a family-centered planning team to develop the plan of service for the participant. For traditional services, the family-centered planning team must include the participant, the parent, legal guardian, or a related or non-related individual with parental power of attorney, and the participant's Case Manager. The team may include others identified by the family or agreed upon as important to the family-centered planning process by the family and the department. Services must also meet federal HCBS requirements as outlined in Home and Community Based Services.

Children's DD HCBS are limited by the participant's individualized budget amount. Duplication of services cannot be provided. Services are considered duplicate when:

- An adaptive equipment and support service address the same goal.
- Multiple adaptive equipment items address the same goal.
- Goals are not separate and unique to each service provided.
- More than one service is provided at the same time, unless otherwise authorized.

Vocational, educational, and recreational services are excluded from reimbursement for Children's DD HCBS. Services covered under the Medicaid Basic Plan cannot be authorized under the Children's DD HCBS Plan option. Refer to the Children's Habilitation Intervention Services, Idaho Medicaid Provider Handbook for a more detailed explanation of excluded services.

Children's DD HCBS are provided in home and community-based settings. Community settings are natural, integrated environments outside of the participant's home, outside of DDA center-based settings, or at school outside of school hours. They are not reimbursable under Idaho Medicaid when provided in an institution, including a Residential Care Facility (RCF). A Developmental Disability Agency (DDA) cannot provide Children's DD HCBS at an RCF.

4.3.1. References: Children's Support Services – Covered Services and Limitations

(a) Idaho State Plan

ID-20-0020 1915(i) Home and Community-Based Services (HCBS) State Plan Children Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-20-0020.pdf.

(b) State Regulations

"Children's DD HCBS State Plan Option: Coverage and Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 582. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Children's DD HCBS State Plan Option: Definitions." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 580. Department of Administration, State of Idaho,

https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Delegation of Powers by Parent or Guardian." Idaho Code 15-5-104 (2003). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title15/T15CH5/SECT15-5-104.

"Educational Services." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 005.22. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(3)(e) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Recreational Services." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 007.16. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"School Age," Idaho Code 33-201 (1998). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/title33/t33ch2/sect33-201.

"Service Categories Not Covered." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 060.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Vocational Services." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 007.35. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

4.3.2. Children's Support Services: Respite

Respite provides intermittent short-term supervision of the participant to relieve the unpaid primary caregiver. Respite is also available in response to a family emergency or crisis. Respite may be provided in the participant's home, the home of an independent respite provider, developmental disability agency (DDA), or in the community.

The following general limitations apply:

- Payment does not include room and board;
- Cannot be provided on a continuous, long-term basis as a daily service that would enable an unpaid caregiver to work;
- Must only be offered to participants living with an unpaid caregiver who requires relief;
- Cannot exceed 14 consecutive days;
- Cannot be provided at the same time other Medicaid services are being provided except when an unpaid caregiver is receiving family education;
- Must not use restraints on the participant, other than physical restraints in the case of an emergency to prevent injury to the participant or others. The use of emergency restraints must be documented in the participant's record; and
- When respite is provided in a group setting, there must be at least one qualified staff providing direct services to every six participants.
    - As the number and severity of the participants with functional impairments or behavioral issues increases, the staff-to-participant ratio must be adjusted accordingly.

Independent respite providers cannot provide respite in a DDA setting. Additionally, independent providers must meet the following criteria to provide group respite:

- The independent respite provider is a relative of every participant; and
- The service is provided in the home of the participant or the independent respite provider.

Covered Respite Codes		
CPT® Code	Modifier	Description
T1005		Respite Care Services - Individual
	HQ	Respite Care Services - Group

Enter the appropriate ICD-10-CM: *Z74.2, "Need for assistance at home and no other household member able to render care,"* code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

(a) References: Children's Support Services – Respite

(i) Idaho State Plan

ID-20-0020 1915(i) Home and Community-Based Services (HCBS) State Plan Children Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-20-0020.pdf.

(ii) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(3)(e) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Respite." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 582.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

4.3.3. Community-Based Supports

Community-Based Supports (CBS) provide assist participants with a developmental disability (DD) by facilitating their independence and integration into the community. This service allows for participants to explore their interests, practice skills learned in other therapeutic environments and learn through interactions in typical community activities. Integration into the community enables participants to expand their skills related to activities of daily living and reinforces skills to achieve or maintain mobility, sensory-motor, communication, socialization, personal care, relationship building, and participation in leisure and community activities.

The following limitations apply:

- CBS is only allowed in a developmental disability agency (DDA) or the participant's home to allow preparation for, or transition from, a community activity, or to assist with needs that cannot be addressed otherwise in the community;
- Part of every CBS session must occur in the community;
- CBS must not replace services provided in school, therapy, or replace the role of the primary caregiver. CBS cannot be provided in a school setting during school hours;
- CBS must ensure the participant is involved in age and peer-appropriate activities according to the ability of the participant; and
- When CBS are provided in a group, there must be at least one qualified staff providing direct services for up to six participants. As the number and severity of participants increases, the staff-to-participant ratio must be adjusted accordingly.
- Cannot be provided in a public school or public charter school.

CBS providers must complete status reviews at least every six months. Provider status reviews must be completed more frequently when required on the plan of service. department approved forms can be found at the 1915(i) HCBS Traditional Supports webpage.

Covered Community-Based Supports Codes		
CPT® Code	Modifier	Description
H2015	HA	Community Based Supports - Individual
	HQ	Community Based Supports - Group

(a) References: Community-Based Supports

(i) Idaho State Plan

ID-20-0020 1915(i) Home and Community-Based Services (HCBS) State Plan Children Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-20-0020.pdf.

(ii) State Regulations

"Community-Based Supports." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 582.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(3)(e) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Provider Status Reviews." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 583.05. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

4.3.4. Family Education

Family education is professional assistance to family members or others who care for the participant to help them better meet the participant's specific needs. Family education provides an orientation to developmental disabilities (DD) and educates families on basic strategies for behavioral modification and individualized intervention techniques.

When family education is provided in a group setting, the group must not exceed five families of children with a DD diagnosis. Family education cannot be provided at the same time other Medicaid services are being provided, except for respite.

Family education providers must survey the parent, legal guardian, or individual with parental power of attorney's satisfaction of the service immediately following each education session. Family education providers must maintain documentation of the training in the participant's record, including the delivery of activities outlined in the plan of service.

Covered Family Education Codes		
CPT® Code	Modifier	Description
H0024		Family Education - Individual
	HQ	Family Education - Group

(a) References: Family Education

(i) Federal Regulations

Prevention of Duplicate Payments, 42 CFR §457.626 (2002). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-D/part-457/subpart-F/section-457.626.

(ii) Idaho State Plan

ID-20-0020 1915(i) Home and Community-Based Services (HCBS) State Plan Children Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-20-0020.pdf.

(iii) State Regulations

"Family Education." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 582.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Delegation of Powers by Parent or Guardian." Idaho Code 15-5-104 (2003). Idaho State Legislature, https://legislature.idaho.gov/wp-content/uploads/statutesrules/idstat/Title15/T15CH5.pdf.

"Documentation." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 584.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(3)(e) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

4.4. Children's Support Services: Prior Authorization

Prior authorization (PA) is intended to help ensure the delivery of appropriate services and supports. Services are reimbursable when identified on the authorized plan of service and are consistent with the department's PA process for Home and Community Based Settings (HCBS).

Services are covered when provided with the right care, in the right place, at the right price, and with the right outcomes to enhance health and safety, and promote participants' rights, self-determination, and independence. Right care is the standard of care for the diagnosis, functional needs, and abilities to achieve the desired outcome. Right place is when services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. Right Price is the most integrated and least expensive services that are sufficient to address the participant's needs as identified in the assessment. Right Outcomes are services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant.

The participant's plan of service must be reauthorized annually. The department must review and authorize the new plan of service before the expiration of the current plan. Before the expiration of the existing plan of service, the Case Manager or support broker must:

- Both contact the parent, or legal guardian, or individual with parental power of attorney to determine the individuals they want to participate in the family centered planning meeting.
- Both meet with the family-centered planning team to develop a new plan of service.
- Case Managers will notify the providers who appear on the plan of service of the annual review date.
- Case Managers will obtain a copy of the current annual provider status review, if applicable, from each provider for use by the family-centered planning team.
- Case Managers will obtain a signed provider signature page for plans at the initial start of services and annually.

Delivery of each service identified on the plan of service cannot be initiated until the plan has been signed by the parent or participant's decision-making authority and has been authorized by the department. PAs are not guarantee of payment, and all other department requirements must be fulfilled.

See the General Billing Instructions, Idaho Medicaid Provider Handbook, for more information regarding PAs.

4.4.1. References: Children's Support Services – Prior Authorization

(a) Federal Regulations

"Person-centered service plan." 42 CFR §441.725 (2024), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-M/section-441.725.

"State Plan Home and Community-Based Services Under Section 1915(i)(1) of the Act." 42 CFR §441.710 (2025), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-M/section-441.710.

(b) Idaho State Plan

ID-20-0020 1915(i) Home and Community-Based Services (HCBS) State Plan Children Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-20-0020.pdf.

(c) State Regulations

"Children's DD HCBS State Plan Option: Coverage and Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 582. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Children's DD HCBS State Plan Option: Service Plan." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 583. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"DD Services: Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 560. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Delegation of Powers by Parent or Guardian." Idaho Code 15-5-104 (2003). Idaho State Legislature, https://legislature.idaho.gov/wp-content/uploads/statutesrules/idstat/Title15/T15CH5.pdf.

"HCBS." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"HCBS Person-Centered Plan Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 536. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

4.5. Children's Support Services: Additional Documentation

Providers must follow the requirements of the Documentation section in addition to the ones presented here.

4.5.1. Plan Development and Monitoring

The participant's plan of service is developed within their individualized budget. The plan must include all children's developmental disabilities (DD) home and community-based services (HCBS) and identify other Medicaid services and supports available to the participant. The plan must also identify services outside of Medicaid, if available, that can help the participant meet their desired goals.

The plan developer must monitor the plan of service. The family-centered planning team will determine their preference for frequency of contact from the plan developer; however, the plan developer must meet face-to-face with the participant and their parent, legal guardian, or individual with parental power of attorney at least annually. The plan of service must always be authorized by the department before the delivery of services. The participant's plan of service must include the following:

- Assessment of needs;
- Strengths and weaknesses;
- Identified goals and desired outcomes;
- Identified services and supports; and
- Risk factors and how they will be minimized.

For traditional support services plan monitoring includes the following:

- At least every six months and annually, a review of the plan of service with the parent, legal guardian, or individual with parental power of attorney to identify the current status of services, barriers to success, and any necessary changes to the plan.
- Documentation of the six month and annual provider status review (PSR) reviews must be submitted to the participant's Case Manager. The annual PSR must be submitted to the plan monitor 45 calendar days before the expiration of the existing plan of service.
- Monthly coordination of services and supports with the family and service providers to assure collaboration across services and identification of any barriers to service delivery.
- Satisfaction surveys regarding quality and quantity of services.

The participant's` plan of service may be adjusted during the year based on needs and the participant's or decision-making authority's request with an addendum to the plan. Adjustment of the plan of service requires the signature of the parent, legal guardian, or individual with parental power of attorney. Before implementing of any plan adjustments, providers must obtain the signed addendum and submit an updated provider signature page to the Case Manager.

As Children's DD HCBS fall under Idaho's 1915(i) Children's DD HCBS State Plan Option, plans for these services that include restrictive interventions must be approved by the Children's DD Program before implementation to ensure compliance with federal requirements. Any restrictive interventions need to be based on a specific assessed need. Parents, guardians, or individuals with parental power of attorney cannot waive the settings requirements in any HCBS setting as a matter of personal preference. If the assessed need is based on a probation/parole requirement upon which an individual's ability to live in the community is contingent, the restrictive intervention review and approval process must be followed and agreed to by the individual. The provider is not responsible for enforcing the provisions of

probation, parole or guardianship order but should inform the participant of the potential violation and possible consequence of such action. Any provider implementing restrictive interventions during the delivery of Children's DD HCBS must complete the Restrictive Interventions Implementation and Instructions and Form and follow the process for review and approval. The instructions and form can be found in the department's 1915(i) HCBS Traditional Supports library.

(a) References: Plan Development and Monitoring

(i) Federal Regulations

Basis and Purpose. 42 CFR §441.700, (2021). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-M/section-441.700.

(ii) Idaho State Plan

ID-20-0020 1915(i) Home and Community-Based Services (HCBS) State Plan Children Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-20-0020.pdf.

(iii) State Regulations

"Children's DD HCBS State Plan Option: Service Plan." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 583. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Delegation of Powers by Parent or Guardian." Idaho Code 15-5-104 (2003). Idaho State Legislature, .

"HCBS Person-Centered Plan Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 536. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individualized Budget Methodology." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 581.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

4.6. Children's Support Services: Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Providers have the burden of proof to establish entitlement to payment. Idaho Medicaid reimburses Children's DD HCBS on a fee-for-service basis. The reimbursement rates calculated for children's HCBS include both services and mileage. No separate charges for mileage will be paid by the department for provider transportation to and from the participant's home or other service delivery location when the participant is not being provided transportation. Usual and customary fees are paid up to the Medicaid maximum allowance listed in the Idaho Medicaid Fee Schedule webpage and the Children's DD & CHIS DDA Fee Schedule or Children's DD & CHIS Independent Provider Fee Schedule. Rate updates require legislative approval.

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third party resources before submitting claims to Medicaid.

4.6.1. References: Children's Support Services – Reimbursement

(a) Idaho State Plan

ID-20-0020 1915(i) Home and Community-Based Services (HCBS) State Plan Children Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-20-0020.pdf.

(b) State Regulations

"Burden of Proof – Provider Cases." IDAPA 16.05.03, "*Contested Case Proceedings and Declaratory Rulings,"* Sec. 133. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/2023%20Archive/16/160503.pdf.

"Burden of Proof (Rule 477)." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 477. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"Children's DD HCBS State Plan Option: Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 586. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"General Payment Procedures." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 030. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Mandatory Application." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 800.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

Provider Payment, Idaho Code 56-265 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265.

5. Aged and Disabled Waiver Services

The Idaho Medicaid Enhanced Plan covers Aged and Disabled (A&D) Waiver services for participants who meet A&D Waiver eligibility requirements. Bureau of Long Term Care (BLTC) staff act as the administrative manager for the A&D Waiver. They determine unmet needs through the Uniform Assessment Instrument (UAI), authorize waiver services, and participate in development of the Individual Service Plan (ISP). The service plan must be prior authorized by the department. Services must also meet federal Home and Community-Based Services (HCBS) requirements as outlined in the Home and Community Based Services (HCBS) section of this handbook.

5.1. References: Aged and Disabled Waiver Services

5.1.1. Idaho State Plan

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

5.1.2. State Regulations

"A&D Waiver Services: Procedural Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 543. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"HCBS." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"HCBS: Participant Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 539. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

5.2. Aged and Disabled Waiver: Provider Qualifications

All providers of Aged and Disabled (A&D) Waiver services must have a valid provider agreement or performance contract with Medicaid including any applicable Additional Terms. Providers cannot be the spouse of the participant.

Providers must follow the requirements of the General Provider Qualifications section in addition to the ones presented here.

5.2.1. References: Aged and Disabled Waiver – Provider Qualifications

(a) Idaho State Plan

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Waiver Services: Provider Qualifications and Duties." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individual Provider Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

5.3. Aged and Disabled Waiver: Participant Eligibility

Aged and Disabled (A&D) Waiver services are available to eligible participants to maintain self-sufficiency, individuality, independence, dignity, choice, and privacy in a cost-effective home-like or community-based setting. To qualify for A&D Waiver services, participants must meet financial eligibility for A&D Waiver services as determined by the department's Self Reliance division. Additionally, the participant must be age 18 or over and have a disabling condition that impairs their mental or physical function or independence. The department establishes the level of impairment based on the uniform assessment instrument (UAI). To meet nursing facility (NF) level of care, a participant must score 12 or more points based on the following indicators:

- Critical Indicators – 12 points each
    - Total assistance with preparing or eating meals
    - Total or extensive assistance in toileting
    - Total or extensive assistance with medications that require decision making prior to taking, or assessment of efficacy after taking
- High Indicators – six points each
    - Extensive assistance with preparing or eating meals
    - Total or extensive assistance with routine medications
    - Total, extensive, or moderate assistance with transferring
    - Total or extensive assistance with mobility
    - Total or extensive assistance with personal hygiene
    - Total assistance with supervision from Section II of the UAI
- Medium Indicator – three points each
    - Moderate assistance with personal hygiene
    - Moderate assistance with preparing or eating meals
    - Moderate assistance with mobility
    - Moderate assistance with medications
    - Moderate assistance with toileting
    - Total, extensive, or moderate assistance with dressing
    - Total, extensive, or moderate assistance with bathing
    - Extensive or moderate assistance with supervision from Section II No. 18 of the UAI

The participant must be able to reside safely and effectively in a non-institutional setting and, in the absence of A&D Waiver services, would need to reside in a NF. The average daily cost of participant waiver and other medical services must not exceed the average daily cost to Medicaid for NF care. A participant who is determined by the department to be eligible for services under the A&D Waiver may elect not to use waiver services and instead choose admission to a NF. The number of Medicaid participants to receive A&D waiver services is limited to the projected number of users in a CMS-approved waiver. Individuals applying for A&D Waiver services after the maximum is reached are placed on a waiting list to have their applications processed after the new waiver year begins.

Financial and medical redetermination for A&D waiver eligibility is conducted at least annually, or sooner at the request of the participant, Self Reliance, a provider agency, or medical provider. Redetermination assesses the participant's continued need and eligibility for A&D Waiver services. Participants who are no longer eligible or no longer need A&D Waiver services will be disenrolled. Participants are notified of the eligibility determination after any assessment, which includes an individualized explanation of the decision and how to appeal a decision.

Not all participants are eligible for all services. Services are available based on the participant's enrollment eligibility. Incarcerated individuals or otherwise ineligible non-citizens with Medicaid coverage are not eligible for these services. Before delivery of services, providers must check eligibility on the date of the service to validate coverage. Providers must maintain documentation of the eligibility check. Eligibility can be checked by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website.

See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more detail on eligibility checks.

5.3.1. References: Aged and Disabled Waiver — Participant Eligibility

(a) Idaho Waivers

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Waiver Services." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 540.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"A&D Waiver Services: Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 541. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"HCBS: Participant Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 539. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

IDAPA 16.03.05, "*Eligibility For Aid to the Aged, Blind, and Disabled (AABD)*." Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160305.pdf.

5.4. Aged and Disabled Waiver: Place of Service

Aged and Disabled (A&D) Waiver services may be provided in the participant's personal residence, a certified family home (CFH), a residential assisted living facility (RALF), day habilitation/supported employment program agency, or in the community. The following living situations are excluded as a place of service for A&D Waiver services:

- Nursing facility (NF)
- Institution for Mental Diseases (IMD)
- Intermediate care facility for individuals with intellectual disabilities (ICF/IID),
- Hospital
- Any other setting that does not meet federal home and community-based setting (HCBS) as detailed in the Home and Community-Based Setting Requirements section of this handbook

5.4.1. References: Aged and Disabled Waiver: — Place of Service

(a) Federal Regulations

"Contents of Request for a Waiver." 42 CFR §441.301 (2024), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-G/section-441.301.

"Home and Community-Based Services: Waiver Requirements ." 42 CFR §441 Subpart G. (2024), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441#subpart-G.

(b) Idaho Waivers

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(c) State Regulations

"A&D Waiver Services." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 540.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

5.5. Aged and Disabled Waiver: Individual Service Plan

The Individual Service Plan (ISP) includes all Medicaid allowable services and supports, and all natural or non-paid services and supports. The ISP is based on a person-centered planning and assessment process using the uniform assessment instrument (UAI), any other medical information that verifies the need for services, and the participant's choice of services. It describes the specific types, amounts, frequency, and duration of Medicaid reimbursed services to be provided. The ISP includes the assessed unmet need scores from the UAI and comments from the Bureau of Long Term Care (BLTC) Nurse Reviewer. The service plan must meet Home and Community-Based Person-Centered Planning Requirements.

BLTC and the participant develop the ISP for the Aged and Disabled (A&D) Waiver. Additional contributors may include:

- The agency registered nurse (RN) or qualified intellectual disabilities professional (QIDP) supervisor.
- The guardian, family, or current service providers, unless specifically excluded by the participant.
- A&D Waiver Case Manager or Dual Plan Care Coordinator/Specialist,
- Others identified by the participant.

All services provided must be based on the written ISP, and services not in the ISP or that exceed what is written in the ISP are not reimbursable by Medicaid. The ISP must be revised and updated by BLTC based upon significant changes in the participant's needs and must be re-authorized at least annually.

For fee-for-service participants, the BLTC transmits the completed UAI and BLTC Service Plan Template to the participant's selected provider. For Medicare-Medicaid Coordinated Plan (MMCP) and Idaho Medicaid Plus enrollees, the UAI and service plan template are transmitted to the participant's chosen health plan. Each provider is responsible for completing the service plan. For in-home services, the service plan must be developed by a Supervisor RN/QIDP. Providers are encouraged to use the BLTC Service Plan Template, which includes all required components. The template and provider-specific help aids are available on the Long-Term Care Provider Resources website.

For MMCP and Idaho Medicaid Plus enrollees, the Managed Care Entity (MCE) Care Coordinator/Specialist also reviews the service plan to ensure compliance with service plan requirements.

The service plan must include the following:

- Type, amount, frequency, and duration of services with the provider(s) identified.
- Support and service needs to be met by the participant's family, friends, and other community resources.
- Understandable language.
- Identify goals and desired outcomes.
- Identify risks and interventions to minimize them, including back-up plans and strategies when needed.
- Identify the plan monitor.
- Health and safety measures to be addressed within the plan year.
- Activities to promote progress, maintain functional skills, or delay or prevent regression.
- The signature of the participant or guardian and the service provider.

These signatures confirm a shared agreement on how services will be delivered in accordance with the UAI and in compliance with Home and Community-Based Services (HCBS) requirements. The completed service plan must be based on the results of the UAI conducted by the Medicaid Nurse Reviewer. The plan must include documentation of the participant's choice between waiver services and institutional placement. All services must be included on the plan and prior authorized by the BLTC or MCE. The ISP must be developed and signed by the participant or legal guardian within 30 days of the assessment or admission date, whichever is first.

The completed service plan must be revised and updated based upon treatment results or a change in the participant's needs. A new plan must be developed and approved at least annually. The plan can be adjusted during the year with an addendum based on changes in the participant's needs or demonstrated outcomes. Addendums may require additional assessments or information, and must be prior authorized by the BLTC and/or the MCE.

Providers are responsible to notify the department, medical provider, A&D case manager or MCE Care Coordinator/Specialist, and family if applicable, when any significant changes in the participant's condition are noted during service delivery. Notification must be documented in the service record. The agency supervising RN or QIDP should visit the participant to assess what functioning areas have been impacted and complete the Significant Change Form. The Significant Change Form must be signed by the agency supervisory RN or QIDP who is responsible for verifying the information on the form is correct. Upon approval of a Significant Change request the service plan must be updated accordingly. The department will not authorize an RN/QIDP supervisory visit or service plan units for completion of the Significant Change Form or resulting plan changes.

A copy of the most current service plan must be available in the participant's home. Services performed, which are not contained in the service plan, are not eligible for Medicaid payment. Failure to follow the approved service plan may result in loss of payment, provider enrollment, or other action as deemed necessary by the department.

Plans that include restrictive interventions must be approved by the department before implementation to ensure compliance with federal HCBS requirements. When an individual imposes restrictions on themselves, such as choosing not to have access to food at all hours of the day, this is not a restrictive intervention. Individuals should receive support to ensure that they make responsible decisions that align with their personal goals. These supports should be clearly outlined and monitored in the person-centered service plan. Any restrictive interventions need to be based on a specific assessed need. Parents or legal guardians cannot waive the settings requirements in any HCBS setting as a matter of personal preference. If the assessed need is based on a probation/parole requirement upon which an individual's ability to live in the community is contingent, the restrictive intervention review and approval process must be followed and agreed to by the individual. The provider is not responsible for enforcing the provisions of probation, parole, or guardianship order but should inform the participant of the potential violation and possible consequence of such action. Restraints and seclusion are prohibited and will not be approved in A&D Waiver service plans.

5.5.1. References: Aged and Disabled Waiver – Individual Service Plan

(a) Federal Regulations

"Contents of Request for a Waiver." 42 CFR §441.301 (2024), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-G/section-441.301.

(b) Idaho Waivers

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(c) State Regulations

"HCBS Person-Centered Plan Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 536. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"A&D Waiver Services: Procedural Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 543. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

5.6. Aged and Disabled Waiver: Covered Services and Limitations

All Aged and Disabled (A&D) Waiver services must meet federal home and community-based services (HCBS) requirements as outlined in the Home and Community Based Services (HCBS) section of this handbook. Details regarding the following covered A&D Waiver services can be found in the linked sections of this provider handbook.

- A&D Case Management
- Adult Day Health
- Adult Residential Care (Certified Family Homes and Residential Assisted Living Facilities)
- Attendant Care
- Chore Services
- Companion Services
- Consultation Services
- Day Habilitation
- Environmental Accessibility Adaptations
- Home Delivered Meals
- Homemaker Services
- Non-Medical Transportation
- Personal Emergency Response System
- Residential Habilitation – Supported Living
- Respite Care Services
- Skilled Nursing
- Specialized Medical Equipment and Supplies
- Supported Employment
- Transition Services

5.6.1. References: Aged and Disabled Waiver — Covered Services and Limitations

(a) Idaho Waivers

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Services: Coverage and Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 542. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"HCBS." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(3)(d) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

5.7. Aged and Disabled Waiver: Additional Documentation

Record information must be maintained for participants receiving A&D Waiver services, including the A&D Waiver Individual Service Plan . Providers must document each visit made or service provided to the participant. Documentation must record the following information:

- Date and time of visit. The time services are delivered must be identified using A.M. or P.M. unless entered using military time.
- Services provided during the visit, including activities of daily living (ADLs) identified in the assessment.
- A statement of the participant's response to the services, if appropriate to the service provided, including any changes in the participant's condition or deviations from the service plan.
- Participant's signature and date, which may be captured using a signature or unique software login.
- Direct care provider's signature and date, which may be captured using a signature or unique software login.

The provider is required to keep the original service delivery record. Service delivery documentation should not be submitted with claims. Providers must make a copy of the Service Delivery documentation available to each participant at a minimum weekly basis. Service Delivery records must either be printed and placed in the participant's home or available to the participant and/or legal representative using a secure electronic record format (e-mail, website with a login, etc.). When Service Delivery records are not printed and maintained in the participant's home, the provider must document the participant's preference for receiving Service Delivery documents using a Service Delivery Document Attestation. The attestation must include the participant's signature and date and clearly indicate the method by which the participant chose to receive their documentation and the participant's acknowledgement that their service delivery documentation is available at least on a weekly basis. The provider must keep all attestation forms available at the agency and make them available to the department if requested. Documentation job aids and templates are available for providers on the Long-Term Care Provider Resources website.

Electronic Visit Verification (EVV) Systems, if applicable, do not replace documentation requirements but may be used to generate documentation. Electronic documentation systems must meet the same minimum requirements as hard-copy service delivery documentation. Failure to maintain to such documentation will result in the recoupment of funds paid for the undocumented services. Providers must notify the plan monitor and document on the service record when any significant changes in participant's condition are noted during service delivery.

Providers must follow the requirements of the Documentation section in addition to the ones presented here.

5.7.1. References: Aged and Disabled Waiver — Additional Documentation

(a) Idaho Medicaid Publications

"Aged and Disabled (A&D) Waiver Program Companion Services." MedicAide Newsletter, June 2022, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202022%20MedicAide.pdf.

(b) Idaho Waivers

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(c) State Regulations

"A&D Waiver Services: Procedural Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 543. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Records." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 035. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

5.8. Aged and Disabled Waiver: Quality Assurance and Improvement

The department conducts audits and reviews to ensure compliance with rules and regulations. Results of a review will be transmitted to the provider within 15 business days of the review being completed. If problems are identified during the review or audit, the provider must implement a qualify improvement plan within 15 business days after the results are received and report the results to the department upon request. If the provider elects not to remediate deficiencies, the department will request the provider complete and submit a Corrective Action Plan (CAP). A CAP must be submitted to the department within 45 calendar days of receiving the CAP Request. The provider shall also submit documentation to the department to verify implementation of the CAP within 45 calendar days of the department's acceptance of the CAP.

5.8.1. References: Aged and Disabled Waiver — Quality Assurance and Improvement

(a) Idaho Waivers

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"Quality Assurance (QA)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544.04. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

5.9. Aged and Disabled Waiver: Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Providers have the burden of proof to establish entitlement to payment. Providers will be paid on a fee-for-service basis based on the type of service provided.

Where this is no Medicare equivalent, the department may promulgate rules for payment rates. These rules are subject to approval by the legislature. Aged & disabled (A&D) case management, personal care services, residential habilitation, and supported employment agencies will be cost-surveyed annually with 15% or more of responses being audited. The department will use information from cost surveys and other sources to develop payment rates. These rates are subject to approval by the legislature. Payment rates will be developed to include allocations to direct care worker wages, employee-related expenses, program-related expenses, and general and administrative costs. Providers are required to expend at least the appropriated amount allocated to direct care worker and employee-related expense categories on an annual basis. Failure to do so may result in a department-approved corrective action plan, closure of intake, or termination of the Medicaid provider agreement.

The reimbursement rates calculated for services include both services and mileage. No separate charges for mileage will be paid by the department for provider transportation to and from the participant's home or other service delivery location when the participant is provided transportation. Rate updates require legislative approval.

All services must be identified on the service plan and prior authorized by the department or MCE. Claims for Attendant Care, Homemaker, and Respite services when provided by a Personal Assistance Agency require electronic visit verification (EVV) compliance to be reimbursable.

See General Billing Instructions and the Public Schedule of Premiums and Cost-sharing Requirements for information on participant cost-sharing requirements.

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third-party resources before submitting claims to Medicaid.

5.9.1. References: Aged and Disabled Waiver — Reimbursement

(a) Idaho Waivers

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(a) State Regulations

"A&D Waiver Services: Provider Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 545. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Burden of Proof – Provider Cases." IDAPA 16.05.03, "*Contested Case Proceedings and Declaratory Rulings,"* Sec. 133. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/2023%20Archive/16/160503.pdf.

"Burden of Proof (Rule 477)." IDAPA 62.01.01, *"Idaho Rules of Administrative Procedure,"* Sec. 477. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"Mandatory Application." IDAPA 62.01.01, *"Idaho Rules of Administrative Procedure,"* Sec. 800.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

Provider Payment, Idaho Code 56-265 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265.

"Specialized Reimbursement: Electronic Visit Verification (EVV)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 054. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

6. Adult Developmental Disability Services – General Information

6.1. Adult Developmental Disability Services: Participant Eligibility

The Idaho Medicaid Enhanced Plan covers developmental disability (DD) state plan Home and Community Based Services (HCBS) option services for participants who meet DD determination standards. DD Waiver services are also covered if additional eligibility requirements are met. Prior to receiving services, an assessment will be conducted to determine participant eligibility. The assessment will include review of documentation demonstrating the participant has a qualifying DD, completion of a medical, social, and developmental assessment (MSDA), and completion of a functional assessment.

A service plan must be developed within the participant's assigned individualized budget and prior authorized by the department. Services must also meet federal HCBS requirements as outlined in the Home and Community Based Services (HCBS) section of this handbook.

Not all participants are eligible for all services. Services are available based on the participant's enrollment eligibility. Incarcerated individuals or otherwise ineligible non-citizens with Medicaid coverage are not eligible for these services.

Before delivery of services, providers must check eligibility on the date of the service to validate coverage. Providers must maintain documentation of the eligibility check. Eligibility can be checked by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website.

See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more detail on eligibility checks.

6.1.1. References: Adult Developmental Disability Services – Participant Eligibility

(a) Federal Regulations

Persons to Whom Services will be Provided, 42 CFR §136.12 (1999). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-I/subchapter-M/part-136/subpart-B/section-136.12.

(b) Idaho State Plan

ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

(c) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

(d) State Regulations

"Adult DD HCBS State Plan Option." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 590. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Services: Coverage and Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 571. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Services: Provider Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 574. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Services: Service Plan Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 573. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"DD Services: Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 560. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"HCBS." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"HCBS: Participant Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 539. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Medical, Social, and Developmental Assessment (MSDA) Summary." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.16. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

6.1.2. DD State Plan Services

To qualify for developmental disability (DD) state plan services, the department, or its designee, must find that the participant is age 18 or over and have a primary DD diagnosis as established in rule and Idaho code. Participants are notified of the eligibility determination after assessment, which includes an individualized explanation of the decision and how to appeal.

The table below outlines the DD determination standards used to determine if a participant has a primary DD diagnosis.

Developmental Disability Determination Standards	
Definition	**Standards**
"Developmental Disability" means a chronic disability of a person that appears before the age of twenty-two (22) years and:	Age of 22 means through the day before the individual's 22nd birthday.
(a) is attributable to one (1) of the following impairments: intellectual disability;	"Is attributable to an impairment" means that there is a causal relationship between the presence of an impairing condition and the developmental disability. **Age Five through Adult:** There is a presumption that an intellectual disability exists when a full-scale IQ score up to 75 exists. (IQ of seventy (70) with a standard error of measurement of five points.) **Birth to Age Five:** An IQ test score is not required below the age of five (5). In these cases, it may be necessary to rely on the results of a functional assessment. There is a presumption that an intellectual disability exists when there is a standard score of 75 or below or a delay of 30% overall.
cerebral palsy;	Medical Diagnosis that requires documentation.
epilepsy;	Medical Diagnosis that requires documentation. On medication controlled or uncontrolled. Does not include a person who is seizure-free and not on medication for three (3) years.
autism;	Includes, but does not require, the diagnosis of pervasive developmental disorder.
or other condition found to be closely related to or similar to one (1) of these impairments that requires similar treatment or services;	For related or similar conditions, documentation must be present to show the causal relationship between the impairing condition and the developmental disability. (Does not include mental illness) **Intellectual Disability:** A full-scale IQ score above 75 can in some circumstances be considered a related or similar condition to an intellectual disability when additional supporting documentation exists showing how the individual's functional limitations make their condition similar to an intellectual disability.

Developmental Disability Determination Standards	
Definition	**Standards**
	Cerebral Palsy: Conditions related or similar to cerebral palsy include disorders that cause a similar disruption in motor function. Epilepsy: Conditions related or similar to epilepsy include disorders that interrupt consciousness.
or is attributable to dyslexia resulting from such impairments;	
AND	
(b) results in substantial functional limitations in three (3) or more of the following major life activities:	"Results in" means that the substantial limitation must be because of the impairment. A "substantial" limitation is one in which the total effect of the limitation results in the need for a "combination and sequence of special interdisciplinary, or generic care, treatment or other services that need to be individually planned and coordinated." Listed below are standards for substantial functional limitations in each major life area. **Age Three through Adult:** A score of two standard deviations below the mean creates a presumption of a functional limitation. **Birth to Age Three:** The following criteria must be utilized to determine substantial functional limitations for children under three: The child scores 30% below age norm; or The child exhibits a six month delay; or The child scores two standard deviations below the mean.
self-care;	**Adult:** A substantial functional limitation is manifest when the person requires physical or non-physical assistance in performing eating, hygiene, grooming, or health care skills, or when the time required for a person to perform these skills him/her self is so substantial as to impair their ability to conduct other activities of daily living or retain employment. **Birth to Age 21:** A functional limitation is manifest when the child's skills are limited according to age-appropriate responses such that the parent, caregiver, or school personnel is required to provide care that is substantially beyond that typically required for a child of the same age (such as excessive time lifting, diapering, supervision).

Developmental Disability Determination Standards	
Definition	**Standards**
receptive and expressive language;	**Age Three through Adult:** A substantial functional limitation is manifest when a person is unable to communicate effectively without the aid of a third person, a person with special skills, or without an assistive device (such as sign language). **Birth to Age Three:** A substantial functional limitation is manifest when they have been diagnosed by a qualified professional who determines that the child performs 30% below age norm (adjusted for prematurity up to two years) or demonstrates at least two standard deviations below the mean in either area or one and a half below in both areas of language development.
learning;	**Birth through Adult:** A substantial functional limitation is manifest when cognition, retention, reasoning, visual or aural communications, or other learning processes or mechanisms are impaired to the extent that special (interventions that are beyond those that an individual normally needs to learn) intervention is required for the development of social, self-care, language, academic, or vocational skills.
mobility;	**Adult:** A substantial functional limitation is manifest when fine or gross motor skills are impaired to the extent that the assistance of another person or an assistive device is required for movement from place to place. **Birth to Age 21:** A substantial limitation would be measured by an age-appropriate instrument that compares the child's skills for postural control and movement and coordinated use of the small muscles with those skills expected of children of the same age.
self-direction;	**Adult:** A substantial functional limitation is manifest when a person requires assistance in managing their personal finances, protecting their self-interest, or making decisions that may affect their well-being. **Birth to Age 21:** A substantial limitation is manifest when the child is unable to help themself or cooperate with others age-appropriate assistance to meet personal needs, learn new skills, follow rules, and adapt to environments.

Developmental Disability Determination Standards	
Definition	**Standards**
capacity for independent living; or	**Adult:** A substantial functional limitation is manifest when, for a person's own safety or well-being, supervision or assistance is required, at least on a daily basis, in the performance of health maintenance, housekeeping, budgeting, or leisure time activities and in the utilization of community resources. **Birth to Age 21:** A substantial limitation would be measured by an age- appropriate instrument that compares the child's personal independence and social responsibility expected of children of comparable age and cultural group.
economic self-sufficiency;	**Adult:** A substantial functional limitation is manifest when a person is unable to perform the tasks necessary for regular employment or is limited in productive capacity to the extent that their earned annual income, after extraordinary expenses occasioned by the disability, is insufficient for self-support. **Age Five to Age 21:** Use the pre-vocational area of a standardized functional assessment to document a limitation in this area. **Birth to Age Five:** A substantial limitation in this area is evidenced by the child's eligibility for social security insurance (SSI), early intervention, or early childhood special education under the Individuals with Disabilities Education Act (IDEA).
AND	
(c) reflects the needs for a combination and sequence of special, interdisciplinary or generic care, treatment or other services that are of life-long or extended duration and individually planned and coordinated.	**Age Five through Adult:** Life-long or extended duration means the developmental disability is one that has the reasonable likelihood of continuing for a protracted period of time, including a reasonable likelihood that it will continue throughout life. **Birth to Age Five:** The expected duration may be frequently unclear. Therefore, determination of eligibility by a multi-disciplinary team for early intervention services through social security insurance (SSI), an IFSP, child study team or early childhood special education services through an individual education plan (IEP) will be an indicator of this criteria.

An appropriate professional must verify tests over one year old reflect the current functional status of the individual. Additionally, a history and physical is required within the year prior to service initiation and must be updated annually.

(a) References: DD State Plan Services

(i) Idaho State Plan

ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

(ii) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

(iii) State Regulations

"Adult DD HCBS State Plan Option: Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 591. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Services: Eligibility Determination." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 569. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Services: Service Plan Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 573. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"DD Determination Standards: Participant Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 561. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"DD Determination Standards: Test Instruments." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 563. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Definitions." Idaho Code 66-402 (2025). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title66/T66CH4/SECT66-402.

"Developmental Disability (DD)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 005.18. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

IDAPA 16.03.05, "*Eligibility For Aid to the Aged, Blind, and Disabled (AABD)*." Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160305.pdf.

6.1.3. DD Waiver Services

Adult Developmental Disability (DD) Waiver services are available to eligible participants to prevent unnecessary institutionalization, allow the greatest degree of independence possible, enhance quality of life, encourage individual choice, and achieve and maintain community integration. Participants must meet financial eligibility for DD Waiver services as determined by the Self Reliance division of the department. In addition to meeting the requirements for DD State Plan Services eligibility, participants must meet intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care criteria to qualify to receive DD Waiver services. Using a department-approved assessment tool, the department must determine that the participant qualifies for ICF/IID level of care based on a functional limitation, maladaptive behavior, a combination of both, or medical condition. The department currently uses the Scales of Independent Behavior-Revised (SIB-R) to determine ICF/IID level of care. A participant qualifies by meeting one of the following requirements:

- Functional Limitation: Age equivalency composite score of eight years and zero months or less
- Maladaptive Behavior: General maladaptive index score of -22 or less
- Combination Functional Limitation and Maladaptive Behavior: Age equivalency composite score of eight and a half years and a general maladaptive index of -17 or less
- Medical Condition: Medical condition significantly affecting the participant's functional level, and it can be determined that they need the level of services provided in an ICF/IID

Participants must also require active treatment. Active treatment includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services directed toward the acquisition of:

- The behaviors necessary to function with as much self-determination and independence as possible, and
- The prevention or deceleration of regression or loss of current optimal functional status.

Active treatment does not include services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous active treatment program.

To qualify for DD Waiver services, the participant must be able to reside safely and effectively in a non-institutional setting and, in the absence of DD Waiver services, would need to reside in an ICF/IID. The average annual cost of participant waiver and other medical services must not exceed the average annual cost to Medicaid for ICF/IID care and other medical costs. A participant who is determined by the department to be eligible for services under the DD Waiver may elect not to use waiver services and instead choose admission to an ICF/IID. The number of Medicaid participants to receive DD Waiver services is limited to the projected number of users in a CMS-approved waiver. Individuals applying for DD Waiver services after the maximum is reached are placed on a waiting list to have their applications processed after March 31st for the new DD Waiver year.

Financial and medical redetermination for DD Waiver eligibility is conducted at least annually, or sooner at the request of the participant, the department, a provider agency, or medical provider. Redetermination assesses if the participant's continued need and eligibility for DD Waiver services. Participants who are no longer eligible or no longer need DD Waiver services will be disenrolled from the waiver program, and have thirty (30) days from the determination to transition to other community supports. Participants are notified of the eligibility

determination after any assessment, which includes an individualized explanation of the decision and how to appeal a decision.

(a) References: DD Waiver

(i) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

(ii) State Regulations

"Adult DD Services: Service Plan Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 573. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Waiver Services." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 610. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Waiver Services: Participant Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 611. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"DD Determination Standards: Participant Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 561. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"HCBS: Participant Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 539. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"ICF/IID Eligibility Criteria." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 501.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

6.2. Adult Developmental Disability Services: Place of Service

Developmental Disability (DD) services may be provided in the participant's personal residence, a certified family home, day habilitation/supported employment program, or community. The following living situations are specifically excluded as a place of service for DD services:

- Skilled or Intermediate Care Facility
- Nursing Facility
- Institution for Mental Diseases
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- Hospital
- Residential Assisted Living Facility
- Any other setting that does not meet federal home and community-based services (HCBS) as detailed in the Home and Community-Based Setting Requirements section of this handbook.

6.2.1. References: Adult Developmental Disability Services – Place of Service

(a) Federal Regulations

"Contents of Request for a Waiver." 42 CFR §441.301 (2024), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-G/section-441.301.

"State Plan Home and Community-Based Services Under Section 1915(i)(1) of the Act." 42 CFR §441.710 (2025), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-M/section-441.710.

(b) Idaho State Plan

ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

(c) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

(d) State Regulations

"Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 612.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

6.3. DD Service Plan

All developmental disability (DD) services must be within the participant's individualized budget and provided based on a service plan written by a plan developer and approved by the department, unless authorized over budget through the exception review process. The department will notify the participant of its decision on their service plan, including and individualized explanation and how to appeal a decision. Authorized services must be delivered by providers who are selected by the participant.

The medical, social, and developmental assessment (MSDA) and other assessments are used in the person-centered planning meeting to develop a person-centered plan that includes the participant's medical conditions, risk of deterioration, living conditions, and individual goals. Behavioral or psychiatric needs also require special consideration. Prior to plan development, the plan developer must document they provided information and support to the participant to maximize their ability to make informed choices regarding the services and supports they receive and from whom. Planning team members must each indicate whether they believe the service plan meets the needs of the participant and represents the participant's choice. If there is a conflict that cannot be resolved among person-centered planning members, or if a member does not believe the plan meets the participant's needs or represents the participant's choice, the service plan or amendment may be referred to the department to negotiate a resolution.

A service plan may be adjusted during the year with an addendum to the plan. These adjustments must be based on a change to a cost, addition of a service or increase to a service, change of provider, addition of a restrictive intervention, or addition or increase of alone time. Additional assessments or information may be clinically necessary. Adjustment of the service plan is subject to prior authorization by the department.

A participant's service plan must be re-authorized annually. Prior to submission, the plan developer must notify the providers who appear on the service plan of the annual review date, obtain a copy of the most recent provider status review, and convene the person-centered planning team to develop a new service plan. The service plan must:

- Identify the type of service to be delivered, goals to be addressed within the plan year, frequency of supports and services, and identified service providers.
- Include activities to promote progress, maintain functional skills, or delay or prevent regression.
- Identify services and supports available outside of Medicaid-funded services that can help the participant meet desired goals.

The annual service plan must be submitted at least 45 days prior to the expiration of the existing plan, or the requested start date for an initial plan. Addendums must be submitted at least 15 days prior to the requested start date. Expedited review of addendums and initial plans outside of these timeframes can be requested for health and safety reasons. The request for expedited review must demonstrate how the requested services will address the health or safety risk.

The plan developer must ensure no duplication of services. Services are duplicative when goals are not separate and unique to each service provided, or when more than one service is provided at the same time, unless otherwise authorized. Duplicative services will not be authorized.

A plan developer is defined as a paid or non-paid person identified by the participant who is responsible for developing a service plan and subsequent addenda that cover all services and

supports, based on a person-centered planning process. Paid plan developers must be employed as a service coordinator and cannot be a paraprofessional. The following cannot be a paid plan developer:

- Providers of direct services to the participant, or be employed by providers for the participant;
- Individuals related to the participant by blood or marriage;
- Individuals who make financial or health-related decisions for the participant;
- Individuals who hold a financial interest in any agency or entity paid to provide care for the participant; or
- The assessor.

The service plan must meet Home and Community-Based Person-Centered Planning Requirements. The plan must be developed with the participant and their person-centered planning team. The person-centered planning team may include family members, a guardian, or individuals who are significant to the participant. Unless the participant has a guardian with appropriate authority, the participant must make decisions regarding the type and amount of services required. Plans that include restrictive interventions must be approved by the department before implementation to ensure compliance with federal home and community-based services (HCBS) requirements. When an individual imposes restrictions on themselves, such as choosing not to have access to food at all hours of the day, this is not a restrictive intervention. Individuals should receive support to ensure that they make responsible decisions that align with their personal goals. These supports should be clearly outlined and monitored in the person-centered service plan.

All restrictive interventions must be identified, agreed to, and documented on a service plan through the person-centered planning process. If the HCBS quality poses a health or safety risk to the participant or others, goals must be identified with strategies to mitigate the risk in the person-centered plan and agreed to by the participant or their guardian. The restrictive intervention shall be unique to the participant based on their needs. Written consent and a behavior change plan is also necessary for the use of restrictive interventions. A written behavior change implementation plan is developed by the participant, their team, and the Qualified Intellectual Disabilities Professional (QIDP), or behavior consultant/crisis management provider. The written behavior change plan must describe how the restrictive intervention will be used. The provider shall use positive behavior interventions prior to the use of restrictive interventions. Restrictive interventions may only be used when documented to be the least restrictive option for the participant to live safely in the community. Personnel involved in restrictive interventions must be trained to meet any health, behavioral or medical requirements of the participant and have appropriate supervision and oversight of a provider with the qualifications of a QIDP or higher. All restrictive intervention plans must be prior authorized by the department prior to implementation. Setting qualities warranting risk mitigation include full integration and access to the community, including:

- Freedom to control personal resources,
- Freedom to work in competitive integrated settings,
- Freedom to engage in community life,
- Freedom to receive services in the community,
- Right to privacy,
- Autonomy in making choices, including daily activities, physical environment, and with whom to interact, and

- Opportunities for choice regarding services and supports.

Setting qualities that may warrant an exception include:

- Lockable bedroom or living unit doors,
- Choice of roommate,
- Freedom to furnish and decorate living spaces,
- Freedom and support to control schedules and activities,
- Access to food,
- Ability to have visitors at any time, and
- Physically accessible setting.

Parents or legal guardians cannot waive the settings requirements in any HCBS setting as a matter of personal preference. If the restrictive intervention is based on a probation/parole requirement that provider will implement the restrictive intervention review and approval process, which must be followed and agreed to by the individual. Idaho Medicaid does not require the provider enforce the provisions of probation, parole or guardianship order but should inform the participant of the potential violation and possible consequence of such action. Restrictive interventions in non-HCBS settings do not require prior authorization.

All restraints must be identified, agreed to, and documented on a service plan through the person-centered planning process. Written consent and a behavior change plan is also necessary for the use of restraints. A written behavior change implementation plan is developed by the participant, their team, QIDP or the behavior consultant/crisis management provider. The written behavior change plan must describe how the restraint will be used. The provider shall use positive behavior interventions prior to the use of restraints, other than physical restraint in an emergency, as documented in the written behavior change plan. Restraints may only be used when documented in the written behavior change plan to be the least restrictive option for the participant to live safely in the community. Personnel involved in restraints must be trained to meet any health, behavioral or medical requirements of the participant and have appropriate supervision and oversight of a provider with the qualifications of a QIDP or higher. All restraint plans must be prior authorized by the department prior to implementation. At a minimum the use of restraints must follow these criteria:

- Chemical restraint shall be used only when authorized by an attending physician.
- Mechanical restraint may be used for medical purposes only when authorized by the attending physician. Mechanical restraints may only be used for non-medical purposes when authorized by a QIDP or behavior consultant/crisis management provider.
- Non-emergency physical restraint may be used only when authorized by a QIDP or behavior consultant/crisis management provider. Emergency physical restraint may be used without a written and approved behavior change plan in isolated incidents to prevent injury to the participant or others. Documentation is required of any emergency use.
- Seclusion may be used only when authorized by a QIDP or behavior consultant/crisis management provider.

The department will distribute the service plan or addendum to all providers responsible to complete Implementation Plans and Provider Status Reviews. These providers must sign the plan or addendum indicating they have reviewed the plan or addendum and will deliver services accordingly. The plan developer must distribute a copy of the service plan or addendum, in whole or in part, to any other provider identified by the participant during the

person-centered planning process. If the department has already provided the plan to a provider, the plan developer does not need to distribute another copy to that provider.

Plan developers are also required to monitor the plan. The plan monitor must be a service coordinator. The planning team must identify the frequency of monitoring, which must be face-to-face at least every 90 days and may occur via synchronous interaction virtual care. Plan monitoring must include a review of the service plan to identify the status of programs and changes if needed, contact with service providers to identify barriers to service provision, discuss with participant satisfaction regarding quality and quantity of services, and review of provider status reviews. Plan monitors must immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, and injuries of unknown origin to the agency administrator, the department, the adult protection authority, and any other entity required under state or federal law.

6.3.1. References: DD Service Plan

(a) Federal Regulations

"Contents of Request for a Waiver." 42 CFR §441.301 (2025), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-G/section-441.301.

"State Plan Home and Community-Based Services Under Section 1915(i)(1) of the Act." 42 CFR §441.710 (2025), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-M/section-441.710.

(b) Idaho State Plan

ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

(c) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

(d) State Regulations

"Adult DD Services: Coverage and Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 571. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Services: Service Plan Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 573. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Waiver Services: Procedural Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 613. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"HCBS Person-Centered Plan Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 536. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Medical, Social, and Developmental Assessment (MSDA) Summary." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.16. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Plan Developer." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 007.04. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Plan Monitor." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 007.05. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Service Coordination: Procedural Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 633. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

6.4. Implementation Plans and Provider Status Reviews

Providers of the following developmental disability (DD) services are responsible for developing an implementation plan:

- Developmental Therapy
- Residential Habilitation (Supported Living and Certified Family Home)
- Supported Employment
- Skilled Nursing
- Behavioral Consultation/Crisis Management

Upon receiving the authorized service plan or subsequent addenda, providers must sign the plan indicating they will deliver services according to the service plan/addendum and consistent with home and community-based requirements and develop an implementation plan. Implementation plans must identify specific objectives that demonstrate how the provider will assist the participant to meet the participant's goals and needs identified in the service plan/addendum. The implementation plan must be completed within 14 days of or receiving the service plan/addendum or the service start date (whichever is later) and revised whenever participant needs change. Documentation of implementation plan changes must be included in the participant record and include the reason for the change, documentation of coordination with other service providers (where applicable), the date the change was made, and the name of the person making the change complete with the date and title.

Providers listed above must submit provider status reviews six months after the start date of the service plan and annually to the plan monitor. The semi-annual review is due 15 days after the end of the six month period. The annual review is due 30 days after plan's end. Provider status reviews must include the status of supports and services to identify progress, maintenance, or delay or prevention of regression.

Provider Implementation Plans and Provider Status Reviews for Certified Family Home (CFH) services are completed by the CFH Program Coordinator. See the Certified Family Home, Idaho Medicaid Provider Handbook for additional details.

6.4.1. References: Implementation Plans and Provider Status Reviews

(a) Federal Regulations

"Contents of request for a waiver." 42 CFR §441.301 (2024), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-G/section-441.301.

"State plan home and community-based services under section 1915(i)(1) of the Act." 42 CFR §441.710 (2014), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-M/section-441.710.

(b) Idaho State Plan

ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

(c) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services,

https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

(d) State Regulations

"Adult DD Services: Service Plan Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 573. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Developmental Therapy: Individual Service Plan (ISP) Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 603. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

6.5. Adult Developmental Disability Services: Covered Services and Limitations

All developmental disability (DD) services must meet federal home and community-based service (HCBS) requirements as outlined in the Home and Community Based Services (HCBS) section of this handbook. Developmental Disability (DD) services may be provided in the participant's personal residence, a certified family home, day habilitation/supported employment program agency, or community. The following living situations are specifically excluded as a place of service for DD services:

- Nursing Facility
- Institution for Mental Diseases
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- Hospital
- Residential Assisted Living Facility
- Any other setting that does not meet federal home and community-based services (HCBS) as detailed in the Home and Community-Based Setting Requirements section of this handbook.

Details regarding the following covered DD services can be found in the linked sections of this provider handbook. For DD waiver participant who wish to self-direct their services, visit the Self-Directed Services website for more information.

DD State Plan:

- Developmental Therapy
- Community Crisis Supports

DD Waiver:

- Adult Day Health
- Behavior Consultation/Crisis Management
- Certified Family Home
- Chore Services
- Environmental Accessibility Adaptations
- Home Delivered Meals
- Non-Medical Transportation
- Personal Emergency Response System
- Respite
- Skilled Nursing
- Specialized Medical Equipment and Supplies
- Supported Employment
- Supported Living
- Transition Services

Services must provide the "right care;" accepted treatment for defined diagnoses, functional needs, and abilities to achieve the desired outcome. The right care is consistent with best practice and continuous quality improvement. Services must be delivered in the "right place;" the most integrated setting in which they normally occur, based on the participant's choice to promote independence. Services must be purchased at the "right price." The selected service must be the most integrated, least expensive, and sufficiently intensive to address the participant's needs. The reimbursement amount is based on the individual's needs for services and supports as identified in the assessment. The "right outcomes" for the service are required. Services must be based on an assessed need to ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression.

All services must be identified on the service plan and prior authorized by the department. The prior authorization process is to ensure the provision of right care, in the right place, at the right price, and with the right outcomes.

All providers must immediately report all allegations, suspicions, or observations of mistreatment, abuse, neglect, or exploitation, and injuries of unknown origin to the agency administrator, the department, the adult protection authority, and any other required entity.

6.5.1. References: Adult Developmental Disability Services – Covered Services and Limitations

(a) Idaho State Plan

ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

(b) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

(c) State Regulations

"Adult DD Services: Procedural Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 572. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"HCBS." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

6.6. Adult Developmental Disability Services: Additional Documentation

Providers must follow the requirements of the Documentation section in addition to the ones presented here. Record information must be maintained on all participants receiving developmental disability (DD) services, including the DD Service Plan and required Implementation Plans and Provider Status Reviews. Direct service provider records include written documentation of each visit made or service provided to the participant. Documentation must record the following information:

- Service date.
- Services provided during the visit.
- A statement of the participant's response to the services, if appropriate to the service provided, including any changes in the participant's condition.
- Length of visit, including time in and time out, if appropriate to the service provided.
- Unless the participant is determined by the service coordinator to be unable to do so, the delivery will be verified by the participant as evidenced by their signature on the service record.

A copy of the above information must be maintained in the participant's home unless authorized to be kept elsewhere by the department. Failure to maintain such documentation will result in the recoupment of funds paid for the undocumented services. Providers must notify the plan monitor and document on the service record when any significant changes in participant's condition are noted during service delivery.

Signatures by guardians or conservators for all Adult DD service documents, including application, assessment, and plan/addendum submission and prior authorization, must follow Idaho law. All guardianships and conservatorships must be issued by an Idaho court, transferred from another court with jurisdiction accepted by Idaho, or registered in the Idaho state courts. If the guardianship or conservatorship originated in another state (foreign guardianship/conservatorship), Idaho law requires it be registered or transferred with an Idaho court assuming jurisdiction. In order to ensure all actions that are taken by the department are legal and enforceable, the following will apply to all individuals in the Adult DD program who have a foreign guardianship/conservatorship:

- Guardians/conservators holding foreign guardianships/conservatorships must register and/or transfer that guardianship/conservatorship to Idaho courts.
- Participants with foreign guardianship/conservatorship must sign all documents that require signature until the foreign guardianship has been registered and/or transferred to Idaho courts.

Additionally, in cases with two guardians or conservators only one guardian/conservator's signature is required on documents unless the appointing order specifies that decisions must be made jointly. If the appointing order specifies that decisions must be made jointly, then both signatures are required.

6.6.1. References: Adult Developmental Disability Services: Additional Documentation

(a) Idaho Medicaid Publications

"Adult DD Signature Requirements." MedicAide Newsletter, November 2024, https://www.idmedicaid.com/MedicAide%20Newsletters/November%202024%20MedicAide.pdf.

"Idaho Guardianship/Conservatorship Laws for Adult DD Signature Requirements." MedicAide Newsletter, January 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202023%20MedicAide.pdf.

(b) Idaho State Plan

ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

(c) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

(d) State Regulations

"Adult DD Services: Service Plan Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 573. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Waiver Services: Procedural Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 613. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Developmental Therapy: Procedural Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 605. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Records." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 035. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Uniform Adult Guardianship and Protective Proceedings Jurisdiction Act." Idaho Code Title 15, Chapter 13 (2025). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title15/T15CH13.

6.7. Adult Developmental Disability Services: Quality Assurance

The department conducts audits and reviews to assure compliance with statute and regulations. If problems are identified during the review or audit, the provider must implement a corrective action plan within 45 days after the results are received. The department may gather and utilize information from providers to evaluate customer and participant satisfaction, participant experience related to home and community-based setting qualities, outcomes monitoring, care management, quality assurance, quality improvement activities, and health and safety. These findings may lead to quality improvement activities to improve provider processes and outcomes for participants. Additionally, the department will obtain the necessary information to determine that participants continue to meet eligibility criteria, participant rights are maintained, services continue to be clinically necessary, services continue to be the choice of the participant, services support participant integration, and services constitute appropriate care to warrant continued authorization or need for the service.

Participant complaints about program operations, quality of services, or other relevant concerns may be referred to the Division of Medicaid and will be tracked and routed for follow-up as warranted. Reviewers finding suspected abuse, fraud, or substandard care must refer their findings for investigation to the department and other regulatory or law enforcement agencies for investigation.

6.7.1. References: Adult Developmental Disability Services – Quality Assurance

(a) Idaho State Plan

ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

(b) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

(c) State Regulations

"DD Services: Quality Improvement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 564. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

6.8. Adult Developmental Disability Services: Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Providers have the burden of proof to establish entitlement to payment. Idaho Medicaid reimburses health care provider services on a fee-for-service basis based on the type of service provided as established by the department and based on a participant's budget. Usual and customary fees are paid up to the Medicaid maximum allowance listed in the Adult Developmental Disabilities Waiver Fee Schedule. Rate updates require legislative approval.

Participant budgets are redetermined annually. Participants are notified of the prior authorization decision, which includes an individualized explanation of the decision and how to appeal a decision. Service plans or addendum that request services exceeding the participant's assigned budget are reviewed by the department during an exception review. An exception review is a clinical review of a plan that falls outside the established standards due to a health or safety risk. Requests are authorized when the services requested on the plan are needed to mitigate a documented health risk or safety risk, or the participant needs supported employment, and the service puts the service plan over the assigned budget.

Health includes the prevention of one's physical or mental health condition, cognitive functioning, or an increase in maladaptive behavior, and is related to the effects of one's disability. Health risks must be established through written documentation and current treatment recommendations from a healthcare provider whose recommendation is within the scope of their license. Such documentation must establish all the following:

- The current physical or mental condition, or cognitive functioning that will likely deteriorate, or the current maladaptive behavior(s) that will likely increase; and
- The specific supports or services being requested, including type and frequency if applicable, that will address the identified need.

To comply with the documentation requirement, the department may require the participant to obtain additional consultation or assessment, available to the participant and covered by Medicaid, from a professional licensed by the State of Idaho acting within the scope of their license. If the department requires additional consultation or assessment, the department will specify the nature of the consultation or assessment and the necessary documentation.

Safety includes the prevention of criminal activity, destruction of property, or injury or harm to self or others. Safety risks must be documented by:

- Current incident reports;
- Police reports;
- Assessments from a provider licensed in Idaho and whose assessment is within the scope of their license; or
- Status reports and implementation plans that reflect the type and frequency of intervention(s) in place to prevent the risk and the participant's progress under such intervention(s).

The documentation of a safety risk must establish all of the following:

- An imminent or likely safety risk; and
- The specific supports or services that are being requested, including the type and frequency if applicable, that are likely to prevent that risk.

The reimbursement rates calculated for services include both services and mileage. No separate charges for mileage will be paid by the department for provider transportation to and from the participant's home or other service delivery location when the participant is

provided transportation. The department will review provider reimbursement rates to ensure compliance with federal regulations to assure payments are consistent with efficiency, economy, quality of care, and safeguard against unnecessary utilization of care and services.

Where this is no Medicare equivalent, the department may promulgate rules for payment rates. These rules are subject to approval by the legislature. Residential habilitation, developmental disability agency services, and community-supported employment, will be cost-surveyed annually with 15% or more of responses being audited. The department will use information from cost surveys and other sources to develop payment rates. These rates are subject to approval by the legislature. Payment rates will be developed to include allocations to direct care worker wages, employee-related expenses, program-related expenses, and general and administrative costs. Providers are required to expend at least the appropriated amount allocated to direct care worker and employee-related expense categories on an annual basis. Failure to do so may result in a department-approved corrective action plan, closure of intake, or termination of the Medicaid provider agreement.

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third-party resources before submitting claims to Medicaid.

See the Public Schedule of Premiums and Cost-sharing Requirements for information on cost-sharing requirements. Idaho Native American Indians who are accessing care from Indian Health facilities or show they are eligible and referred through contract health services are exempted from cost sharing requirements. See the Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable.

6.8.1. References: Adult Developmental Disability Services – Reimbursement

(a) Idaho State Plan

ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

(b) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

(c) State Regulations

"Adult DD Services: Coverage and Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 571. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Services: Definitions." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 568. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Services: Provider Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 574. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Services: Service Plan Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 573. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Waiver Services: Provider Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 615. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Burden of Proof – Provider Cases." IDAPA 16.05.03, "*Contested Case Proceedings and Declaratory Rulings,"* Sec. 133. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/2023%20Archive/16/160503.pdf.

"Burden of Proof (Rule 477)." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 477. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"DD Services: Administrative Appeals." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 566. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"DD Services: Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 560. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"General Payment Procedures." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 030. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Mandatory Application." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 800.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

Provider Payment, Idaho Code 56-265 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265.

6.8.2. Billing Date Spans

Dates of service must be within the Sunday through Saturday calendar week on a single claim. The calendar week begins at 12:00 a.m. on Sunday and ends at 11:59 p.m. on Saturday. Failure to comply with the Sunday through Saturday billing will result in claims being denied. In addition, one detail line on a DD claim form cannot span more than one calendar month. If the end of the month falls in the middle of a week two separate claims must be used.

In the example below, the last week in August begins Sunday, August 26th, and ends Saturday, September 1st. Two separate claims must be entered for this week. One claim will have service dates of 08/26 through 08/31. The second claim will have service dates of 09/01 through 09/01. Consecutive dates of service that fall in one calendar week (Sunday through Saturday) can be billed on one claim as long as the same quantity of services have been provided each day.

Calendar Billing Example						
Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
			Aug. 1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	Sept. 1

7. Adult Day Health

7.1. Adult Day Health: Provider Qualifications

Providers must be able to provide care and supervision appropriate to the participant's needs as identified in the service plan and be free from communicable disease. Services provided in a facility must meet the building and health standards for Developmental Disabilities Agencies (DDA). Providers who provide direct care and services must receive a clearance from an Idaho Department of Health and Welfare background check. The provider must be enrolled with Idaho Medicaid prior to submitting claims for services and sign the provider agreement with adult day health additional terms.

For Aged and Disabled (A&D) Waiver participants, these services can be provided by an Adult Day Health agency, a Certified Family Home (CFH), a DDA, or a Residential Assisted Living Facility (RALF) with a signed Additional Terms – Adult Day Health Provider Agreement. Additionally, providers must meet the training requirements in the Idaho Provider Training Matrix. These requirements can be met by formal training or by demonstrated competency. Direct care workers cannot be the participant's spouse. See the Certified Family Homes, Idaho Medicaid Provider Handbook for additional CFH provider requirements. See the Long Term Care Facility Services, Idaho Medicaid Provider Handbook for additional RALF provider requirements.

For Developmental Disabilities (DD) Waiver participants, these services can be provided by an Individual or Agency provider. Providers must follow the requirements of the General Provider Qualifications section in addition to the ones presented here.

7.1.1. References: Adult Day Health – Provider Qualifications

(a) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Waiver Services: Provider Qualifications and Duties." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult Day Health." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544.10. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult Day Health." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 614.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Background Checks," Idaho Code Title 56, Chapter 27 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH27/SECT56-27.

"Individual Provider Requirements." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individuals Subject to a Background Check." IDAPA 16.05.06, "*Criminal History and Background Checks*," Sec. 100. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Provider." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Providers Subject to Background Check Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 003.04. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

7.2. Adult Day Health: Participant Eligibility

Participants are eligible to receive adult day health when they meet A&D Waiver Eligibility or DD Waiver Eligibility requirements. Not all participants are eligible for all services. Services are available based on the participant's enrollment eligibility. Incarcerated individuals or otherwise ineligible non-citizens with Medicaid coverage are not eligible for these services.

Before delivery of services, providers must check eligibility on the date of the service to validate coverage and prior authorization for Adult Day Health services. Providers must maintain documentation of the eligibility check. Eligibility can be checked by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website.

See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more detail on eligibility checks.

7.2.1. References: Adult Day Health – Participant Eligibility

(a) Federal Regulations

Persons to Whom Services will be Provided, 42 CFR §136.12 (1999). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-I/subchapter-M/part-136/subpart-B/section-136.12.

(b) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(c) State Regulations

"Adult DD Waiver Services: Participant Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 611. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"A&D Waiver Services: Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 541. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"*Eligibility for Aid to the Aged, Blind, and Disabled (AABD)*." Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160305.pdf.

"Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

7.3. Adult Day Health: Covered Services and Limitations

Adult day health is a supervised, structured service provided outside the home of the participant in a non-institutional, community-based setting. It encompasses health services, social services, recreation, supervision for safety, and assistance with activities of daily living (ADL) needed to ensure optimal functioning of the participant. Adult day health services do not include room and board payments. Adult day health must meet federal Home and Community Based Services (HCBS) requirements as outlined in the Home and Community Based Services (HCBS) section of this handbook.

For Developmental Disability (DD) Waiver participants, adult day health is limited to 30 hours per week. The combination of adult day health and developmental therapy cannot exceed 30 hours per week. Additionally, the combination of adult day health, supported employment, and developmental therapy cannot exceed 40 hours per week.

Providers must ensure all quality assurance requirements for Aged & Disabled (A&D) Waiver and adult DD as applicable are met.

7.3.1. References: Adult Day Health – Covered Services and Limitations

(a) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"Adult Day Care," Idaho Code 67-5006(5), "*Definitions.*" (2011). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/title67/t67ch50/sect67-5006.

"Adult Day Health." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 542.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult Day Health." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544.10. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult Day Health." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 612.12. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult Day Health (ADH)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 005.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Waiver Services: Coverage and Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 612. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"HCBS." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 602.02.b. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

7.4. Adult Day Health: Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Providers have the burden of proof to establish entitlement to payment. Idaho Medicaid reimburses adult day health services on a fee-for-service basis. This service requires prior authorization. The Adult DD Services Reimbursement section of this handbook and the A&D Waiver Services Reimbursement section of this handbook detail the reimbursement requirements for adult day health. Rate updates require legislative approval.

Reimbursement for a high or intense level of supported living services includes adult day health and is not separately reimbursable. For participants receiving hourly support, the combination of hourly supported living, developmental therapy, supported employment, and adult day health cannot exceed the maximum set daily rate for H2022 – Daily Supported Living Services – High Support, except when all of the following are present:

- A participant is eligible for high support.
- Supported employment is in the service plan causing the daily limit to be exceeded.
- Documentation that the Person-Centered Planning team explored other lower-cost options and supports.
- A participant's health and safety needs can be met using hourly services.

Adult day health services provided to DD waiver participants are prior authorized by the Bureau of Developmental Disability Services (BDDS). Adult day health services provided to A&D waiver participants are prior authorized by the Bureau of Long Term Care (BLTC).

Enter the appropriate ICD-10-CM: Z74.2, "Need for assistance at home and no other household member able to render care," code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Adult Day Health can only be provided in the following POS:

12 Home
99 Other (Community)

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Adult Day Health Billing Code	
HCPCS	**Description**
S5100	Adult Day Health, 1 Unit = 15 minutes

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third-party resources before submitting claims to Medicaid. See the Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable including co-payment.

7.4.1. References: Adult Day Health – Reimbursement

(a) Idaho Medicaid Publications

"New Daily Spending Cap for Hourly Supported Living – Effective October 1, 2024." *Information Release MA24-23 (9/24/2024)*. Division of Medicaid, Department of Health and Welfare, State of Idaho,

https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=31325&dbid=0&repo=PUBLIC-DOCUMENTS.

(b) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(c) State Regulations

"A&D Waiver Services: Provider Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 545. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Waiver Services: Provider Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 615. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Burden of Proof – Provider Cases." IDAPA 16.05.03, "*Contested Case Proceedings and Declaratory Rulings,"* Sec. 133. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/2023%20Archive/16/160503.pdf.

"Burden of Proof (Rule 477)." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 477. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"General Payment Procedures." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 030. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Mandatory Application." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 800.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

Provider Payment, Idaho Code 56-265 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265.

"Supported Living Levels of Support." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 574.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

8. Adult Residential Care

See the Certified Family Homes, Idaho Medicaid Provider Handbook for information and requirements for services provided in a CFH reimbursed by Medicaid.

See the Long-Term Care Facility Services, Idaho Medicaid Provider Handbook for information and requirements for services provided in a Residential Assisted Living Facility (RALF).

9. Aged and Disabled Case Management

9.1. Aged and Disabled Case Management: Provider Qualifications

Aged and Disabled (A&D) case management must be provided by case managers employed by a Personal Assistance Agency (PAA) or a Service Coordination Agency. Providers must complete a department approved training course. The training course is available on the Idaho DCP Online Training System. Case managers must have a high school diploma or equivalent, be able to read and write at an appropriate level to process the documentation required for this service and have at least 12 months of experience working with individuals with disabilities or the elderly. Case managers must be supervised by an agency supervisor with a bachelor's degree in a human services field or licensed as a registered nurse (RN) or qualified intellectual disabilities professional (QIDP). Additionally, providers must meet the training requirements in the Idaho Provider Training Matrix. These requirements can be met by formal training or by demonstrated competency. Providers who provide direct care and services must receive a clearance from an Idaho Department of Health and Welfare background check.

Providers must follow the requirements of the General Provider Qualifications section in addition to the ones presented here. The spouse, legal representative, or designee only assists the participant with directing services. They cannot provide A&D case management.

9.1.1. References: Aged and Disabled Case Management – Provider Qualifications

(a) Idaho Waivers

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Case Management." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544.21. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"A&D Waiver Services: Provider Qualifications and Duties." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Background Checks," Idaho Code Title 56, Chapter 27 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH27/SECT56-27.

"Individual Provider Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individuals Subject to a Background Check." IDAPA 16.05.06, "*Criminal History and Background Checks*," Sec. 100. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Provider." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

9.2. Aged &Disabled Case Management: Participant Eligibility

Participants are eligible to receive Aged and Disabled (A&D) case management when they meet A&D Waiver Eligibility requirements and are authorized to receive State Plan Personal Care Services (PCS and/or A&D Waiver Attendant Care services. Participants may not receive duplicative case management supports concurrently with A&D case management. As such, participants enrolled in Medicare Medicaid Coordinated Plan (MMCP) or Idaho Medicaid Plus, receiving case management through the Idaho Behavior Health Plan (IBHP), or adult developmental disability service coordination are not eligible to receive this service. Participants that reside in a residential assisted living facility (RALF) are eligible to receive A&D case management; however, it may not be provided by the RALF.

Before delivery of services, providers must check eligibility on the date of the service to validate coverage and prior authorization for the A&D case management service. Providers must maintain documentation of the eligibility check. Eligibility can be checked by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website.

See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more detail on eligibility checks.

9.2.1. References: Aged and Disabled Case Management – Participant Eligibility

(a) Idaho Waivers

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Waiver Services: Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 541. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 632.07. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

9.3. Aged and Disabled Case Management: Covered Services and Limitations

Aged and Disabled (A&D) case management assists participants with gaining and coordinating access to necessary care and services appropriate to their needs. A&D case management includes the following allowable activities:

- Referrals and related activities that help connect the participant with service providers as well as community services and resources to support the individual's health and ability to remain in the community-based setting of their choice.
- Monitoring and follow-up contacts to ensure the individual's service plan is implemented appropriately and services delivered in a person-centered manner.
- Connection to food resources and housing supports. This may also include supporting an individual in researching and identifying alternative placement options and facilitating transitions between home and community-based services (HCBS) settings.
- Stabilization when an individual has or will imminently experience a crisis, including, but not limited to: loss of housing, loss of primary natural supports, medical emergency, significant decline in health or increase in support needs.
- Annual service and health risk assessment to identify effectiveness of existing services and supports and identification of gaps, to include recommendations if needed.

A&D case management may include, but does not necessarily require, face-to-face activity with the participant present. Activities that include research and collateral contacts that fit into the scope of allowable activities are allowed. A&D case management cannot be duplicative of any other services provided, including duals enrolled in a MCO.

A&D crisis case management refers to a specialized approach in which case managers work with individuals experiencing (or imminently experiencing) a crisis, including, but not limited to: loss of housing, loss of primary natural supports, medical emergency, significant decline in health or increase in support needs. The goal of A&D crisis case management is to provide immediate support and resources to stabilize the individual, address urgent needs, and help them regain a sense of control and safety while preventing unnecessary institutionalization.

A&D crisis case management must be requested by the provider using the Case Management Crisis Request Form available on the ACT online submission system and must include detailed information to support a request for additional units to be authorized. This may include supporting documentation. A&D crisis case management must be authorized by the Bureau of Long Term Care (BLTC), who will review and approve or deny the request and notify the agency.

To avoid conflict of interest, A&D case management cannot be delivered by the same agency that provides direct care services to the participant. Registered nurse (RN) oversight is required by the personal assistance agency (PAA) or service coordination agency and is not the responsibility of the case manager.

A&D case management is available to eligible Medicaid participants residing in a Residential Assisted Living Facility (RALF). However, RALF providers are not permitted to deliver case management services. These services may only be provided by an authorized agency.
A&D case management must meet federal HCBS requirements as outlined in the Home and Community Based Services (HCBS) section of this handbook.

9.3.1. References: Aged and Disabled Case Management - Covered Services and Limitations

(a) Idaho State Plan

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Case Management." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 542.19 Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"A&D Waiver Services: Coverage and Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 542. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"HCBS." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(3)(c) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

9.4. Aged and Disabled Case Management: Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Providers have the burden of proof to establish entitlement to payment. Aged and Disabled (A&D) case management is reimbursed on a fee for service basis and must be prior authorized. The A&D Waiver Services: Reimbursement section of this handbook details the reimbursement requirements for A&D case management. A&D case management is prior authorized by the Bureau of Long Term Care (BLTC) for participants who are not enrolled in a dual plan. Rate updates require legislative approval.

Enter the appropriate ICD-10-CM: Z74.2, "Need for assistance at home and no other household member able to render care," code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

A&D case management can only be provided in the following POS:

12 Home
99 Other (Community)

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

A&D Case Management		
HCPCS	**Modifier**	**Description**
G9002	CC	Case Management - Agency, 1 Unit = 15 minutes

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third-party resources before submitting claims to Medicaid. See the Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable including co-payment.

9.4.1. References: Aged and Disabled Case Management – Reimbursement

(a) Idaho State Plan

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Waiver Services: Provider Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 545. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Burden of Proof – Provider Cases." IDAPA 16.05.03, "*Contested Case Proceedings and Declaratory Rulings,"* Sec. 133. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/2023%20Archive/16/160503.pdf.

"Burden of Proof (Rule 477)." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 477. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"General Payment Procedures." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 030. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Mandatory Application." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 800.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

Provider Payment, Idaho Code 56-265 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265.

10. Attendant Care

10.1. Attendant Care : Provider Qualifications

Attendant care must be provided by an employee of a Personal Assistance Agency (PAA) with a signed Additional Terms – PCS and A&D Waiver Services provider agreement. When a participant's relative, legal representative, or designee is assisting the participant to self-direct their services through a fiscal intermediary (FI), they may not provide attendant care. Spouses of a participant may not provide Attendant Care. Direct care workers providing services must receive a clearance from an Idaho Department of Health and Welfare background check. Additionally, providers must meet the training requirements in the Idaho Provider Training Matrix. These requirements can be met by formal training or by demonstrated competency.

Providers must follow the requirements of the General Provider Qualifications section in addition to the ones presented here. Participants, the spouse, legal representative, or designee only assists the participant with directing services. They cannot provide

10.1.1. References: Attendant Care – Provider Qualifications

(a) Idaho Waivers

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Waiver Services: Provider Qualifications and Duties." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Attendant Care." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544.12. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Background Checks," Idaho Code Title 56, Chapter 27 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH27/SECT56-27.

"Individual Provider Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individuals Subject to a Background Check." IDAPA 16.05.06, "*Criminal History and Background Checks*," Sec. 100. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Provider." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

10.2. Attendant Care : Participant Eligibility

Participants are eligible to receive attendant care when they meet A&D Waiver Eligibility requirements and receive prior authorization for the service. Attendant Care is an extended State Plan Personal Care Service (PCS), therefore a waiver participant also must exhaust the maximum PCS benefit (16 hours per week or EPSDT) prior to accessing Attendant Care. Participants eligible for Attendant Care under fee-for-service may also qualify for A&D Case Management. Not all participants are eligible for all services. Services are available based on the participant's enrollment eligibility. Incarcerated individuals or otherwise ineligible non-citizens with Medicaid coverage are not eligible for these services.

Before delivery of services, providers must check eligibility on the date of the service to validate coverage, verify available prior authorization for Attendant Care and that all available PCS hours have been used. Providers must maintain documentation of the eligibility check. Eligibility can be checked by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website.

See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more detail on eligibility checks.

10.2.1. References: Attendant Care – Participant Eligibility

(a) Federal Regulations

Persons to Whom Services will be Provided, 42 CFR §136.12 (1999). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-I/subchapter-M/part-136/subpart-B/section-136.12.

(b) Idaho Waivers

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(c) State Regulations

"A&D Waiver Services: Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 541. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

10.3. Attendant Care : Covered Services and Limitations

Attendant care involves personal and medically oriented tasks dealing with the functional needs of the participant and accommodating the participant's needs for long-term maintenance, supportive care, or activities of daily living (ADL). These services may include personal assistance and medical tasks that can be performed by unlicensed persons or delegated to an unlicensed person by a licensed health care professional, or the participant. Services are based on the participant's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. This assistance may take the form of hands-on assistance (performing a task for the person) or cuing to prompt the participant to perform a task. Attendant care must meet federal home and community-based service (HCBS) requirements as outlined in the Home and Community Based Services (HCBS) section of this handbook.

Attendant Care is an extended State Plan personal care services (PCS) service. Participants must use all available State Plan PCS hours (16 hours per week or as authorized under EPSDT) prior to accessing Attendant Care waiver services.

10.3.1. References: Attendant Care – Covered Services and Limitations

(a) Idaho Waivers

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Waiver Services: Coverage and Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 542. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Attendant Care." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 542.05. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"HCBS." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(3)(d) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

10.4. Attendant Care – Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Providers have the burden of proof to establish entitlement to payment. Attendant care is reimbursed on a fee for service basis and must be prior authorized. The A&D Waiver Services - Reimbursement section of this handbook details the reimbursement requirements for attendant care. Attendant care is prior authorized by the Bureau of Long Term Care (BLTC). Rate updates require legislative approval.

Enter the appropriate ICD-10-CM: Z74.2, "Need for assistance at home and no other household member able to render care," code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Enter the place of service (POS) in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form. Attendant care can only be provided in the following POS:

03 School
12 Home
33 Custodial Care Facility (certified family homes, assisted living facilities, residential care facility, and other living situations where care is furnished commercially) when the service plan does not identify this service as the responsibility of the facility
99 Other (Community)

Attendant Care Billing Code	
HCPCS	**Description**
S5125	Attendant Care, 1 Unit = 15 minutes

PAAs must submit Electronic Visit Verification (EVV) data to the state's MMIS Aggregator (managed by Sandata) in order to be eligible to receive payment for this service. See "Electronic Visit Verification (EVV)" in the *General Billing Instructions,* Idaho Medicaid Provider Handbook for information related to EVV requirements. Claims may pend for up to 10 days, in order to identify a correlating visit that was submitted through the state's aggregator, however 90% of these claims process within three days. It's best practice to submit claims earlier in the week to allow the necessary time for the visit search to be completed. Claims submitted on Thursday will not have enough time to pend; search for the visit and be picked up and included in the financial cycle by Thursday evening. Please note that all claims may pend for up to 30 days for reasons other than EVV, if manual review and intervention is necessary.

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third-party resources before submitting claims to Medicaid. See the Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable including co-payment.

10.4.1. References: Attendant Care – Reimbursement

(a) Idaho Waivers

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) Idaho Medicaid Publications

"Attention Home Health and PCS Providers – Claim Processing Timeframe." MedicAide Newsletter, February 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/February%202023%20MedicAide.pdf.

(c) State Regulations

"A&D Waiver Services: Provider Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 545. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Burden of Proof – Provider Cases." IDAPA 16.05.03, "*Contested Case Proceedings and Declaratory Rulings,"* Sec. 133. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/2023%20Archive/16/160503.pdf.

"Burden of Proof (Rule 477)." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 477. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"General Payment Procedures." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 030. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Mandatory Application." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 800.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

Provider Payment, Idaho Code 56-265 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265.

"Specialized Reimbursement: Electronic Visit Verification (EVV)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 054. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

11. Behavior Consultation/Crisis Management

11.1. Behavior Consultation/Crisis Management: Provider Qualifications

Behavior Consultation/Crisis Management providers must be an individual or agency provider enrolled with Idaho Medicaid. Providers must be a licensed pharmacist, be a qualified intellectual disabilities professional (QIDP), or have a master's degree in a behavior science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education, or a closely related course of study. Providers of direct care and services must satisfactorily complete an Idaho Department of Health and Welfare background check.

Individuals and agency staff providing this service must work under the direct supervision of a licensed psychologist or Ph.D. in Special Education, with training and experience in treating severe behavior problems and applied behavior analysis.

Emergency back-up providers must meet residential habilitation agency direct care staff qualifications.

Behavior consultation crisis management providers must follow the provider handbook and all applicable state and federal regulations. Providers must sign the Additional Terms – Behavior Consultation Agreement before providing services. Providers must follow the requirements of the General Provider Qualifications section in addition to the ones presented here.

11.1.1. References: Behavior Consultation/Crisis Management – Provider Qualifications

(a) Idaho Waivers

"Appendix C, " Idaho Adult Developmental Disabilities Waiver (ID.0076.R07). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

(b) State Regulation

"Background Checks," Idaho Code Title 56, Chapter 27 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH27/SECT56-27.

"Behavior Consultation or Crisis Management." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 614.10. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individual Provider Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individuals Subject to a Background Check." IDAPA 16.05.06, "*Criminal History and Background Checks*," Sec. 100. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Provider." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Providers Subject to Background Check Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 003.04.b. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Developmental Disabilities Agencies (DDA), *Residential Habilitation Agencies*, *and Adult Residential Care Facilities*" IDAPA 16.03.21. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160321.pdf.

11.2. Behavior Consultation/Crisis Management: Participant Eligibility

Participants are eligible to receive Behavior Consultation/Crisis Management when they meet DD Waiver Eligibility requirements and are currently experiencing or expected to experience a psychological, behavioral, or emotional crisis. The Bureau of Developmental Disability Services (BDDS) authorizes Behavior Consultation/Crisis Management during service plan development.

When possible, before delivery of services, providers must check eligibility on the date of the service to validate coverage. Providers must maintain documentation of the eligibility check. Eligibility can be checked by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website.

See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more detail on eligibility checks.

11.2.1. References: Behavior Consultation/Crisis Management – Participant Eligibility

(a) Federal Regulations

Persons to Whom Services will be Provided, 42 CFR §136.12 (1999). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-I/subchapter-M/part-136/subpart-B/section-136.12.

(b) Idaho Waivers

"Appendix B*," Idaho Adult Developmental Disabilities Waiver (ID.0076.R07)*. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

"Appendix D," *Idaho Adult Developmental Disabilities Waiver (ID.0076.R07)*. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

(c) State Regulations

"Adult DD Waiver Services: Participant Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 611. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Behavior Consultation/Crisis Management." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 612.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

11.3. Behavior Consultation/Crisis Management: Covered Services and Limitations

Behavior consultation (BC) and crisis management (CM) services provide direct consultation and clinical evaluation to eligible participants. This service may include training and staff development related to the participant's needs and include emergency back-up through direct support of the participant in crisis by assisting direct care staff with intervention and stabilizing the individual. BC/CM services must meet federal Home and Community Based Services (HCBS) requirements.

11.3.1. References: Behavior Consultation/Crisis Management – Covered Services and Limitations

(a) Idaho Waivers

"Appendix C," Idaho Adult Developmental Disabilities Waiver (ID.0076.R07). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

(b) State Regulations

"Behavior Consultation/Crisis Management." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 612.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"HCBS." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

11.4. Behavior Consultation/Crisis Management: Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Providers have the burden of proof to establish entitlement to payment. Idaho Medicaid reimburses behavior consultation/crisis management on a fee for service basis and must be prior authorized. The Adult DD Services Reimbursement section of this handbook details the reimbursement requirements for this service. Behavior Consultation/Crisis Management is prior authorized by the Bureau of Developmental Disability Services (BDDS). Rate updates require legislative approval.

Behavior Consultation/Crisis Management		
HCPCS	**Modifier**	**Description**
H2019		Behavioral Consultation by a QIDP/Clinician, 1 Unit = 15 minutes
		Behavioral Consultation by a Psychiatrist, 1 Unit = 15 minutes
	HM	Behavioral Consultation Emergency Intervention Technician, 1 Unit = 15 minutes

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third-party resources before submitting claims to Medicaid. See the Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable including co-payment.

11.4.1. References: Behavior Consultation/Crisis Management – Reimbursement

(a) Idaho Waivers

"Appendix I." Idaho Adult Developmental Disabilities Waiver (ID.0076.R07). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

(b) State Regulations

"Adult DD Waiver Services: Provider Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 615. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Burden of Proof – Provider Cases." IDAPA 16.05.03, "*Contested Case Proceedings and Declaratory Rulings,"* Sec. 133. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/2023%20Archive/16/160503.pdf.

"Burden of Proof (Rule 477)." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 477. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"General Payment Procedures." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 030. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Mandatory Application." IDAPA 62.01.01, *"Idaho Rules of Administrative Procedure,"* Sec. 800.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

Provider Payment, Idaho Code 56-265 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265.

12. Chore Services

12.1. Chore Services: Provider Qualifications

Providers of chore services must be skilled in the type of service to be provided and demonstrate the ability to provide services according to a service plan. Providers who provide direct care and services must receive a clearance from an Idaho Department of Health and Welfare background check.

Additionally, providers must meet the training requirements in the Idaho Provider Training Matrix if providing the service to Aged & Disabled (A&D) Waiver participants. These requirements can be met by formal training or by demonstrated competency. Direct care workers must be employees of an agency and cannot be a participant's spouse. When an A&D waiver participant's spouse, legal representative, or designee is assisting the participant to self-direct their services through a fiscal intermediary (FI), they may not provide chore services.

For Developmental Disability (DD) Waiver participants, these services can be provided by an Individual or Agency provider. For A&D waiver participants, the spouse, legal representative, or designee only assists the participant with directing services. They cannot provide chore services. Providers must follow the requirements of the General Provider Qualifications section in addition to the ones presented here.

12.1.1. References: Chore Services – Provider Qualifications

(a) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"Background Checks," Idaho Code Title 56, Chapter 27 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH27/SECT56-27.

"Chore Services." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544.19. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Chore Services." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 614.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individual Provider Requirements." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider Qualifications." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Providers Subject to Background Check Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 003.04. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

12.2. Chore Services: Participant Eligibility

Participants are eligible to receive chore services when they meet A&D Waiver Eligibility or DD Waiver Eligibility requirements.

Before delivery of services, providers must check eligibility on the date of the service to validate coverage. Providers must maintain documentation of the eligibility check. Eligibility can be checked by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website.

See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more detail on eligibility checks.

12.2.1. References: Chore Services – Participant Eligibility

(a) Federal Regulations

Persons to Whom Services will be Provided, 42 CFR §136.12 (1999). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-I/subchapter-M/part-136/subpart-B/section-136.12.

(b) Idaho State Plan

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(c) State Regulations

"Adult DD Waiver Services: Participant Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 611. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"A&D Waiver Services: Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 541. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

12.3. Chore Services: Covered Services and Limitations

Chore services include the following services when necessary to maintain the functional use of the home, or to provide a clean, sanitary, and safe environment. Intermittent assistance may include yard maintenance, minor home repair, heavy housework, sidewalk maintenance, or trash removal to assist the participant to remain in their home. Chore activities may include washing windows, moving heavy furniture, shoveling snow to provide safe access inside and outside the home, chopping wood when wood is the participant's primary source of heat, or tacking down loose rugs and flooring.

Services are only available when neither the participant, nor anyone else in the home, is capable of performing or financially providing for them. There must be no other non-paid support, landlord, agency, or third-party payer willing or able to provide the service. The home must be rented or owned by the participant. For rental property, the department will examine the lease agreement for landlord responsibilities during plan review. Additionally, chore services must meet federal HCBS requirements as outlined in the Home and Community Based Services (HCBS) section of this handbook.

An Adult Developmental Disabilities waiver provider implementation plan (PIP) is not necessary for chore services.

12.3.1. References: Chore Services – Covered Services and Limitations

(a) Idaho State Plan

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"Chore Services." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 542.06. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Chore Services." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 612.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"HCBS." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider Implementation Plan (PIP)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 573.08.a.vii. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

12.4. Chore Services: Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Providers have the burden of proof to establish entitlement to payment. Idaho Medicaid reimburses chore services on a fee for service basis and must be prior authorized. The Adult DD Services Reimbursement section of this handbook and the A&D Waiver Services Reimbursement section of this handbook detail the reimbursement requirements for chore services. Chore services provided to Developmental Disabilities (DD) Waiver participants are prior authorized by the Bureau of Developmental Disability Services (BDDS). Chore services provided to Aged and Disabled (A&D) Waiver participants are prior authorized by the Bureau of Long Term Care (BLTC). Rate updates require legislative approval.

Enter the appropriate ICD-10-CM: Z74.2 – Need for assistance at home and no other household member able to render care code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Chore services can only be provided in the following POS:

12 Home

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Chore Service Billing Codes	
HCPCS	**Description**
S5120	A&D Waiver Chore Services – Agency, 1 Unit = 15 minutes
S5121	DD Waiver Chore Services, Manually Priced

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third-party resources before submitting claims to Medicaid. See the Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable including co-payment.

12.4.1. References: Chore Services – Reimbursement

(a) Idaho State Plan

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Waiver Services: Provider Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 545. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Waiver Services: Provider Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 615. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Burden of Proof – Provider Cases." IDAPA 16.05.03, "*Contested Case Proceedings and Declaratory Rulings,"* Sec. 133. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/2023%20Archive/16/160503.pdf.

"Burden of Proof (Rule 477)." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 477. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"General Payment Procedures." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 030. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Mandatory Application." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 800.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

Provider Payment, Idaho Code 56-265 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265.

13. Community Crisis Supports

13.1. Community Crisis Supports: Provider Qualifications

The following provider types may provide community crisis supports:

- Residential Habilitation Agency
- Certified Family Home
- Supported Employment Agency
- Behavior Consultation and Crisis Management
- Service Coordination Agency (DD Crisis Assistance)

Providers must follow the requirements of the General Provider Qualifications section in addition to the ones presented here.

13.1.1. References: Community Crisis Supports – Provider Qualifications

(a) Idaho State Plan

"Services," *ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal*. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

13.2. Community Crisis Supports: Participant Eligibility

Participants are eligible to receive community crisis supports when they meet Eligibility for Adult developmental disabilities (DD) State home and community-based services (HCBS) Plan Services and are at risk of losing housing, employment, or income, or are at risk of incarceration, physical harm, or family altercations.

Before delivery of services, providers must check eligibility on the date of the service to validate coverage. Providers must maintain documentation of the eligibility check. Eligibility can be checked by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website.

See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more detail on eligibility checks.

13.2.1. References: Community Crisis Supports – Participant Eligibility

(a) Federal Regulations

Persons to Whom Services will be Provided, 42 CFR §136.12 (1999). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-I/subchapter-M/part-136/subpart-B/section-136.12.

(b) Idaho State Plan

"Evaluation/Reevaluation of Eligibility," ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

(c) State Regulations

"Adult DD HCBS State Plan Option." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 590. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD HCBS State Plan Option: Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 591. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Services: Eligibility Determination." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 569. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Community Crisis Supports." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 592. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

13.3. Community Crisis Supports: Covered Services and Limitations

Services are authorized after an intervention when a documented need for immediate intervention exists, no other supports were available, and services were appropriate to rectify the crisis. Services are limited to a maximum of 20 hours during any consecutive five day period.

Community crisis supports may be provided in an emergency room (ER) during the evaluation process if the goal is to prevent hospitalization and return the participant to the community. Services may be provided before completion of the service plan. When the initial service plan is submitted, it must identify the factors that lead to the crisis and a strategy for addressing those factors in the future. This service is not self-directed but must meet federal Home and Community Based Services (HCBS) requirements as outlined in the Home and Community Based Services (HCBS) section of this handbook. After the services are provided, a crisis resolution plan must be completed and submitted to the department within five business days.

13.3.1. References: Community Crisis Supports – Covered Services and Limitations

(a) Federal Regulations

State Plan Home and Community-Based Services Under Section 1915(i)(1) of the Act, 42 CFR §441.710 (2014). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-M/section-441.710.

(b) Idaho State Plan

"Services," *ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal*. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

(c) State Regulations

"Community Crisis Supports: Coverage and Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 593. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"HCBS." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

13.4. Community Crisis Supports: Prior Authorization

The Bureau of Developmental Disability Services (BDDS) prior authorizes Community Crisis Services during service plan development. Community Crisis Supports may be retroactively authorized within 72 hours of service delivery, when a provider documents the need for immediate intervention, no other means of support are available, and the services are appropriate to rectify the crisis.

See the General Billing Instructions, Idaho Medicaid Provider Handbook for information on billing and requesting prior authorized services.

13.4.1. References: Community Crisis Supports – Prior Authorization

(a) Idaho State Plan

"Services," *ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal*. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

(b) State Regulations

"Prior Authorization (PA)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 025.08. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

13.5. Community Crisis Supports: Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Providers have the burden of proof to establish entitlement to payment. Idaho Medicaid reimburses community crisis supports on a fee for service basis and must be authorized. The Adult DD Services Reimbursement section of this handbook details the reimbursement requirements for Community crisis supports. Rate updates require legislative approval.

Enter the appropriate ICD-10-CM: Z74.2, "Need for assistance at home and no other household member able to render care," code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Community crisis supports can only be provided in the following POS:

12 Home
99 Other (Community)

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Community Crisis Supports Billing Codes		
HCPCS	**Modifiers**	**Description**
H2011		Community Crisis Supports, 1 Unit = 15 minutes
		DD Crisis Assistance (Service Coordinator) – 1 Unit = 15 minutes
	HM	DD Crisis Assistance (Paraprofessional) – 1 Unit = 15 minutes

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third-party resources before submitting claims to Medicaid. See the Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable including co-payment.

13.5.1. References: Community Crisis Supports – Reimbursement

(a) Idaho State Plan

"Methods and Standards for Establishing Payment Rates," *ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal*. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

(b) State Regulations

"Adult DD Services: Provider Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 574. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Burden of Proof – Provider Cases." IDAPA 16.05.03, "*Contested Case Proceedings and Declaratory Rulings,"* Sec. 133. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/2023%20Archive/16/160503.pdf.

"Burden of Proof (Rule 477)." IDAPA 62.01.01, *"Idaho Rules of Administrative Procedure,"* Sec. 477. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"General Payment Procedures." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 030. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Mandatory Application." IDAPA 62.01.01, *"Idaho Rules of Administrative Procedure,"* Sec. 800.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

Provider Payment, Idaho Code 56-265 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265.

14. Companion Services

14.1. Companion Services: Provider Qualifications

Companion services must be provided by an employee of a Personal Assistance Agency (PAA) who is not the participant's spouse. When a participant's relative, legal representative, or designee is assisting the participant to self-direct their services through a fiscal intermediary (FI), they may not provide companion services. Providers who provide direct care and services must satisfactorily complete an Idaho Department of Health and Welfare background check. Additionally, providers must meet the training requirements in the Idaho Provider Training Matrix. These requirements can be met by formal training or by demonstrated competency.

Providers must follow the requirements of the General Provider Qualifications section in addition to the ones presented here. The spouse, legal representative, or designee only assists the participant with directing services. They cannot provide companion services.

14.1.1. References: Companion Services – Provider Qualifications

(a) Idaho State Plan

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Waiver Services: Provider Qualifications and Duties." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Background Checks," Idaho Code Title 56, Chapter 27 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH27/SECT56-27.

"Individual Provider Requirements." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individuals Subject to a Background Check." IDAPA 16.05.06, "*Criminal History and Background Checks*," Sec. 100. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Provider." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider Qualifications." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

14.2. Companion Services: Participant Eligibility

Participants are eligible to receive companion services when they meet A&D Waiver Eligibility requirements.

Before delivery of services, providers must check eligibility on the date of the service to validate coverage. Providers must maintain documentation of the eligibility check. Eligibility can be checked by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website.

See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more detail on eligibility checks.

14.2.1. References: Companion Services – Participant Eligibility

Persons to Whom Services will be Provided, 42 CFR §136.12 (1999). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-I/subchapter-M/part-136/subpart-B/section-136.12.

(a) Idaho State Plan

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Waiver Services: Eligibility." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 541. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

14.3. Companion Services: Covered Services and Limitations

Companion services include non-medical care, supervision, and socialization provided to a functionally impaired adult. Companion services are in-home services to ensure the safety and well-being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergency situations, or other conditions that would require a person onsite. The service provider, who may live with the participant, may provide voice cuing and occasional assistance with toileting, personal hygiene, dressing, and other activities of daily living (ADL). Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant; however, the primary responsibility is to provide companionship and be there in case they are needed. "Supervision" means the action of supervising the participant while delivering companion services. Supervision is not a discrete care task and should not be documented in place of companion services.

Companion services are only available to individuals who reside in the community. This service is not available to individuals who reside in a certified family home (CFH) or residential assisted living facility (RALF). Companion service is a supplemental service that is authorized separately from attendant care to eligible individuals. Companion services must meet federal home and community-based service (HCBS) requirements as outlined in the Home and Community Based Services (HCBS) section of this handbook.

14.3.1. References: Companion Services – Covered Services and Limitations

(a) Idaho Medicaid Publications

"Aged and Disabled (A&D) Waiver Program Companion Services." MedicAide Newsletter, June 2022, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202022%20MedicAide.pdf.

(b) Idaho State Plan

*ID Aged and Disabled Waiver (*1076.*R07.00)*. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(c) State Regulations

"Companion Services." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 542.07. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"HCBS." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

14.4. Companion Services: Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Providers have the burden of proof to establish entitlement to payment. Idaho Medicaid reimburses companion services on a fee for service basis and must be prior authorized. The A&D Waiver Services Reimbursement section of this handbook details the reimbursement requirements for companion services. Companion services are prior authorized by the Bureau of Long Term Care (BLTC). Rate updates require legislative approval.

Enter the appropriate ICD-10-CM: Z74.3, "Need for continuous supervision," code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Companion services can only be provided in the following POS:

12 Home

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Companion Services Billing Code	
HCPCS	**Description**
S5135	Companion Services, 1 Unit = 15 minutes

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third-party resources before submitting claims to Medicaid. See the Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable including co-payment.

14.4.1. References: Companion Services – Reimbursement

(a) Idaho State Plan

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Waiver Services: Provider Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 545. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Burden of Proof – Provider Cases." IDAPA 16.05.03, "*Contested Case Proceedings and Declaratory Rulings,"* Sec. 133. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/2023%20Archive/16/160503.pdf.

"Burden of Proof (Rule 477)." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 477. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"General Payment Procedures." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 030. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Mandatory Application." IDAPA 62.01.01, *"Idaho Rules of Administrative Procedure,"* Sec. 800.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

Provider Payment, Idaho Code 56-265 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265

15. Consultation Services

15.1. Consultation (Self Direction): Provider Qualifications

Consultation (Self Direction) services must be provided through a Personal Assistance Agency (PAA) by a person who has demonstrated skills in training participants/family members in hiring, firing, training, and supervising their own care providers. Providers of direct care and services must receive a clearance from an Idaho Department of Health and Welfare background check. When a participant's relative, legal representative, or designee is assisting the participant to self-direct their services through a fiscal intermediary (FI), they may not provide consultation services. Additionally, Consultation (Self-Direction) services cannot be provided by the participant's spouse.

Participants, the spouse, legal representative, or designee only assists the participant with directing services. They cannot provide consultation services. Providers must follow the requirements of the General Provider Qualifications section in addition to the ones presented here.

15.1.1. References: Consultation (Self Direction)– Provider Qualifications

(a) Idaho State Plan

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Waiver Services: Provider Qualifications and Duties." IDAPA 16.03.26, "*Medicaid Plan Benefits,*" Sec. 544. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Background Checks," Idaho Code Title 56, Chapter 27 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH27/SECT56-27.

"Consultation Services." IDAPA 16.03.26, "*Medicaid Plan Benefits,*" Sec. 544.06. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Fiscal Intermediary Services (FI)." IDAPA 16.03.26, "*Medicaid Plan Benefits,*" Sec. 544.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individual Provider Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individuals Subject to a Background Check." IDAPA 16.05.06, "*Criminal History and Background Checks*," Sec. 100. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Provider." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

15.2. Consultation (Self Direction): Participant Eligibility

Participants are eligible to receive consultation services when they meet A&D Waiver Eligibility requirements. Before delivery of services, providers must check eligibility on the date of the service to validate coverage. Providers must maintain documentation of the eligibility check. Eligibility can be checked by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website.

See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more detail on eligibility checks.

15.2.1. References: Consultation (Self Direction) – Participant Eligibility

(a) Federal Regulations

Persons to Whom Services will be Provided, 42 CFR §136.12 (1999). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-I/subchapter-M/part-136/subpart-B/section-136.12.

(b) Idaho State Plan

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(c) State Regulations

"A&D Waiver Services: Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 541. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

15.3. Consultation (Self Direction): Covered Services and Limitations

Consultation services are provided to a participant or family member by a Personal Assistance Agency operating as a Fiscal Intermediary to increase their skills as an employer or manager of the participant's care. Services are directed at achieving the highest level of independence and self-reliance possible for the participant and the participant's family. Services include consulting with the participant and family to gain a better understanding of the special needs of the participant and the role of the caregiver.

Consultation services must meet federal home and community-based service (HCBS) requirements as outlined in the Home and Community Based Services (HCBS) section of this handbook.

15.3.1. References: Consultation (Self Direction) – Covered Services and Limitations

(a) Idaho Waivers

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Waiver Services: Coverage and Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 542. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Consultation (Self-Direction)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 542.08. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"HCBS." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

15.4. Consultation (Self Direction): Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Providers have the burden of proof to establish entitlement to payment. Idaho Medicaid reimburses consultation services on a fee for service basis and must be prior authorized. The A&D Waiver Services Reimbursement section of this handbook details the reimbursement requirements for consultation services. Consultation services are prior authorized by the Bureau of Long Term care (BLTC). Rate updates require legislative approval.

Enter the appropriate ICD-10-CM: Z74.2 – Need for assistance at home and no other household member able to render care code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Enter place of service (POS) in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form. Consultation services can only be provided in the following POS:

03 School
12 Home
33 Custodial Care Facility (certified family homes, assisted living facilities, residential care facility, and other living situations where care is furnished commercially) when the service plan does not identify this service as the responsibility of the facility
99 Other (Community)

Consultation Service Billing	
HCPCS	**Description**
S5115	Consultation Services – Non-Family, 1 Unit = 15 minutes

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third-party resources before submitting claims to Medicaid. See the Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable including co-payment.

15.4.1. References: Consultation (Self Direction) – Reimbursement

(a) Idaho State Plan

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Waiver Services: Provider Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 545. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Burden of Proof – Provider Cases." IDAPA 16.05.03, "*Contested Case Proceedings and Declaratory Rulings,"* Sec. 133. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/2023%20Archive/16/160503.pdf.

"Burden of Proof (Rule 477)." IDAPA 62.01.01, *"Idaho Rules of Administrative Procedure,"* Sec. 477. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"General Payment Procedures." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 030. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Mandatory Application." IDAPA 62.01.01, *"Idaho Rules of Administrative Procedure,"* Sec. 800.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

Provider Payment, Idaho Code 56-265 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265.

16. Day Habilitation Services

16.1. Day Habilitation: Provider Qualifications

Day habilitation providers must be provided by an employee of a Residential Habilitation Agency. Providers must have a minimum of two years of experience working directly with persons with a traumatic brain injury, must provide documentation of standard licensing specific to their discipline, and must have taken a traumatic brain injury course approved by the department. Providers who provide direct care and services must satisfactorily complete an Idaho Department of Health and Welfare background check.

Providers must follow the requirements of the General Provider Qualifications section in addition to the ones presented here.

16.1.1. References: Day Habilitation – Provider Qualifications

(a) Idaho Waivers

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Waiver Services: Provider Qualifications and Duties." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Background Checks," Idaho Code Title 56, Chapter 27 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH27/SECT56-27.

"Day Habilitation." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544.16. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individual Provider Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individuals Subject to a Background Check." IDAPA 16.05.06, "*Criminal History and Background Checks,*" Sec. 100. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Provider." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

16.2. Day Habilitation: Participant Eligibility

Participants are eligible to receive day habilitation services when they meet A&D Waiver Eligibility requirements.

Before delivery of services, providers must check eligibility on the date of the service to validate coverage. Providers must maintain documentation of the eligibility check. Eligibility can be checked by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website.

See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more detail on eligibility checks.

16.2.1. References: Day Habilitation – Participant Eligibility

(a) Idaho Waivers

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Waiver Services: Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 541. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

16.3. Day Habilitation: Covered Services and Limitations

Day habilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting, separate from the home or facility in which the participant resides. Services will normally be furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, unless provided as an adjunct to other day activities included in a participant's service plan. Day habilitation is limited to 30 hours per week.

Day habilitation services will focus on enabling the participant to attain or maintain his or her maximum functional level and will be coordinated with any physical therapy, occupational therapy, or speech-language pathology services listed in the service plan. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings. Day habilitation must meet federal home and community-based service (HCBS) requirements as outlined in the Home and Community Based Services (HCBS) section of this handbook.

16.3.1. References: Day Habilitation – Covered Services and Limitations

(a) Idaho Waivers

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Waiver Services: Coverage and Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 542. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Day Habilitation." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 542.16. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"HCBS." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

16.4. Day Habilitation: Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Providers have the burden of proof to establish entitlement to payment. Idaho Medicaid reimburses day habilitation on a fee for service basis and must be prior authorized. The A&D Waiver Services Reimbursement section of this handbook details the reimbursement requirements for day habilitation services. Day habilitation is prior authorized by the Bureau of Long Term care (BLTC). Rate updates require legislative approval.

Enter the appropriate ICD-10-CM: Z74.2, "Need for assistance at home and no other household member able to render care," code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Enter the place of service (POS) in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form. Day habilitation can only be provided in the following POS:

11 Office
99 Other (Community)

Day Habilitation Billing Code	
HCPCS	**Description**
T2021	Day Habilitation – Individual or Group, 1 Unit = 15 minutes

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third-party resources before submitting claims to Medicaid. See the Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable including co-payment.

16.4.1. References: Day Habilitation – Reimbursement

(a) Idaho State Plan

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Waiver Services: Provider Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 545. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Burden of Proof – Provider Cases." IDAPA 16.05.03, "*Contested Case Proceedings and Declaratory Rulings,"* Sec. 133. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/2023%20Archive/16/160503.pdf.

"Burden of Proof (Rule 477)." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 477. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"General Payment Procedures." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 030. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Mandatory Application." IDAPA 62.01.01, *"Idaho Rules of Administrative Procedure,"* Sec. 800.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

Provider Payment, Idaho Code 56-265 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265.

17. Developmental Therapy

17.1. Developmental Therapy: Provider Qualifications

The provider must be a certified developmental disability agency (DDA) prior to submitting claims for services. Legally responsible individuals (spouses), legal guardians, and relatives of a participant may not provide paid developmental therapy to that participant. Providers must follow the requirements of the General Provider Qualifications section in addition to the ones presented here.

17.2. Developmental Therapy: Participant Eligibility

Participants are eligible to receive developmental therapy when they meet Eligibility for Adult DD State Plan Services and live in the community such as, but not limited to, a residential assisted living facility (RALF), a certified family home (CFH) or anywhere a home and community-based service is provided. Participants must also have a referral annually from a medical provider within their scope of practice to receive this service. Services must be prior authorized. The Bureau of Developmental Disability Services (BDDS) authorizes developmental therapy during service plan development.

Before delivery of services, providers must check eligibility on the date of the service to validate coverage. Providers must maintain documentation of the eligibility check. Eligibility can be checked by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website.

See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more detail on eligibility checks.

17.2.1. References: Developmental Therapy – Participant Eligibility

(a) Federal Regulations

Persons to Whom Services will be Provided, 42 CFR §136.12 (1999). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-I/subchapter-M/part-136/subpart-B/section-136.12.

(b) Idaho State Plan

"Evaluation/Reevaluation of Eligibility," *ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal*. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

(c) State Regulations

"Adult DD HCBS State Plan Option." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 590. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD HCBS State Plan Option: Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 591. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Services: Eligibility Determination." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 569. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Developmental Therapy." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 600. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"History and Physical." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 573.01.a. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

17.3. Developmental Therapy: Covered Services and Limitations

Developmental therapy is a service for adult participants with developmental disabilities which is directed toward the rehabilitation or habilitation of physical or mental disabilities in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. It must include age-appropriate instruction in activities of daily living (ADLs) not gained by a participant during normal developmental stages or not likely to develop without training or therapy. Developmental therapy may be provided in group or individual formats in the center, home, or community. Participants living in a certified family home must not receive home-based developmental therapy.

Developmental therapy does not include tutorial activities or assistance with educational tasks associated with education needs resulting from a disability, educational services, vocational services, or recreational services. Both individual and group therapy must be available based on participant needs, interests, or choices. For group therapy, there must be a minimum of one qualified staff, a paraprofessional or developmental specialist, providing direct services for every 12 participants when the developmental therapy is center-based. In the community, developmental therapy must occur in integrated, inclusive settings with no more than three participants per qualified staff. Additional staff must be added when necessary to meet the needs of the participants served.

Developmental therapy must be prior authorized and cannot exceed 22 hours per week. The combination of developmental therapy and adult day health cannot exceed 30 hours per week. The combination of developmental therapy, adult day health, and supported employment cannot exceed 40 hours per week. Developmental therapy may be provided seven days a week, as long as the hours per week do not exceed the 22 hour limit. Only one type of therapy is eligible for reimbursement during the same period. Transportation to and from the agency is not reimbursable as part of developmental therapy. It may be available under a separate transportation benefit.

When participants receive rehabilitative or habilitative services from other providers, the Developmental Disability Agency (DDA) must coordinate each participant's program with their providers to maximize skill acquisition and generalization of skills across environments and avoid duplication of services. Documentation must be maintained of the collaboration with the participant's other service plans such as the Aged & Disabled (A&D) Waiver service plan, Individual Education Plan (IEP), personal care services (PCS) plan, Residential Habilitation service plan and the outpatient behavioral health service plan. The file must reflect how all service plans were integrated into the DDA's service plans.

A comprehensive developmental assessment and specific skill assessments are covered. Comprehensive developmental assessments must be conducted by a developmental specialist to determine the necessity of treatment, guide treatment, and identify the participant's strengths, needs, and interests. It must be completed or updated at least every two years to reflect the status of the participant in the areas of self-care, receptive and expressive language, learning, gross and fine motor development, self-direction, capacity for independent living, and economic self-sufficiency. A new assessment is needed earlier when the participant's status changes. Specific skills assessments are conducted by developmental specialists to determine a participant's skill level in an area relating to a goal on the plan and are used to determine baselines and the program implementation plan. The maximum amount of all evaluation, assessment, and diagnostic services billed by all therapy providers is four

hours per calendar year per participant. The assessment must be signed and dated by the professional completing the document and include their credentials or qualifications.

Developmental therapy is not self-directed but must meet federal HCBS requirements as outlined in the Home and Community Based Services (HCBS) section of this handbook.

17.3.1. References: Developmental Therapy – Covered Services and Limitations

(a) Federal Regulations

State Plan Home and Community-Based Services Under Section 1915(i)(1) of the Act. 42 CFR §441.710 (2014). Government Printing Office. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-M/section-441.710.

(b) Idaho State Plan

"Services," *ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal*. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

(c) State Regulations

"Collaboration with Other Providers." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 606.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Developmental Therapy: Coverage and Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 602. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Developmental Therapy: Procedural Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 605. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"HCBS." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Services, Treatments, and Procedures Not Covered by Medicaid." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 060. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

17.4. Developmental Therapy: Additional Documentation

Providers must meet all documentation requirements listed in the Adult DD Services section of this handbook. Developmental Disability Agencies (DDAs) must obtain the participant's Medical, Social, and Developmental Assessment (MSDA) prior to providing developmental therapy. DDAs must also maintain documentation of any collaboration that includes other service plans. Participant records must also reflect how all services are integrated into a DDA's plan for each participant. Providers must follow the requirements of the Documentation section in addition to the ones presented here. All documentation must follow standard retention requirements including, but not limited to, those listed in the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook.

17.4.1. References: Developmental Therapy – Additional Documentation

(a) Idaho State Plan

ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

(b) State Regulations

"Developmental Therapy: Provider Qualifications and Duties." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 606. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Documentation Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 605.03 Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Intake." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 603.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

17.4.2. Developmental Therapy Service Plans

Developmental therapy must be provided based on an individual service plan (ISP) written by a plan developer and approved by the department. Service plan information and requirements are found in the developmental disability (DD) Service Plan section of this handbook.

(a) References: Developmental Therapy Service Plans

(i) Federal Regulations

Person-Centered Service Plan, 42 CFR §441.725 (2024). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-M/section-441.725.

(ii) Idaho State Plan

ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

(iii) State Regulations

"Developmental Therapy: Individual Service Plan (ISP) Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 603. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"HCBS." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

17.4.3. Developmental Therapy Program Implementation Plans and Status Reviews

Developmental Disability Agencies (DDAs) must develop a program implementation plan (PIP) for each DDA objective included on the participant's individual service plan (ISP) and complete provider status reviews as detailed in the Implementation Plans and Provider Status Reviews section of this handbook. For developmental therapy, the PIP must include:

- Participant name;
- A baseline statement addressing the participant's current skill level and abilities related to the specific skills to be learned;
- Measurable, behaviorally stated objectives corresponding to the goals or objectives authorized in the service plan;
- Individualized, written instructions for staff that include curriculum, interventions, task analyses, activity schedules, type and frequency of reinforcement, and data collection including probe, directed at the achievement of each objective. These instructions must be revised as necessary to promote participant progress toward stated objectives;
- Location where services are provided; and
- Target date from completion.

(a) References: Developmental Therapy Program Implementation Plans and Status Reviews

(i) Idaho State Plan

ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

(ii) State Regulations

"Developmental Therapy: Procedural Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 605. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

17.5. Developmental Therapy: Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Providers have the burden of proof to establish entitlement to payment. Idaho Medicaid reimburses developmental therapy on a fee for service basis and must be prior authorized. The Adult DD Services Reimbursement section of this handbook details the reimbursement requirements for developmental therapy. Rate updates require legislative approval.

Reimbursement for a high or intense level of supported living services includes developmental therapy and is not separately reimbursable. For participants receiving hourly support, the combination of hourly supported living, developmental therapy, supported employment, and adult day health cannot exceed the maximum set daily rate for H2022 – Daily Supported Living Services – High Support, except when all of the following are present:

- A participant is eligible for high support.
- Supported employment is in the service plan causing the daily limit to be exceeded.
- Documentation that the Person-Centered Planning team explored other lower-cost options and supports.
- A participant's health and safety needs can be met using hourly services.

Developmental therapy is prior authorized by the Bureau of Developmental Disability Services (BDDS). When billing for services, bill for the calendar week from Sunday through Saturday. Services must be consecutive dates when billing a date span.

Developmental therapy can only be provided in the following POS:

12 Home
99 Other (Community)

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Developmental Therapy Billing Codes	
HCPCS	**Description**
97537	Home/Community Individual and/or Group Developmental Therapy for Adults – 1 Unit = 15 minutes
H2032	Center-Based Individual and/or Group Developmental Therapy for Adults – 1 Unit = 15 minutes
H2000	Developmental Therapy Evaluation – 1 Unit = 15 minutes

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third-party resources before submitting claims to Medicaid. See the Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable including co-payment.

17.5.1. References: Developmental Therapy – Reimbursement

(a) Idaho Medicaid Publications

"New Daily Spending Cap for Hourly Supported Living – Effective October 1, 2024." *Information Release MA24-23 (9/24/2024)*. Division of Medicaid, Department of Health and Welfare, State of Idaho,

https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=31325&dbid=0&repo=PUBLIC-DOCUMENTS.

(b) Idaho State Plan

"Methods and Standards for Establishing Payment Rates," *ID-22-0022 Adult Developmental Disabilities 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal*. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-22-0022.pdf.

(c) State Regulations

"Adult DD Services: Provider Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 571. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Burden of Proof – Provider Cases." IDAPA 16.05.03, "*Contested Case Proceedings and Declaratory Rulings,"* Sec. 133. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/2023%20Archive/16/160503.pdf.

"Burden of Proof (Rule 477)." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 477. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"General Payment Procedures." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 030. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Mandatory Application." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 800.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

Provider Payment, Idaho Code 56-265 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265.

"Supported Living Levels of Support." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 574.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

18. Environmental Accessibility Adaptations

See the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Provider Handbook for information and requirements.

19. Home Delivered Meals

19.1. Home Delivered Meals: Provider Qualifications

Providers of home delivered meal services in any state are eligible to participate in the Medicaid Program so long as the meals are delivered in Idaho. They must be a public agency or private business. The provider cannot be the participant's spouse. The provider must have any licenses required by Idaho and general liability insurance. The provider must have workers compensation insurance for any employees unless the owners of the company are the only service providers.

Providers are required to have their site credentialed. The provider's food preparation service location must be inspected and licensed as a food establishment. Providers may use a secondary location as a distribution hub. Should the provider have a change of address they must complete and submit a new W9 that reflects the new address, a new provider agreement, and proof of the new site being credentialed before billing for meals prepared at the new location.

Providers of home delivered meals must be skilled in the type of service to be provided and demonstrate the ability to provide services according to a service plan. Providers who provide direct care and services must receive clearance from an Idaho Department of Health and Welfare background check. Employees or volunteers who deliver meals to participants are considered to be providing a direct service.

Additionally, providers must meet the training requirements in the Idaho Provider Training Matrix if providing the service to Aged and Disabled (A&D) Waiver participants. These requirements can be met by formal training or by demonstrated competency.

Providers must follow the requirements of the General Provider Qualifications section in addition to the ones presented here.

19.1.1. References: Home Delivered Meals – Provider Qualifications

(a) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"Background Checks," Idaho Code Title 56, Chapter 27 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH27/SECT56-27.

"Home Delivered Meals." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544.08. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Home-Delivered Meals." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 614.09. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

IDAPA 16.02.19, "*Idaho Food Code*," Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160219.pdf

"Individual Provider Requirements." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individuals Subject to a Background Check." IDAPA 16.05.06, "*Criminal History and Background Checks*," Sec. 100. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Provider." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider Qualifications." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

19.2. Home Delivered Meals: Participant Eligibility

Participants are eligible to receive home delivered meals when they meet A&D Waiver Eligibility or DD Waiver Eligibility requirements. This service is restricted to participants who rent or own their home, are alone for significant parts of the day, have no regular caregiver for extended periods of time, and are unable to prepare a meal without assistance.
Before delivery of services, providers must check eligibility on the date of the service to validate coverage. Providers must maintain documentation of the eligibility check. Eligibility can be checked by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website.

See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more detail on eligibility checks.

19.2.1. References: Home Delivered Meals – Participant Eligibility

(a) Federal Regulations

Persons to Whom Services will be Provided, 42 CFR §136.12 (1999). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-I/subchapter-M/part-136/subpart-B/section-136.12.

(b) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(c) State Regulations

"Adult DD Waiver Services: Participant Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 611. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"A&D Waiver Services: Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 541. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

19.3. Home Delivered Meals: Covered Services and Limitations

Home delivered meals is a service covered under the Developmental Disability (DD) Waiver, and the Aged and Disabled (A&D) Waiver to promote adequate participant nutrition. Home Delivered Meals must meet federal HCBS requirements as outlined in the Home and Community Based Services (HCBS) section of this handbook. A registered dietitian must review and document approval of menus, menu cycles, and changes or substitutions to the menu. Each meal provided must meet one-third of the recommended daily allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. Meals must be delivered in accordance with the service plan, in a sanitary manner, and at the correct temperature for the specific type of food. Coverage is limited to one to two meals per day.

Services provided to participants of the A&D waiver must have documentation demonstrating that the meals served are made from the highest USDA grade.

Providers of home-delivered meals are not required to have a DD waiver provider implementation plan (PIP).

19.3.1. References: Home Delivered Meals – Covered Services and Limitations

(a) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"HCBS." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Home Delivered Meals." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 612.09. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Home-Delivered Meals." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 542.09. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Home-Delivered Meals." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544.08. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider Implementation Plan (PIP)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 573.08(a). Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Service Categories Not Covered." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 060.01(k). Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

19.4. Home Delivered Meals: Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Providers have the burden of proof to establish entitlement to payment. Idaho Medicaid reimburses home delivered meals on a fee for service basis and must be prior authorized. The Adult DD Services Reimbursement and the A&D Waiver Services Reimbursement sections of this handbook detail the reimbursement requirements for home delivered meals. Home delivered meals provided to Developmental Disability (DD) Waiver participants are prior authorized by the Bureau of Developmental Disability Services (BDDS). Home delivered meals provided to Aged and Disabled (A&D) Waiver participants are prior authorized by the Bureau of Long Term Care (BLTC). Rate updates require legislative approval.

Enter the appropriate ICD-10-CM: Z74.2, "Need for assistance at home and no other household member able to render care," code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Home delivered meals can only be provided in the following POS:

12 Home

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Home-Delivered Meal Billing Codes	
HCPCS	**Description**
S5170	Home Delivered Meals, including preparation – 1 unit = 1 meal

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third-party resources before submitting claims to Medicaid. See the Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable including co-payment.

19.4.1. References: Home Delivered Meals – Reimbursement

(a) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Waiver Services: Provider Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 545. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Waiver Services: Provider Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 615. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Burden of Proof – Provider Cases." IDAPA 16.05.03, "*Contested Case Proceedings and Declaratory Rulings,"* Sec. 133. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/2023%20Archive/16/160503.pdf.

"Burden of Proof (Rule 477)." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 477. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"General Payment Procedures." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 030. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Mandatory Application." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 800.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

Provider Payment, Idaho Code 56-265 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265.

20. Homemaker Services

20.1. Homemaker Services: Provider Qualifications

Homemaker services must be provided by an employee of a Personal Assistance Agency (PAA). When a participant's relative, legal representative, or designee is assisting the participant to self-direct their services through a fiscal intermediary (FI), they may not provide homemaker services. Spouses may not provide homemaker services. Providers of direct care and services must satisfactorily complete an Idaho Department of Health and Welfare background check. Additionally, providers must meet the training requirements in the Idaho Provider Training Matrix. These requirements can be met by formal training or by demonstrated competency.

Providers must follow the requirements of the General Provider Qualifications section in addition to the ones presented here.

20.1.1. References: Homemaker Services – Provider Qualifications

(a) Idaho Waivers

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Waiver Services: Provider Qualifications and Duties." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Background Checks," Idaho Code Title 56, Chapter 27 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH27/SECT56-27.

"Homemaker Services." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544.13. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individual Provider Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individuals Subject to a Background Check." IDAPA 16.05.06, "*Criminal History and Background Checks*," Sec. 100. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Provider." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

20.2. Homemaker Services: Participant Eligibility

Participants are eligible to receive homemaker services when they meet A&D Waiver Eligibility requirements and no one else in the household is capable of performing or financially providing these tasks.

Before delivery of services, providers must check eligibility on the date of the service to validate coverage. Providers must maintain documentation of the eligibility check. Eligibility can be checked by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website.

See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more detail on eligibility checks.

20.2.1. References: Homemaker Services – Participant Eligibility

(a) Federal Regulations

Persons to Whom Services will be Provided, 42 CFR §136.12 (1999). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-I/subchapter-M/part-136/subpart-B/section-136.12.

(b) Idaho Waivers

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(c) State Regulations

"A&D Waiver Services: Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 541. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Homemaker Services." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 542.10. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

20.3. Homemaker Services: Covered Services and Limitations

Homemaker services consist of performing or assisting participants with laundry, essential errands, meal preparation, and other routine housekeeping duties. Services are only available when neither the participant, nor anyone else in the home, is capable of performing or financially providing for them. Homemaker services must meet federal home and community-based service (HCBS) requirements as outlined in the Home and Community Based Services (HCBS) section of this handbook.

20.3.1. References: Homemaker Services – Covered Services and Limitations

(a) Idaho Waivers

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Waiver Services: Coverage and Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 542. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"HCBS." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Homemaker Services." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 542.10. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

20.4. Homemaker Services: Reimbursement

PAAs must be enrolled to receive reimbursement from Idaho Medicaid. Providers have the burden of proof to establish entitlement to payment. Idaho Medicaid reimburses homemaker services on a fee for service basis and must be prior authorized. The A&D Waiver Services Reimbursement section of this handbook details the reimbursement requirements for homemaker services. Homemaker services are prior authorized by the Bureau of Long Term Care (BLTC). Rate updates require legislative approval.

Enter the appropriate ICD-10-CM: Z74.2, "Need for assistance at home and no other household member able to render care," code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Enter place of service (POS) in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form. Homemaker services can only be provided in the following POS:

12 Home

Homemaker Service Billing Code	
HCPCS	**Description**
S5130	Homemaker Services, 1 Unit = 15 minutes

PAAs must submit Electronic Visit Verification (EVV) data to the state's MMIS Aggregator (managed by Sandata) in order to be eligible to receive payment for this service. See "Electronic Visit Verification (EVV)" in the *General Billing Instructions*, Idaho Medicaid Provider Handbook for information related to EVV requirements. Claims may pend for up to 10 days, in order to identify a correlating visit that was submitted through the state's aggregator, however 90% of these claims process within three days. It's best practice to submit claims earlier in the week to allow the necessary time for the visit search to be completed. Claims submitted on Thursday will not have enough time to pend, search for the visit and be picked up and included in the financial cycle by Thursday evening. Please note that all claims may pend for up to 30 days for reasons other than EVV, if manual review and intervention is necessary.

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third-party resources before submitting claims to Medicaid. See the Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable including co-payment.

20.4.1. References: Homemaker Services – Reimbursement

(a) Idaho Waivers

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) Idaho Medicaid Publications

"Attention Home Health and PCS Providers – Claim Processing Timeframe." MedicAide Newsletter, February 2023,

https://www.idmedicaid.com/MedicAide%20Newsletters/February%202023%20MedicAide.pdf.

(c) State Regulations

"A&D Waiver Services: Provider Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 545. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Burden of Proof – Provider Cases." IDAPA 16.05.03, "*Contested Case Proceedings and Declaratory Rulings,"* Sec. 133. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/2023%20Archive/16/160503.pdf.

"Burden of Proof (Rule 477)." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 477. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"General Payment Procedures." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 030. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Mandatory Application." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 800.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

Provider Payment, Idaho Code 56-265 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265.

"Specialized Reimbursement: Electronic Visit Verification (EVV)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 054. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

21. Non-Medical Transportation Services

See the Transportation Services, Idaho Medicaid Provider Handbook for information and requirements.

22. Personal Care Services

22.1. Personal Care Services: Provider Qualifications

Personal care services (PCS) must be provided by a certified family home (CFH), an employee of a personal assistance agency (PAA), a residential assisted living facility (RALF), or provided as a school-based service (SBS). PAAs must also sign an Additional Terms – Aged and Disabled Waiver, Personal Care Services Provider Agreement. Providers must also receive a clearance from the Department of Health and Welfare's background check.

See the Long-Term Care Facility Services, Idaho Medicaid Provider Handbook for PCS provided by a RALF.

Information regarding School-based PCS can be found on the School-Based Medicaid website.

When care for a child is delivered in the provider's home, the provider must be licensed or certified for the appropriate level of child foster care or day care for care of individuals under age 18 or approved by a licensed children's agency. Non-compliance with these standards is cause for termination of the provider agreement. When care for an adult is provided in a home owned or leased by the provider, the provider must be certified as a certified family home (CFH). See the Certified Family Homes, Idaho Medicaid Provider Handbook for PCS provided by a CFH.
Spouses or parents of a minor child are prohibited from providing PCS. A&D case managers of a participant are not able to provide PCS to that participant.

Providers must follow the requirements of the General Provider Qualifications section in addition to the ones presented here.

22.1.1. References: Personal Care Services – Provider Qualifications

(a) Federal Regulations

Personal Care Services, 42 CFR §440.167 (1997), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-A/section-440.167.

(b) Idaho State Plan

Enhanced Alternative Benefit Plan. Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=2084&dbid=0&repo=PUBLIC-DOCUMENTS.

(c) State Regulations

"Background Checks," Idaho Code Title 56, Chapter 27 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH27/SECT56-27.

"Individual Provider Requirements." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individuals Subject to a Background Check." IDAPA 16.05.06, "*Criminal History and Background Checks*," Sec. 100. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

Licensing Authority, Idaho Code 39-1213 (2025). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title39/T39CH12/SECT39-1213.

"PCS: Provider Qualifications and Duties." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 554. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"PCS: Quality Improvement (QI)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 556. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Supervision." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 553.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

22.2. Personal Care Services: Participant Eligibility

The Idaho Medicaid Enhanced Plan covers state plan Personal Care Services (PCS) for participants when the department finds they require PCS due to a medical condition that impairs their physical, or mental function, or independence. PCS is a state plan service, not a waiver service. The Bureau of Long Term Care (BLTC) completes an assessment to determine the participant's medical and social history and assess the need for services. The department must determine that the participant is capable of being maintained safely and effectively in their own house or personal residence using PCS. BLTC reviews the assessment and any other documentation for medical necessity of PCS.

Eligibility for PCS must be redetermined at least annually. Redetermination assesses the participant's continued need for PCS, discharge from PCS, or referral to a nursing facility (NF). An assessment can be requested due to changes in a participant's needs at any time. Participants on the Aged and Disabled (A&D) waiver receiving PCS may also qualify for A&D case management.

Before delivery of services, providers must check eligibility on the date of the service to validate coverage. Providers must maintain documentation of the eligibility check. Eligibility can be checked by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website.

See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more detail on eligibility checks.

22.2.1. References: Personal Care Services – Participant Eligibility

(a) Federal Regulations

Persons to Whom Services will be Provided, 42 CFR §136.12 (1999). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-I/subchapter-M/part-136/subpart-B/section-136.12.

(b) Idaho State Plan

Enhanced Alternative Benefit Plan. Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=2084&dbid=0&repo=PUBLIC-DOCUMENTS.

(c) State Regulations

"PCS: Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 551. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

22.3. Personal Care Services: Covered Services and Limitations

Personal care services (PCS) include medically oriented tasks related to a participant's physical or functional requirements provided in the participant's home or personal residence. PCS does not include housekeeping or skilled nursing care.

PCS must deliver at least one of the following medical service tasks:

- Basic personal care and grooming that may include bathing, hair care, assistance with clothing and dressing, bathroom assistance, and basic skin care;
- Assistance with bladder or bowel requirements, which may include helping the participant to and from the bathroom or assisting the participant with bedpan routines;
- Assistance with food, nutrition, and diet activities, including meal preparation if the physician determines the participant has a medical need for such assistance;
- Assistance with physician ordered medications that are ordinarily self-administered, in compliance with the Idaho Board of Nursing; or
- For participants with developmental disabilities, continuation of active treatment training programs in the home setting to increase or maintain participant independence, referred to as independence training, must be provided by a qualified intellectual disabilities professional (QIDP). The QIDP must specifically identify such services on the PCS service plan. Examples of independence training include personal hygiene, getting dressed, or taking the participant grocery shopping.
- Non-nasogastric gastrostomy tube feeding may be provided if authorized by the Bureau of Long Term Care (BLTC) prior to implementation. To be authorized, the task may not be a complex task and must be able to be safely performed in the participants care situation. A registered nurse (RN) supervisor must have assessed the participant's nursing care needs and developed a written standardized procedure for gastrostomy tube feedings. The procedure must be individualized for the participant's characteristics and needs. The written plan must identify individuals to whom the supervisor RN can delegate the procedure by name. The supervisor RN must provide proper instruction in the performance of the procedure, supervise a return demonstration of safe performance of the procedure, state in writing the strengths and weaknesses of the individual performing the procedure, and evaluate the performance of the procedure at least monthly. Any change in the participant's status or problem related to the procedure must be reported to the supervisor RN immediately. The individualized procedure, the supervised performance of the procedure, and follow-up evaluation of the performance of the procedure must be documented in writing by the supervising RN and must be readily available for review with the participant's record. Routine medication may be given by the direct care worker through the non-nasogastric tube if authorized by the supervising RN.

PCS may also include non-medical tasks if no natural supports are available. They include:

- Incidental household services Medicaid determines to be essential to a participant's comfort, safety, and health. For children, these services must be ordered by the physician. These services may include:
    - Changing of bed linens for the participant.
    - Rearranging of furniture to enable the participant to move about more easily.
    - Doing laundry for the participant.
    - Cleaning of areas used by the participant when required for the participant's treatment.
- Accompanying the participant to clinics, a physician's office, or other medical appointments.

- Shopping for groceries or other household items required specifically for the health and maintenance of the participant.

Services for any other occupant of the participant's residence are excluded. The following procedures are also excluded:

- Irrigating or suctioning any body cavity requiring sterile procedures or applying dressings with prescription medication or aseptic techniques;
- Catheter insertion or sterile irrigation;
- Injecting fluids into veins, muscles or skin; and
- Administering medication not authorized by a supervisor RN.

PCS is limited to a maximum of 16 hours per week per participant. Aged & Disabled Waiver participants receiving PCS who require more services may be eligible for extended state plan PCS under the waiver's Attendant Care benefit. Waiver participants receiving PCS and Attendant Care who are not enrolled in and Idaho Medicaid Plus or Medicare Medicaid Coordinated Plan (MMCP) dual plan may be authorized A&D case management to coordinate these services.

Participants under the age of 21 who need PCS as a medically necessary service, can receive additional services through the Early Periodic Screening, Diagnosis, & Treatment (EPSDT) benefit when ordered by the child's primary care provider (PCP). Prior to obtaining the additional services, the parents or guardians must coordinate with the personal assistance agency for Medicaid authorization. An EPSDT PCS Request Form, Service Provider Statement of Need, Primary Care Provider Statement of Need, and other required documentation must be submitted to Medicaid.

No home, regardless of the number of providers in the home, may service more than two children authorized for eight hours of PCS per day. PCS must meet federal home and community-based services (HCBS) requirements as outlined in the Home and Community Based Services (HCBS) section of this handbook.

22.3.1. References: Personal Care Services – Covered Services and Limitations

(a) Idaho State Plan

Enhanced Alternative Benefit Plan. Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=2084&dbid=0&repo=PUBLIC-DOCUMENTS.

(b) State Regulations

"HCBS." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"PCS: Coverage and Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 552. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

22.4. Personal Care Services: Documentation

Personal care services (PCS) services are provided based on a written service plan when provided by a Personal Assistance Agency (PAA) or a negotiated service agreement (NSA) when provided by a certified family home (CFH) or residential assisted living facility (RALF). The plan must meet Home and Community-Based Person-Centered Planning Requirements. The assessment and service plan are sent to the CFH, PAA, or RALF selected by the participant. The provider and participant complete the service plan. The provider is responsible to develop health and safety and personal goals with the participant to be included in the service plan.

Participants receiving services in a CFH or RALF, must have a service plan or NSA meeting their certification requirements. Participants receiving services in their own home, or in a PCS family alternative care home (FACH), must have a service plan based on healthcare provider information, information obtained from the participant, and the results of the assessment completed by Bureau of Long Term Care (BLTC), and if applicable, the qualified intellectual disability professional (QIDP)'s assessment and observations of the participant.

The service plan must include all aspects of medical and non-medical care that the provider needs to perform, including the amount, type, and frequency of necessary services. The service plan must be updated annually, or more frequently if needed, based upon treatment results or a change in the participant's needs. The provider is responsible to notify Medicaid and the participant's healthcare provider when any significant changes in the participant's condition are noted during service delivery and document the notification in the participant's service record. The provider must sign the service plan indicating they will deliver service according to the authorized plan and consistent with home and community-based services (HCBS) requirements.

PCS records, including the service plan, must be maintained for all participants receiving PCS in their own homes or in a PCS FACH. Service delivery records must either be printed and placed in the participant's home or available to the participant and/or legal representative using a secure electronic record format (email, website with a login, etc.). PCS providers must document the following information in the service delivery record:

- Date of visit.
- Time the service(s) begins and ends. The time services are delivered must be identified using A.M. or P.M. unless entered using military time.
- Services provided. Services provided during each visit, including the Activities of Daily Living (ADL) identified on the assessment.
- A narrative related to the participant's response to the service(s), any changes noted in the participant's condition, or any deviations from the service plan.
- Participant or legal guardian's signature and date. This may be captured using a signature or unique software login.
- Direct care worker's signature and date. This may be captured using a signature or unique software login.

Failure to maintain this information may result in recovery of funds paid for undocumented services. Electronic visit verification (EVV) systems do not take the place of these documentation requirements but can be used to generate the required documentation to be retained in the participant's home.

When a participant requests to receive service delivery records in an alternate method other than in a printed format kept in their home, the provider must document the participant's choice using an attestation. The attestation must include the participant's signature and date, clearly indicate the method by which the participant chose to receive their documentation

(print, email, website with a login, etc.) and the participant's acknowledgement that their service delivery documentation is available at least on a weekly basis. The provider must keep all attestation forms available at the agency and make them available to the department if requested.

Providers must follow the requirements of the Documentation section in addition to the ones presented here.

22.4.1. References: Personal Care Services – Documentation

(a) Idaho State Plan

Enhanced Alternative Benefit Plan. Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=2084&dbid=0&repo=PUBLIC-DOCUMENTS.

(b) State Regulations

"HCBS Person-Centered Plan Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 536. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"PCS: Procedural Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 553. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Records." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 035. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

22.5. Personal Care Services: Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Providers have the burden of proof to establish entitlement to payment. Idaho Medicaid reimburses personal care services (PCS) are reimbursed on a fee for service basis and must be prior authorized. PCS is prior authorized by the Bureau of Long Term Care (BLTC). Rate updates require legislative approval.

The reimbursement rates calculated for PCS include both services and mileage. No separate charges for mileage will be paid by the department for provider transportation to and from the participant's home or other service delivery location when the participant is provided transportation.

Annually, Idaho Medicaid will conduct a poll of all Idaho nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICF/IID) and establish the weighted average hourly rates (WAHR) for nursing facility industry employees in comparable positions (i.e. registered nurse (RN), certified and non-certified nurse's aides) in Idaho to be used in calculating the PCS reimbursement rate to be effective in rate rebase years. The department will establish personal assistance agency (PAA) rates for PCS based on the WAHR. The WAHR is multiplied by a supplemental component composed of costs reported for travel, administration, training, and all payroll taxes and fringe benefits collected during the most recent State Fiscal Year.

Wage rates will be used in the reimbursement methodology when the expenditure is incurred by the provider type executing the program. Wages will be identified by the Bureau of Labor Statistics (BLS) when there is a comparable occupation title for the direct care staff. When there is no comparable occupation title for the direct care staff, then a weighted average hourly rate methodology will be used.

The department will survey 100% of providers customized to each of the services provided. Cost surveys are unaudited, but a provider that refuses or fails to respond to the periodic state surveys may be disenrolled as a Medicaid provider. The department will derive reimbursement rates using direct care staff costs, employment related expenditures, program related costs, and indirect general and administrative costs in the reimbursement methodology, when these costs are incurred by a provider.

Cost surveys to collect indirect general, administrative, and program related costs will be used when these expenditures are incurred by the provider type executing the program. The costs will be ranked by costs per provider, and the Medicaid cost used in the reimbursement rate methodology will be established at the seventy-fifth percentile in order to efficiently set a rate.

In rate rebase years, the department will establish PCS Family Alternate Care Home (FACH) rates for PCS based on the WAHR. Based on the survey conducted, the department will calculate a supplemental component using costs reported for administration, and training. The survey data is the cost information collected during the prior State Fiscal Year.

PCS hours for certified family home (CFH) and residential assisted living facility (RALF) residents are authorized based on their assessed care level as follows:

- Level I, any diagnosis EXCEPT Serious and Persistent Mental Illness (SPMI), Developmental Disability (DD), Alzheimer's Disease and Related Dementias (ADRD) = 1.25) hours per day or 8.75 hours per week.

- Level II, any diagnosis EXCEPT SPMI, DD, ADRD = 1.5 hours per day or 10.5 hours per week.
- Level III, any diagnosis= 2.25 hours per day or 15.75 hours per week.
- Level IV, ONLY SPMI, DD, ADRD who scores at level I or II = 1.79 hours per day or 12.5 hours per week.

Healthcare providers are reimbursed for services provided using current payment levels and methodologies for other services provided to Medicaid-eligible participants. The supervisory RN and qualified intellectual disability professional (QIDP) are reimbursed at a per visit amount for supervisory visits. The number of supervisory visits per calendar quarter will be approved as part of the PCS service plan. Additional evaluations or emergency visits in excess of those contained in the approved service plan will be authorized when needed. Service plan development will also be reimbursed. Rates will be established by the department.

PAAs must submit Electronic Visit Verification (EVV) data to the state's MMIS Aggregator (managed by Sandata) in order to be eligible to receive payment for this service. See "Electronic Visit Verification (EVV)" in the *General Billing Instructions,* Idaho Medicaid Provider Handbook for information related to EVV requirements. Claims may pend for up to 10 days, in order to identify a correlating visit that was submitted through the state's aggregator, however 90% of these claims process within three days. It's best practice to submit claims earlier in the week to allow the necessary time for the visit search to be completed. Claims submitted on Thursday will not have enough time to pend, search for the visit and be picked up and included in the financial cycle by Thursday evening. Please note that all claims may pend for up to thirty (30) days for reasons other than EVV, if manual review and intervention is necessary.

Dates of service must be within the Sunday through Saturday calendar week on a single claim. The calendar week begins at 12:00 a.m. on Sunday and ends at 11:59 p.m. on Saturday. Failure to comply with the Sunday through Saturday billing will result in claims being denied. In addition, a claim cannot span more than one calendar month. If the end of the month falls in the middle of a week, two separate claims must be used. For an example of this, see the following calendar. The last week in April begins Sunday, April 25, and ends Saturday, May 1. Two separate claims must be entered for this week. One claim will have service dates of 4/25 through 4/30. The second claim will have service dates of 5/01 through 5/01. Consecutive dates of service that fall in one calendar week (Sunday through Saturday) can be billed on one claim as long as the same quantity of services has been provided each day.

Sun	Mon	Tues	Wed	Thurs	Fri	Sat
April				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	May 1

Enter the appropriate ICD-10-CM: Z74.2, "Need for assistance at home and no other household member able to render care," code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

PCS can only be provided in a participant's personal residence unless specifically authorized in the PCS service plan.

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Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

PCS Billing Codes		
HCPCS	**Modifier**	**Description**
Supervisory RN Codes		
G9002		RN Care Plan Development and Placement Initial = 10 units Redetermination = 5 units
T1001		Nursing Assessment/Evaluation - Agency
QIDP Codes		
G9001		Coordinated Care Fee – Initial - Agency
H2020		Therapeutic Behavioral Services - Agency
PCS Codes		
T1019		PCS – Agency
T1019	UM	PCS – Family Alternative Care Home

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third-party resources before submitting claims to Medicaid. See the Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable. PCS is exempt from Share of Cost (SOC).

22.5.1. References: Personal Care Services – Reimbursement

(a) Idaho State Plan

Enhanced Alternative Benefit Plan. Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=2084&dbid=0&repo=PUBLIC-DOCUMENTS.

(b) Idaho Medicaid Publications

"Attention Home Health and PCS Providers – Claim Processing Timeframe." MedicAide Newsletter, February 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/February%202023%20MedicAide.pdf.

(c) State Regulations

"Burden of Proof – Provider Cases." IDAPA 16.05.03, *"Contested Case Proceedings and Declaratory Rulings,"* Sec. 133. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/2023%20Archive/16/160503.pdf.

"Burden of Proof (Rule 477)." IDAPA 62.01.01, *"Idaho Rules of Administrative Procedure,"* Sec. 477. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"General Payment Procedures." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 030. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Mandatory Application." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 800.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"PCS: Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 555. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Provider Payment, Idaho Code 56-265 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265.

"Specialized Reimbursement: Electronic Visit Verification (EVV)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 054. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

23. Personal Emergency Response System (PERS)

See the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), Idaho Medicaid Provider Handbook for information and requirements.

24. Residential Habilitation: Certified Family Home

See the Certified Family Homes, Idaho Medicaid Provider Handbook for more information and requirements.

25. Residential Habilitation: Supported Living

25.1. Supported Living: Provider Qualifications

Providers must have policies and procedures for qualified personnel, including duties, compensations, benefits, training and conduct. Staff providing direct care or services must meet the following requirements:

- Be at least 18 years of age.
- Demonstrate the ability to provide services according to a service plan.
- Have current CPR and First Aid certifications.
- Be free from communicable diseases.
- Have a valid driver's license and vehicle insurance, if transporting participants.
- Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or complete other department-approved training.
- Residential habilitation service providers who provide direct care or services must receive clearance from an Idaho Department of Health and Welfare background check.
- Have appropriate certification or licensure if required to perform tasks which require certification or licensure.

Prior to delivering services to a participant, agency direct service staff must complete an orientation program. The orientation program must include the following subjects:

- Purpose and philosophy of services
- Service rules
- Policies and procedures
- Proper conduct in relating to waiver participants
- Handling of confidential and emergency situations that involve the waiver participant
- Participant rights
- Methods of supervising participants
- Training specific to the needs of the participant

Training requirements that must be completed within six months of employment with the residential habilitation agency include:

- Instructional techniques: Methodologies for training in a systematic and effective manner
- Managing behaviors: Techniques and strategies for teaching adaptive behaviors
- Feeding
- Communication
- Mobility
- Activities of daily living (ADL)
- Body mechanics and lifting techniques
- Housekeeping techniques
- Maintenance of a clean, safe, and healthy environment

The agency will be responsible for providing ongoing training specific to the needs of the participant.

Providers must follow the requirements of the General Provider Qualifications section in addition to the ones presented here.

25.1.1. References: Supported Living – Provider Qualifications

(a) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"Background Checks," Idaho Code Title 56, Chapter 27 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH27/SECT56-27.

"Developmental Disabilities Agencies (DDA), *Residential Habilitation Agencies and Adult Residential Care Facilities*." Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160321.pdf.

"Individuals Subject to a Background Check." IDAPA 16.05.06, "*Criminal History and Background Checks*," Sec. 100. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Residential Habilitation." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Residential Habilitation – Supported Living." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 614.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

25.2. Supported Living: Participant Eligibility

Participants are eligible to receive residential habilitation-supported living services when they meet A&D Waiver Eligibility or DD Waiver Eligibility requirements. Using a department-approved assessment, the department determines the level of support the participant is eligible to receive. Providers must have policies and procedures for the admission of a participants and termination of services.

Participants who require supports and supervision 24 hours per day may be eligible for high or intense supported living. High supported living allows for a blend of one-to-one and group staffing. To qualify for high supported living, the participant's support level must be either Pervasive (1-24), Extensive (25-39), or Frequent (40-54). The intense supported living level requires one-on-one staffing, but requests for a blend of one-on-one and group staffing will be reviewed on a case-by-case basis. Intense supported living has additional criteria and must meet one of the following:

- Recent felony convictions or charges for offenses related to the serious injury or harm of another. These participants must have been placed in a supported living setting directly from incarceration or directly after being diverted from incarceration.
- History of predatory sexual offenses and are at high risk to re-offend based on a sexual offender risk assessment completed by an appropriate professional.
- Documented, sustained history of serious aggressive behavior showing a pattern of causing harm to themselves or others. The serious aggressive behavior must be such that the threat or use of force on another person makes that person reasonably fear bodily harm. The participant must also have the capability to carry out such a threat. The frequency and intensity of this type of aggressive behavior must require continuous monitoring to prevent injury to themselves or others.
- Chronic or acute medical conditions that are so complex or unstable that one-to-one staffing is required to provide frequent interventions and constant monitoring. Without this intervention and monitoring the participant would require placement in a nursing facility, hospital, or intermediate care facility for individuals with intellectual disabilities (ICF/IID) with 24 hour on-site nursing. Verification of the complex medical condition and the need for this level of service requires medical documentation.

Participants who are authorized for High or Intense Supported Living receive 24-hour supports and supervision. They will not be authorized to receive developmental therapy services, adult day health, or non-medical transportation (NMT) – these services are included in the daily rate. Residential habilitation agency providers cannot utilize Developmental Disability Agency (DDA) services for High or Intense supported living participants, regardless of the payment source (i.e., private payment from the Residential Habilitation agency or the participant). Care cannot be subcontracted.

Hourly supported living is for participants who do not meet criteria for either high or intense supported living or who qualify for a daily rate but whose needs can be met with less than 24-hour per day support. The combination of hourly supported living, developmental therapy, supported employment, and adult day health will not be authorized to exceed the maximum set daily amount established by the department. The department has determined the daily spending cap will match the rate for H2022 Daily Supported Living Services-High Support. Services will not be prior authorized above this amount except when:

- The participant is eligible to receive the high supported living daily rate;
- Supported employment is included in the plan and is causing the combination to exceed the daily limit;
- There is documentation that the Person-Centered Planning team has explored other options using lower-cost services and natural supports; and

- Health and safety needs will be met using hourly services despite having been assessed to qualify for 24-hour care.

Before delivery of services, providers must check eligibility on the date of the service to validate coverage. Providers must maintain documentation of the eligibility check. Eligibility can be checked by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website.

See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more detail on eligibility checks.

25.2.1. References: Supported Living – Participant Eligibility

(a) Federal Regulations

Persons to Whom Services will be Provided, 42 CFR §136.12 (1999). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-I/subchapter-M/part-136/subpart-B/section-136.12.

(b) Idaho Medicaid Publications

"MA24-23 Hourly Supported Living Cap" MedicAide Newsletter, October 2024, https://www.idmedicaid.com/MedicAide%20Newsletters/October%202024%20MedicAide.pdf.

(c) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(d) State Regulations

"A&D Waiver Services: Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 541. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Waiver Services: Participant Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 611. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Supported Living Levels of Support." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 574.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

25.3. Supported Living: Covered Services and Limitations

Supported living is defined as participants who live in their own home or apartment and require staff assistance. A residence is the participant's own home when it is owned or rented by the participant. The home is defined as when the participant has entered into a valid mortgage, lease, or rental agreement for the residence and when the participant is able to provide the department with a copy of the agreement.

Residential habilitation services consist of an integrated array of individually tailored services and supports furnished to eligible participants and designed to assist them to reside successfully in their own homes, with their families, or certified family home (CFH). The services and supports that may be furnished consist of the following:

- Habilitation services aimed at assisting the individual to acquire, retain, or improve the participant's ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one or more of the following areas:
    - Self-direction consists of identifying and responding to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities.
    - Money management consists of training or assistance in handling personal finances, making purchases, and meeting personal financial obligations.
    - Daily living skills consist of training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self-administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, as well as following home safety, first aid, and emergency procedures.
    - Socialization consists of training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities, and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities that are merely diversional or recreational in nature.
    - Mobility consists of training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community.
    - Behavior shaping and management consist of training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors, or extension of therapeutic services that consist of reinforcing physical, occupational, speech, and other therapeutic programs.
- Personal assistance services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the participant is unable to accomplish on his or her own behalf. Personal care activities may include direct assistance with grooming, bathing, and eating, assistance with medications that are ordinarily self-administered; supervision; communication assistance, reporting changes in the waiver participant's condition and needs; household tasks essential to health care at home to include general cleaning of the home, laundry, meal planning and preparation, shopping, and correspondence. Personal assistance services can also include skill building to allow the participant to care for themselves.

Developmental Disability (DD) Waiver services also include skills training to teach waiver participants, family members, alternative family caregivers, a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self-direction, money management, socialization, mobility, and other therapeutic programs. Skills training services that may be provided to a participant under the DD Waiver cannot duplicate skill training services the same participant may be receiving under the Idaho Behavioral Health Plan.

The number of residents in a supported living setting is limited to three participants. When more than one participant resides in the same home, services may be provided through individual, or group staffing arrangements as approved by the department.

All service plans that include supported living must include community integration goals that provide for maintained or enhanced independence, quality of life, and self-determination. As a participant's independence increases and they are less dependent on supports, they must transition to less intense supports.

It is the responsibility of the provider to notify the plan monitor, i.e. service coordinator, when there is a significant change in the participant's circumstances, including accidents, injuries, and health related activities. Providers must ensure all quality assurance requirements for Aged & Disabled (A&D) Waiver and Adult DD as applicable are met.

25.3.1. References: Supported Living – Covered Services and Limitations

(a) Idaho Medicaid Publications

"Attention Residential Habilitation Providers and Service Coordinators." MedicAide Newsletter, May 2022, https://www.idmedicaid.com/MedicAide%20Newsletters/May%202022%20MedicAide.pdf.

"Supported Living: Resident Limits." MedicAide Newsletter, April 2024, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202024%20MedicAide.pdf.

(b) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(c) State Regulations

"HCBS." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Residential Habilitation." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 612.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Residential Habilitation." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 542.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Supported Living Levels of Support." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 574.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

25.4. Supported Living: Additional Documentation

Providers must meet all documentation requirements listed in the Adult DD Services section of this handbook, or the A&D Waiver Services section of this handbook, based on which waiver the participant is enrolled. Providers must follow the requirements of the Documentation section in addition to the ones presented here.

Records for residential habilitation services must be standardized across participants. Residential habilitation agency program coordinators are responsible for establishing a standardized format for record keeping that includes all required information. It is the responsibility of the provider to ensure service delivery records are maintained in the participant's home. For Aged and Disabled (A&D) Waiver participants, this includes the last six months of service delivery records. For Developmental Disability (DD) Waiver participants, this includes the last 30 days of service delivery records.

Documentation for residential habilitation services must include:

- The date and time of visit. The date must be in MMDDCCYY format. The time must include when the service began and ended. The time for A&D Waiver services must also include the duration in decimal form to the hundredth place.
- A statement of the participant's response to the services, including any changes noted in the participant's condition must be included. Additionally, documentation must include any changes in the service plan authorized by the department as a result of changes in the participant's condition or skill level. The participant must sign the service record, unless the department or service coordinator determines the participant is unable to.

For participants on the DD waiver, if they were unable to sign the service plan, a participant cannot sign service records. When staffing differs from the approved plan, providers must document the specific reason for the change including a statement demonstrating that the change was member driven.

Continuity of services requires for participants when a participant moves, selects a different provider, or changes service coordinators, that all of the foregoing participant records will be delivered to and held by the new provider.

Documentation must be made available to department personnel acting in their official capacity immediately upon request. Services without documentation are not eligible for reimbursement. Providers should only submit records requested by the department. Documentation sent unsolicited, or not for a service requiring prior authorization, will not be reviewed by the department. Unreviewed documentation does not constitute approval or authorization of a service.

25.4.1. References: Supported Living – Additional Documentation

(a) Idaho Medicaid Publications

"Update to Intense Supported Living Billing Practices," Medicaid Information Release MA26-08, 13 March 2026, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=36170&dbid=0&repo=PUBLIC-DOCUMENTS.

(b) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(c) State Regulations

"A&D Waiver Services: Procedural Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 543. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Documentation Required." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 613.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Records." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 035. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

25.5. Supported Living: Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Providers have the burden of proof to establish entitlement to payment. Idaho Medicaid reimburses supported living services on a fee for service basis based on the participant's assessed level of support need, and must be prior authorized. Reimbursement for supported living services is based on the participant's assessed level of support need. High and Intense Supported Living is paid at a daily rate. Rate updates require legislative approval.

For Developmental Disability (DD) Waiver participants, intense supported living is paid at a daily rate only when the participant requires and receives continuous one-to-one staffing for the full 24-hour service day, and does not spend any portion of the day outside of services or with a blended one-to-one and group staffing. If at any part of the day, the participant is not receiving supported living services or the participant is not receiving blended group staffing, the provider must bill using 15-minute codes for the rest of the day. 15-minute procedure codes cannot be billed on the same date of service as daily procedure codes. See the General Billing Instructions, Idaho Medicaid Provider Handbook for more information on billing 15-minute codes.

For DD waiver participants who have been prior authorized to receive H2016 - Intense Supported Living – Reduction of Services Due to School Attendance, providers may continue to bill with this daily rate when the services provided meet the following requirements:

- The participant would otherwise meet Intense Supported Living daily rate criteria, with reductions in 24-hour 1:1 staffing occurring only due to school attendance; and
- The participant does not receive any blended staffing.

If the participant has additional, consistent time away from services beyond school attendance, or if blended staffing is part of ongoing service delivery, the plan should be authorized using 15-minute units. The Person-Centered Planning team may choose to use either the school-based daily rate or 15-minute units when the participant receiving Intense Supported Living attends school. This decision should be based on which approach best reflects the participant's actual time in and out of provider care.

Minor day-to-day variations in staffing levels may occur to support health, safety, and community participation. Minor daily variations do not require an immediate plan amendment if total billed units remain within annual authorization limits. However, providers must notify the Service Coordinator in a timely manner when service delivery reflects a sustained pattern of change in the member's needs. In those cases, a plan addendum and updated authorization must be completed.

The Adult DD Services Reimbursement section of this handbook and the A&D Waiver Services Reimbursement section of this handbook detail the reimbursement requirements for supported living services. Supported living services provided to DD Waiver participants are prior authorized by the Bureau of Developmental Disability (BDDS). Supported living services provided to Aged and Disabled (A&D) Waiver participants are prior authorized by the Bureau of Long Term Care (BLTC).

Enter the appropriate ICD-10-CM: Z74.2, "Need for assistance at home and no other household member able to render care," code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Supported living services can only be provided in the following place of service (POS):

12 Home

99 Other (Community) This code should only be used when the participant receives hourly supported living to access the community. All other supported living should be coded as 'Home.'

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Supported Living Services – DD Waiver		
HCPCS	**Modifier**	**Description**
H2015		Individual Hourly Supported Living, 1 Unit = 15 minutes
H2015	HQ	Group Hourly Supported Living, 1 Unit = 15 minutes
H2016		Intense Supported Living, 1 Unit = 1 day
H2016		Intense Supported Living – Reduction of Services Due to School Attendance, 1 Unit = 1 day
H2016	U2	Individual Intense Supported Living , 1 Unit = 15 minutes
H2016	U3	Group Intense Supported Living, 1 Unit = 15 minutes
H2016		High Supported Living – Reduction of Services Due to School Attendance, 1 Unit = 1 day
H2022		High Supported Living, 1 Unit = 1 day

*When H2016 is authorized for reduction of services due to school attendance, the rate is manually priced on the prior authorization based on the published fee schedule.

Supported Living Services – A&D Waiver		
HCPCS	**Modifier**	**Description**
H2015		Individual Hourly Supported Living, 1 Unit = 15 minutes
H2015	HQ	Group Hourly Supported Living, 1 Unit = 15 minutes
H2016		Intense Supported Living, 1 Unit = 1 day
H2022		High Supported Living, 1 Unit = 1 day

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third-party resources before submitting claims to Medicaid. See the Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable including co-payment.

25.5.1. References: Supported Living – Reimbursement

(a) Idaho Medicaid Publications

"Update to Intense Supported Living Billing Practices," Medicaid Information Release MA26-08, 13 March 2026, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=36170&dbid=0&repo=PUBLIC-DOCUMENTS.

(b) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(c) State Regulations

"Adult DD Waiver Services: Provider Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 615. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Burden of Proof – Provider Cases." IDAPA 16.05.03, "*Contested Case Proceedings and Declaratory Rulings,"* Sec. 133. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/2023%20Archive/16/160503.pdf.

"Burden of Proof (Rule 477)." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 477. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"General Payment Procedures." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 030. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Mandatory Application." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 800.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

Provider Payment, Idaho Code 56-265 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265.

"Rates." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 545.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Supported Living Levels of Support." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 574.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

26. Respite Care

Respite care includes short-term breaks from care giving responsibilities to non-paid caregivers for participants receiving Aged and Disabled (A&D) Waiver or Developmental Disability (DD) Waiver services. Information on respite care services for non-waiver participants can be found as follows:

- Respite for Children's Support Services
- Respite for Hospice
- Respite under the Idaho Behavioral Health Plan

26.1. Respite Care: Provider Qualifications

Respite care providers must have received caregiving instructions in the participant's needs, demonstrate the ability to provide services according to a service plan, and have no communicable diseases. Providers of direct care and services must receive a clearance from an Idaho Department of Health and Welfare background check. The provider must be enrolled with Idaho Medicaid prior to submitting claims for services.

For Aged & Disabled (A&D) Waiver participants, respite care must be provided by a certified family home (CFH), developmental disabilities agency (DDA), residential assisted living facility (RALF), respite agencies, or personal assistance agency (PAA). PAAs must sign an Additional Terms Aged and Disabled Waiver, Personal Care Services Provider Agreement.

Additionally, providers must meet the training requirements in the Idaho Provider Training Matrix. These requirements can be met by formal training or by demonstrated competency. The direct care worker cannot be the participant's spouse. See Certified Family Homes, Idaho Medicaid Provider Handbook for information specific to CFHs. See the Long-Term Care Facility Services, Idaho Medicaid Provider Handbook for information specific to RALFs.

For Developmental Disability (DD) Waiver participants, these services can be provided by an Individual or Agency provider.

Providers must follow the requirements of the General Provider Qualifications section in addition to the ones presented here.

26.1.1. References: Respite Care – Provider Qualifications

(a) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"Background Checks," Idaho Code Title 56, Chapter 27 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH27/SECT56-27.

"Individual Provider Requirements." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individuals Subject to a Background Check." IDAPA 16.05.06, "*Criminal History and Background Checks*," Sec. 100. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Provider." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider Qualifications." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Providers Subject to Background Check Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 003.04. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Respite Care." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544.17. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Respite Care." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 614.04. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

26.2. Respite Care: Participant Eligibility

Participants are eligible to receive respite care when they meet A&D Waiver Eligibility or DD Waiver Eligibility requirements.

Before delivery of services, providers must check eligibility on the date of the service to validate coverage. Providers must maintain documentation of the eligibility check. Eligibility can be checked by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website.

See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more detail on eligibility checks.

26.2.1. References: Respite Care – Participant Eligibility

(a) Federal Regulations

Persons to Whom Services will be Provided, 42 CFR §136.12 (1999). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-I/subchapter-M/part-136/subpart-B/section-136.12.

(b) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(c) State Regulations

"A&D Waiver Services: Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 541. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Waiver Services: Participant Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 611. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

26.3. Respite Care: Covered Services and Limitations

Respite care includes short-term breaks from caregiving responsibilities to non-paid caregivers for participants. The caregiver or participant is responsible for selecting, training, and directing the provider. Respite care services may be provided in the participant's residence, a certified family home (CFH), the community, a developmental disabilities agency (DDA), or an adult day health facility. Developmental Disability (DD) Waiver participants may receive services in the private home of the respite provider. While receiving respite care services, participants cannot receive other services that are duplicative in nature. Respite care services do not include room and board payments. Additionally, respite care must meet federal Home and Community Based Services (HCBS) requirements as outlined in the Home and Community Based Services (HCBS) section of this handbook.

A provider implementation plan (PIP) is not required for respite services.

26.3.1. References: Respite Care – Covered Services and Limitations

(a) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"HCBS." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Exceptions." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 573.08.(a) Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Respite Care." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 542.13. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Respite Care." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 612.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

26.4. Respite Care: Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Providers have the burden of proof to establish entitlement to payment. Idaho Medicaid reimburses respite care is reimbursed on a fee for service basis and must be prior authorized. The Adult DD Services Reimbursement section of this handbook and the A&D Waiver Services Reimbursement section of this handbook detail the reimbursement requirements for respite care. Respite care provided to Developmental Disability (DD) Waiver participants is prior authorized by the Bureau of Developmental Disability (BDDS). Respite care provided to Aged and Disabled (A&D) Waiver participants is prior authorized by the Bureau of Long Term care (BLTC). Rate updates require legislative approval.

Certified family home (CFH) providers under the DD waiver who provide respite care must bill either the S9125 for a daily rate or the T1005 code for 15-minute increments. However, the total billed with T1005 cannot exceed the daily rate charged by S9125. Additionally, T1005 billing is limited to a maximum of six hours per day, or 24 units. When providing CFH services, the provider will bill using the appropriate codes for each type of service.

Respite Care services under the A&D Waiver are only authorized per unit under T1005. Personal Assistance Agencies (PAA) providing respite care services must submit Electronic Visit Verification (EVV) data to the state's MMIS Aggregator (managed by Sandata) to be eligible for payment for services provided in the home. See "Electronic Visit Verification (EVV)" in the *General Billing Instructions*, Idaho Medicaid Provider Handbook for information related to EVV requirements. Claims may pend for up to 10 days, in order to identify a correlating visit that was submitted through the state's aggregator, however 90% of these claims process within three days. It's best practice to submit claims earlier in the week to allow the necessary time for the visit search to be completed. Claims submitted on Thursday will not have enough time to pend, search for the visit and be picked up and included in the financial cycle by Thursday evening. Please note that all claims may pend for up to 30 days for reasons other than EVV, if manual review and intervention is necessary.

Enter the appropriate ICD-10-CM: Z74.2, "Need for assistance at home and no other household member able to render care code," for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Respite care can only be provided in the following place of service (POS):

12 Home
99 Other (Community)

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Respite Care Billing Codes	
HCPCS	**Description**
T1005	Respite Care, 1 Unit = 15 minutes
S9125	Respite Care, Daily

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third-party resources before submitting claims to Medicaid. See the Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable including co-payment.

26.4.1. References: Respite Care – Reimbursement

(a) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) Idaho Medicaid Publications

"Attention Home Health and PCS Providers – Claim Processing Timeframe." MedicAide Newsletter, February 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/February%202023%20MedicAide.pdf.

(c) State Regulations

"Adult DD Waiver Services: Provider Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 615. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Burden of Proof – Provider Cases." IDAPA 16.05.03, "*Contested Case Proceedings and Declaratory Rulings,"* Sec. 133. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/2023%20Archive/16/160503.pdf.

"Burden of Proof (Rule 477)." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 477. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"General Payment Procedures." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 030. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Mandatory Application." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 800.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"Electronic Visit Verification (EVV) Compliance." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 545.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Provider Payment, Idaho Code 56-265 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265.

"Specialized Reimbursement: Electronic Visit Verification (EVV)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 054. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

27. Service Coordination

Service coordination assists eligible participants in gaining and coordinating access to necessary care and services appropriate to the needs of an individual. Service coordination services are delivered through a brokerage model and do not include the provision of direct services.

27.1. References: Service Coordination

27.1.1. State Regulations

"Service Coordination." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 007.23. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

27.2. Service Coordination: Participant Eligibility

Service coordination is available for participants with Idaho Medicaid Enhanced Benefits who are unable, or have limited ability to gain access, coordinate or maintain services on their own or through other means. Participants must not receive hospice services or live in hospitals, nursing facilities, or intermediate care facilities for individuals with intellectual disabilities (ICF/IID). There are additional requirements for based on being Adults or Children.

Before delivery of services, providers must check eligibility on the date of the service to validate coverage. Providers must maintain documentation of the eligibility check. Eligibility can be checked by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website.

See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more detail on eligibility checks.

27.2.1. References: Service Coordination – Participant Eligibility

(a) Federal Regulations

Persons to Whom Services will be Provided, 42 CFR §136.12 (1999). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-I/subchapter-M/part-136/subpart-B/section-136.12.

(b) State Regulations

"Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Service Coordination: Coverage and Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 632. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Service Coordination: Participant Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 631. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

27.2.2. Service Coordination for Adults

Service coordination is a benefit available for participants of 18 years of age or older diagnosed with a Developmental Disability. The participant must require and choose assistance to adequately access services and supports necessary to maintain their independence in the community.

Aged and Disabled (A&D) Waiver participants who qualify for service coordination may not receive A&D case management services as they are considered duplicative services.

(a) References: Service Coordination for Adults

(i) State Regulations

"Adults." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 631.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"DD Determination Standards: Participant Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 561. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"DD Determination Standards: Test Instruments." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 563. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Definitions, Idaho Code 66-402 (2020). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/title66/t66ch4/sect66-402.

27.2.3. Service Coordination for Children

Service coordination is a benefit available for participants between the ages of 37 months and through the end of the month of their 21 birthday. Eligibility is determined annually based on information from the service coordination agency or family. All information must be received by the department 20 business days prior to the start date of any service coordination services. Services must be approved by the department prior to initiation of plan development and services. Participants must:

- Have special health care needs requiring medical and multidisciplinary habilitation or rehabilitation services to prevent or minimize a disability as identified by a medical provider acting within their scope of practice.
- Have needs that cannot be met by other available service coordination or case management resources, including paid and non-paid sources. This includes case management resources provided by the department for children with developmental disabilities and other case management resources such as those available through the department's behavioral health managed care program.
- Have one or more of the following problems associated with their diagnosis:
    - The condition has resulted in a level of functioning below normal age level in one or more life areas such as school, family, or community.
    - They are at risk of placement in a more restrictive environment, or they are returning from an out-of-home placement because of the condition.
    - There is danger to their health or safety, or the parents are unable to meet their needs.
    - Further complications may occur because of the condition without provision of service coordination services.
    - They require multiple service providers and treatments.

Participants receiving children's service coordination between the ages of 18 and 21 who are eligible for the Aged and Disabled (A&D) Waiver may not receive A&D Case Management services as they are considered duplicative services.

(a) References: Service Coordination for Children

(i) State Regulations

"Children." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 631.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

27.3. Service Coordination: Covered Services and Limitations

Service coordination includes plan Assessments and periodic reassessment, Plan Development, Referral and Related Activities, Monitoring and Follow-up Activities and Crisis Assistance. Participants are only eligible for one type of service coordination even if they qualify for multiple kinds. This does not apply to case management services provided under a managed care contract such as the Idaho Behavioral Health Plan. Participants are not eligible to receive A&D case management, another type of service coordination, if they receive any other type of case management service or service coordination.

Service coordination is not generally covered while the participant is in a medical institution, incarcerated, or receiving hospice services; however, plan development is covered prior to discharge or for hospice participants. When admitted to a medical institution, service coordination is only reimbursable on the day the participant is admitted or discharged, provided it is before admission and after discharge except as noted. Service coordination for reintegration to the community is eligible for reimbursement. Claims must be held until the participant is discharged and using community resources. Reintegration activities are covered when:

- The participant has been institutionalized less than 180 days. Services are only available the 14 days before discharge.
- The participant has been institutionalized more than 180 days. Services are only available the 60 days before discharge.
- Services do not duplicate the admission and discharge procedures of the institution.

Contacts with the participant or other parties must involve two-way communication to be reimbursable. The time spent on phone calls with interested parties and providers is billable. Time spent on e-mail is only reimbursable when communications being read or responded to are directly related to identifying the needs and supports to help the participant access services and involve two-way communication. When it is necessary for the children's service coordinator to conduct a face-to-face contact with a child participant without the parent or legal guardian present, the service coordinator must notify the parent or legal guardian prior to the face-to-face contact with the participant. Notification must be documented in the participant's file.

Service coordinators are required to report any concerns about health and safety to the appropriate governing agency and to Idaho Medicaid. This includes allegations or suspicions of mistreatment, abuse, neglect, or exploitation. Below are links to appropriate authorities with information on how to make a report and details on mandatory reporting requirements.

Children and Family Services Reporting

Adult Protective Services Reporting

BLTC Complaint Submission System

Service coordinators must also report fraud, including billing of services that were not provided, to the department unit responsible for authorizing the service; and to the Medicaid Provider Integrity Unit (MPIU) within the department using its hotline at (208) 334-5754.

Adult participants receiving service coordination cannot receive both service coordination and direct services from the same service coordinator. Service coordinators can provide both service coordination and direct services for children provided it is documented the participant

had a free choice of provider for both services. The total caseload of a service coordinator must assure quality service delivery and participant satisfaction.

27.3.1. References: Service Coordination – Covered Services and Limitations

(a) State Regulations

"Case Loads." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 634.07. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Contact and Availability." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 633.05. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Duty to Report Cases of Vulnerable Adult Maltreatment. Idaho Code 39-5303 (2023). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title39/T39CH53/SECT39-5303/.

"Health, Safety and Fraud Reporting." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 634.06. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

Reporting of Abuse, Abandonment or Neglect. Idaho Code 16-1605 (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title16/T16CH16/SECT16-1605/.

"Service Coordination: Coverage and Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 632. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Service Coordination: Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 637. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

27.3.2. Service Coordination: Paraprofessionals

Covered paraprofessional services include, but are not limited to:

- Linking participants to appropriate resources and providers to address needs and goals identified in the participant's service coordination plan.
- Coordinating participant programs, services, job training, and transportation.
- Assisting participants with applications for benefits and entitlement programs.
- Advocating for adequate, timely and cost-effective services for the participant.
- Responding to any issues that occur during the delivery of services.
- Contacting the participant, family members, providers, or others when directly related to identifying needs and supports to help the participant access services.
- Monitoring the services being provided to the participant and staying up to date on any services being added or discontinued.
- Assisting participants with accessing community-based services.
- Providing crisis assistance to help participants access community resources to resolve a crisis.

Paraprofessionals must not conduct assessments, evaluations, person-centered planning meetings, 90 day face-to-face contacts, 180 day progress reviews, plan development, or plan changes. Paraprofessionals cannot be identified as the service coordinator on the plan, and they cannot supervise service coordinators or other paraprofessionals. The documentation of services completed by a paraprofessional must be reviewed by the participant's service coordinator and include the date of review and the service coordinator's signature on the documentation.

When developing an Individual Support Plan (ISP) that will include service coordination by a paraprofessional, the service coordinator and the paraprofessional must both be identified on the ISP. Specifically, the ISP Supports and Services and the Prior Authorization Worksheet (costing sheet) must differentiate those services and units rendered by the paraprofessional separately from those rendered by the service coordinator. When a paraprofessional will be providing services, the ISP Supports and Services and the Prior Authorization Worksheet (costing sheet) cannot assign all services and units to a service coordinator. Additionally, the ISP Prior Authorization Worksheet (costing sheet) must match the units and services identified for the paraprofessional and the service coordinator as listed in the ISP Supports and Services.

If a Service Coordination agency is utilizing paraprofessionals but has only listed a service coordinator on the ISP, an addendum adjusting the costing page to differentiate units for the service coordinator from those for the paraprofessional must be submitted. The addendum also must include updated ISP Supports and Services clarifying which provider is rendering which service.

(a) References: Service Coordination – Paraprofessionals

(i) Idaho Medicaid Publications

"Paraprofessionals and Service Coordination." MedicAide Newsletter, April 2024, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202024%20MedicAide.pdf.

"Service Coordination by Paraprofessionals for Adult Developmental Disability Services." MedicAide Newsletter, September 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/September%202023%20MedicAide.pdf.

(ii) State Regulations

"Paraprofessional Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 634.05. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

27.3.3. Service Coordination: Assessments

The plan assessment determines the participant's need for service coordination. The participant must be included in the process. The parent or legal guardian, when appropriate, and pertinent service providers as identified by the participant must also be included during the assessment process. Plan assessment must be completed by the service coordinator as part of the person-centered planning process. Plan assessment and periodic reassessment includes taking a participant history, identifying the participant's needs and completing related documentation, and gathering information from other sources such as family members, medical providers, social workers, and educators to form a complete assessment of the participant. If the participant is a child, the family's needs must be considered when determining the needs of the participant. Time spent getting consent and choice forms signed is reimbursable. Assessments must document:

- Basic needs;
- Medical needs;
- Health and safety needs;
- Therapy needs;
- Educational needs;
- Social and integration needs;
- Personal needs;
- Family needs and supports;
- Long range planning;
- Legal needs; and
- Financial needs.

(a) References: Service Coordination – Assessments

(i) State Regulations

"Plan Assessment and Reassessment." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 632.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Plan Development." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 632.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Service Coordination: Plan Development – Assessment." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 635. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

27.3.4. Service Coordination: Plan Development

Plan development is the development of a plan by a service coordinator that includes information collected in the assessment, specific and measurable goals, and actions needed by the participant to create a written service coordination plan. The plan must include a list of problems and needs and describe activities to connect the participant with appropriate resources to address them. The plan must identify potential risks, or substantiation that there are no potential risks.

The plan must be developed and implemented within 60 days of a service coordinator being chosen. It must be updated annually and as needed for the participant. Plan development also includes the completion of addendums to the service plan. Other service coordination activities cannot be provided until the plan is developed.

Plans include person-centered planning which is a planning process facilitated by the service coordinator that includes the participant and individuals significant to the participant, to collaborate and develop a plan based on the expressed needs and desires of the participant. For children, this planning process must involve the child's family, and parent or legal guardian. The plan documents the supports and services required to meet the service coordination needs of the participant. Supports are formal and informal services and activities that are not paid for by the department that enable an individual to reside safely in the setting of their choice. The plan includes documentation of everyone involved in the service planning.

The plan will include:

- Schedules for monitoring.
- Progress review
- Reassessment and documentation of any unmet needs and service gaps.
- Goals to address any needs and gaps identified.
- Time frames for achievement of goals and objectives.

The plan shall include the frequency of contact, mode of contact, and person or entity to be contacted for the service coordinator that meets the needs of the participant. The contacts must verify the participant's wellbeing and whether services are being provided according to the written plan. Service coordinators do not have to be available on a 24 hour basis, but the plan must include an objective describing what the participant, families, and providers should do in an emergency. The objective must include how the service coordinator will coordinate the services needed after an emergency.

Plans for adult participants must also follow the DD waiver Plan of Service. The service coordination plan must be included into the participant's developmental disability service plan.

(a) References: Service Coordination – Plan Development

(i) Federal Regulations

"Contents of Request for a Waiver." 42 CFR §441.301 (2024), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-G/section-441.301.

"Person-Centered Service Plan." 42 CFR §441.725 (2024), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-M/section-441.725.

(ii) Idaho Medicaid Publications

"Service Coordination by Paraprofessionals for Adult Developmental Disability Services." MedicAide Newsletter, September 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/September%202023%20MedicAide.pdf.

(iii) State Regulations

"Plan Assessment and Reassessment." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 632.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Plan Development." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 632.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Plan Development." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 633.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Service Coordination Plan." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 636. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Supports." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 007.29. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

27.3.5. Service Coordination: Referral and Related Activities

Referral and related activities help link the participant with providers able to address identified needs and achieve goals specified in the plan. This includes assisting the participant in finding, arranging and maintaining services, supports, and community resources identified on the service plan; advocating for the unmet needs of the participant; and encouraging independence.

(a) References: Service Coordination – Referral and Related Activities

(i) State Regulations

"Contacts." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 632.05. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Payment." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 637.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

27.3.6. Service Coordination: Monitoring and Follow Up

Monitoring and follow-up activities include contacts needed to ensure the plan is implemented and addresses the participant's needs. Contacts include family members, providers, or other entities or involved individuals. Contact is conducted as frequently as necessary to assist in the coordination and retention of services, and to adjust the plan as needed. Service coordinators must have face-to-face contact at least every 90 days with the participant, legal guardian, or provider who can verify the participant's well-being and whether services are being provided according to the written plan and adequate to meet their needs. This can be done via virtual care. If any changes to the plan are needed, this includes making needed addendums to the plan or service arrangements.

(a) References: Service Coordination – Monitoring and Follow Up

(i) State Regulations

"Contact and Availability." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 633.05. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Contacts." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 632.05. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Monitoring and Follow-Up." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 632.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

27.3.7. Service Coordination: Crisis Service Coordination

Crisis assistance is service coordination used to link, coordinate or advocate for a participant to access community resources to resolve a crisis. A crisis is an unanticipated event, circumstance, or life situation that places a participant at risk of at one of the following:

- Hospitalization;
- Loss of housing;
- Loss of employment or major source of income;
- Incarceration;
- Physical harm to self or others including family altercation; or
- Psychiatric relapse.

Crisis assistance, including services to prevent hospitalization or incarceration, may be provided before the completion of an assessment and development of a service plan. Crisis service coordination does not include crisis counseling, transportation to emergency service providers, or direct skill building services. Crisis hours are not available until all available hours of service coordination have already been provided in the current rolling month. Service coordination units rolled over from the previous month do not have to be used before requesting crisis assistance. Crisis hours are limited to a maximum of 20 hours during any consecutive five-day period.

Crisis assistance must be authorized by the department. Authorization can be requested retroactively when the participant's service coordination benefits have been exhausted, and no other means of support is available to the participant. Retroactive authorizations require the service coordinator to complete a crisis resolution plan and submit a request to the department within five business days of the last day of the service.

(a) References: Service Coordination – Crisis Service Coordination

(i) State Regulations

"Community Crisis Supports: Coverage and Limitations." "*Medicaid Plan Benefits*," Sec. 593. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Crisis." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 630.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Crisis Assistance." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 632.04. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Service Coordination: Coverage and Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 632. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

27.4. Service Coordination: Conflict of Interest

A conflict of interest is a situation where an agency or person directly or indirectly influences, or appears to influence, the direction of a participant to other services for financial gain. Individuals and agency employees or contractors who develop a participant's service plan cannot be:

- Related to the participant or any paid caregiver by blood or marriage.
- Financially responsible for the participant.
- Empowered to make financial or health decisions for the participant.
- Hold any financial interests to anyone that is paid to provide care for the participant.
- A provider (or employee of provider) of the state plan home and community based services (HCBS) (Idaho's 1915(i) Children's or Adult's Developmental Disability State Plan Amendments) or waiver services (1915(c) HCBS Aged & Disabled Waiver and 1915(c) HCBS Developmental Disabilities Waiver) for the participant.

Service coordinators must ensure that a conflict of interest does not exist for any participant that is on their direct caseload. For example, a service coordinator would not be allowed to be employed by any provider that any of the participants on their direct caseload receive services from. The service coordinator would need to end service coordination services to any participant receiving services from their employer or terminate their employment with said provider. A service coordinator can be employed by an agency that provides other services, if it is not the same agency where the participant receives services.

Service coordinators are required to be alert to and avoid conflicts of interest with the exercise of professional discretion and impartial judgement. Should a conflict arise they are required to inform the participant, parent, and/or legal guardian and take reasonable steps to resolve the issue in a manner that makes the participant's interests primary and protects their interests to the greatest extent possible.

Service coordination agencies are responsible for ensuring its employees and contractors meet the conflict of interest standards. The agencies are required to review and explain to the participant or their legal guardian what a conflict of interest is according to this section. This must be documented in each participant's file with a signature by the agency representative and the participant, parent, and/or legal guardian.

27.4.1. References: Service Coordination – Conflict of Interest

(a) Idaho Medicaid Publications

"Service Coordination: Conflict of Interest." MedicAide Newsletter, September 2024, https://www.idmedicaid.com/MedicAide%20Newsletters/September%202024%20MedicAide.pdf.

(b) State Regulations

"Conflict of Interest." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 633.06. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Conflict of Interest." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 630.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

27.5. Service Coordination: Prior Authorization: Children

The assessment and plan development for service coordination for Children with Special Health Care Needs does not require prior authorization (PA). However, a PA is required prior to the delivery of service coordination services. Crisis hours must also be authorized, and may be authorized retroactively. See the General Billing Instructions, Idaho Medicaid Provider Handbook for information on billing and requesting prior authorized services.

27.5.1. References: Service Coordination – Prior Authorization – Children

(a) State Regulations

"Prior Authorization." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 633.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

27.6. Service Coordination: Documentation

Agencies must maintain records that contain documentation describing the services provided, review of the continued need for service coordination, and progress toward each service coordination goal. Documentation must include:

- Participant's name.
- Name of the agency and person providing services.
- The date, time, duration, and the place of services.
- The nature, content, units of service coordination received, and whether goals specified in the plan have been achieved.
- Whether the participant declined any services.
- The need for and occurrences of coordination with any non-Medicaid case managers.
- The timeline for obtaining needed services.
- The timeline for re-evaluation of the plan.
- A copy of the assessment or prior authorization that documents eligibility for service coordination services, and a dated and signed plan.
- Agency records must contain documentation describing details of the service provided, signed by the person who delivered the service.
- Review of participant's continued need for service coordination and progress toward each service coordination goal. A review must be completed at least every one hundred and eighty (180) days after the plan development or update. Progress reviews must include the date of the review, and the signature of the service coordinator completing the review.
- The participant, family, or legal guardian's satisfaction with service.
- A copy of the informed consent form signed by the participant, parent, or legal guardian that documents that the participant has been informed of the purposes of service coordination, their rights to refuse service coordination, and their right to choose their service coordinator and other service providers.
- A plan that is signed by the participant, parent, or legal guardian, and the service coordinator. The plan must reflect person-centered planning principles and document the participant's inclusion in the development of the plan. The service coordinator must also document that a copy of the plan was given to the participant or their legal representative. The plan must be updated and authorized when required, but at least annually. Children's service coordination plans cannot be effective before the date that the child's parent or legal guardian has signed the plan.

Paraprofessional documentation must be reviewed by the participant's service coordinator and be documented with the date of review and the coordinator's signature. Time spent sending required documentation to service providers is reimbursable.

Providers must follow the requirements of the Documentation section in addition to the ones presented here.

27.6.1. References: Service Coordination – Documentation

(a) State Regulations

"Documentation." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 633.03. Department of Administration, State of Idaho,
https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Service Coordination: Provider Qualifications and Duties." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 634. Department of Administration, State of Idaho,

https://adminrules.idaho.gov/rules/current/16/160326.pdf.

27.7. Service Coordination: Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Providers have the burden of proof to establish entitlement to payment. Idaho Medicaid reimburses service coordination on a fee-for-service basis in 15-minute increments. Instructions for billing in 15-minute increments are included in the General Billing Instructions, Provider Handbook. All time must be tracked and documented for services to be reimbursable. Usual and customary fees are paid up to the Medicaid maximum allowance listed in the Targeted Service Coordination Fee Schedule. Rate updates require legislative approval. Reimbursement is not available during the assessment until after the plan is completed. Reimbursement must not duplicate payment made to public or private sector entities under other program authorities. Only one service coordinator or paraprofessional can bill at a time.

Payment for service coordination is limited to:

- Service coordination plan development.
- Face-to-face contact between the service coordinator and the participant, participant's family members, legal representative, primary caregivers, providers, or other interested persons.
- Two-way communication between the service coordinator and the participant, participant's service providers, family members, primary care givers, legal guardian, or other interested persons.
- Referral and related activities associated with obtaining needed services as identified in the service coordination plan. These activities are not required to be two-way communications so long as the activity is necessary for the participant to obtain their services.

Reimbursement for service coordination services is limited to 4.5 hours per month except when using hours rolled over from a previous month. The start date for the rolling month corresponds with the day of the month the participant's plan started and the end date for that same rolling month is the date just before the start date, but on the following month (e.g. May 15th—June 14th, December 20th—January 19th, August 3rd—September 2nd, etc.)

Reimbursement for assessment and plan development is limited to 12 hours per year.

Service Coordination HCPCS		
Procedure Code	**Modifier**	**Description**
G9002		Service Coordination
G9002	HM	Service Coordination – Paraprofessional
G9007		Plan Development
H2011		Crisis Assistance
H2011	HM	Crisis Assistance – Paraprofessional

Medicaid does not pay for service coordination for missed appointments, attempted contacts, travel to provide the service, leaving messages, scheduling appointments with the Medicaid service coordinator, transporting participants, or documenting services. Delivery of direct services, group service coordination, or services integral to another Medicaid, foster care, or non-medical services (except as required under the Individuals with Disabilities Education Act) are also non-covered. Contacts with individuals not eligible for service coordination are only reimbursed when the contact is directly related to identifying the needs and supports to help the participant access services.

The following are responsibilities of the service coordination agency and not reimbursed:

- Administrative tasks such as filing, making copies, printing, faxing, mailing, downloading emails or documents, or backing up data. Tasks that are required service coordination services, such as sending the plan to a specific provider, are reimbursable.
- Supervision of employees or contractors.
- Staffing clients with supervisors
- Observation of direct service providers.
- Billing for services provided.
- The cost for cell phone minutes, long distance charges and leaving messages.
- Back-up drives.
- Mileage.

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third-party resources before submitting claims to Medicaid. See the Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable including co-payment.

27.7.1. References: Service Coordination – Reimbursement

(a) State Regulations

"Burden of Proof – Provider Cases." IDAPA 16.05.03, "*Contested Case Proceedings and Declaratory Rulings,"* Sec. 133. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/2023%20Archive/16/160503.pdf.

"Burden of Proof (Rule 477)." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 477. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"Contacts." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 632.05. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Exclusions." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 632.06. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"General Payment Procedures." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 030. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 632.07. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Mandatory Application." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 800.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

Provider Payment, Idaho Code 56-265 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265.

"Service Coordination: Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 637. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

28. Skilled Nursing

See the Nursing Services Idaho Medicaid Provider Handbook for information and requirements.

29. Specialized Medical Equipment and Supplies

See the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), Idaho Medicaid Provider Handbook for information and requirements.

30. Supported Employment Services

30.1. Supported Employment: Provider Qualifications

Supported employment must be provided by an agency that supervises the direct service and is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or other comparable standards or meets State requirements to be a Medicaid provider. Providers of direct care and services must receive a clearance from an Idaho Department of Health and Welfare background check. The agency must be enrolled with Idaho Medicaid and sign an Additional Terms – Supported Employment Provider Agreement prior to submitting claims for supported employment services.

Providers must follow the requirements of the General Provider Qualifications section in addition to the ones presented here.

30.1.1. References: Supported Employment – Provider Qualifications

(a) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"Background Checks," Idaho Code Title 56, Chapter 27 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH27/SECT56-27.

"Individual Provider Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individuals Subject to a Background Check." IDAPA 16.05.06, "*Criminal History and Background Checks*," Sec. 100. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Provider." IDAPA 16.03.26, "*Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Providers Subject to a Background Check Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 003. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Supported Employment." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544.18. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Supported Employment." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 614.05. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

30.2. Supported Employment: Participant Eligibility

Participants are eligible to receive supported employment when they meet A&D Waiver Eligibility or DD Waiver Eligibility requirements.

Before delivery of services, providers must check eligibility on the date of the service to validate coverage. Providers must maintain documentation of the eligibility check. Eligibility can be checked by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website.

See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more detail on eligibility checks.

30.2.1. References: Supported Employment – Participant Eligibility

(a) Federal Regulations

Persons to Whom Services will be Provided, 42 CFR §136.12 (1999). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-I/subchapter-M/part-136/subpart-B/section-136.12.

(b) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(c) State Regulations

"A&D Waiver Services: Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 541. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Waiver Services: Participant Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 611. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

30.3. Supported Employment: Covered Services and Limitations

Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent because of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services to perform such work. Supported employment is limited to 40 hours per week. For DD waiver participants, the combination of supported employment, adult day health, and developmental therapy cannot exceed 40 hours per week.

Supported employment services are not available when funded under another program such as the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Additionally, supported employment is not reimbursable for incentive payments, subsidies, or unrelated vocational training expenses. Non-reimbursable expenses include incentive payments made to an employer of waiver participants to encourage or subsidize the employers' participation in a supported employment program, payments passed through to beneficiaries of supported employment programs, or payments for vocational training that are not directly related to a waiver participant's supported employment program.

Supported employment services may receive an exception for plans or addenda requesting services that exceed an Adult Developmental Disabilities Waiver participant's authorized budget. Exceptions are considered when the service is needed to obtain or maintain employment. The request must be submitted on the approved form with the following:

- A recommendation addressing amount of service, level of support needed, employment goals and a transition plan. When a participant transitions from the Idaho Division of Vocational Rehabilitation (IDVR), the recommendation must be completed by IDVR. When the participant is employed at an established job, it is completed by the supported employment agency.
- A service plan developed by the participant and their person-centered planning team with a goal for supported employment services. A comprehensive review of all services on the plan is required before submission of the exception request. The combination of services must support an addition or increase of supported employment.
- An acknowledgement signed by the participant and their legal guardian, if applicable, that additional budget dollars approved must not be reallocated to purchase any other Medicaid service.

Supported employment must meet federal Home and Community Based Services (HCBS) requirements as outlined in the Home and Community Based Services (HCBS) section of this handbook. Providers must ensure all quality assurance requirements for Aged & Disabled (A&D) Waiver and adult DD as applicable are met.

30.3.1. References: Supported Employment – Covered Services and Limitations

(a) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"A&D Waiver Services: Coverage and Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 542. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Waiver Services: Coverage and Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 612. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Exception Review." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 574.02(b). Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"HCBS." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 602.02(b). Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Service Categories Not Covered." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 060.01(f). Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Supported Employment." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 542.17. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Supported Employment." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 612.04. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

30.4. Supported Employment: Documentation

Documentation must be maintained verifying the service is not available or funded under the Rehabilitations Act of 1973 or the Individuals with Disabilities Education Act (IDEA). Providers must meet all documentation requirements listed in the Adult DD Services section or the A&D Waiver Services sections, based on which waiver the participant is receiving services from. All documentation must follow standard retention requirements including, but not limited to, those listed in the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook.

Providers must follow the requirements of the Documentation section in addition to the ones presented here.

30.4.1. References: Supported Employment – Documentation

(a) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(b) State Regulations

"Documentation Required." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 613.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider Records." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 543.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Records." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 035. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

30.5. Supported Employment: Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Providers have the burden of proof to establish entitlement to payment. Supported employment is reimbursed on a fee for service basis and must be prior authorized. Rate updates require legislative approval. The Adult DD Services Reimbursement section of this handbook and the A&D Waiver Services Reimbursement section of this handbook detail the reimbursement requirements for supported employment.

For participants receiving hourly residential habilitation – supported living services, the combination of hourly supported living, developmental therapy, supported employment, and adult day health cannot exceed the maximum set daily rate for H2022 – Daily Supported Living Services – High Support, except when all of the following are present:

- A participant is eligible for high support.
- Supported employment is in the service plan causing the daily limit to be exceeded.
- Documentation that the Person-Centered Planning team explored other lower-cost options and supports.
- A participant's health and safety needs can be met using hourly services.

Supported employment services provided to DD waiver participants are prior authorized by the Bureau of Developmental Disability (BDDS). Supported employment services provided to A&D waiver participants are prior authorized by the Bureau of Long Term Care (BLTC).

Enter the appropriate ICD-10-CM: Z74.2, "Need for assistance at home and no other household member able to render care," code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Supported employment can only be provided in the following place of service (POS):

99 Other (Community)

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Supported Employment Billing Code	
HCPCS	**Description**
H2023	Supported Employment Services, 1 Unit = 15 minutes

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third-party resources before submitting claims to Medicaid. See the Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable including co-payment.

30.5.1. References: Supported Employment – Reimbursement

(a) Idaho Medicaid Publications

New Daily Spending Cap for Hourly Supported Living – Effective October 1, 2024. *Information Release MA24-23 (9/24/2024)*. Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=31325&dbid=0&repo=PUBLIC-DOCUMENTS.

(b) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(c) State Regulations

"A&D Waiver Services: Provider Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 545. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Waiver Services: Provider Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 615. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Burden of Proof – Provider Cases." IDAPA 16.05.03, "*Contested Case Proceedings and Declaratory Rulings,"* Sec. 133. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/2023%20Archive/16/160503.pdf.

"Burden of Proof (Rule 477)." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 477. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"General Payment Procedures." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 030. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Mandatory Application." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 800.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

Provider Payment, Idaho Code 56-265 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265.

"Supported Living Levels of Support." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 574.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

31. Transition Management and Services

31.1. Transition Management and Services: Provider Qualifications

Providers of transition management and transition services must be Transition Managers. Transition managers must have a bachelor's degree in a human services field from a nationally accredited university or college, or three years' supervised work experience with the population being served. Transition managers must complete a department approved Transition Management training prior to providing services and be employed by an agency. Transition managers may not provide both transition management services and direct services to the same Medicaid participant but could provide service coordination. Providers who provide direct care and services must receive clearance from an Idaho Department of Health and Welfare background check. The provider must be enrolled with Idaho Medicaid prior to submitting claims for services.

Aged & Disabled (A&D) Waiver transition managers must be employees of a Personal Assistance Agency or a Service Coordination Agency. When an A&D Waiver participant's relative, legal representative, or designee is assisting the participant to self-direct their services through a personal assistance agency (PAA) acting as a fiscal intermediary (FI), they may not provide transition services. A participant's spouse may not provide transition services.

Providers must follow the requirements of the General Provider Qualifications section in addition to the ones presented here. For A&D waiver participants, the spouse, legal representative, or designee only assists the participant with directing services. They cannot provide transition management or services.

31.1.1. References: Transition Management and Services – Provider Qualifications

(a) Federal Regulations

Persons to Whom Services will be Provided, 42 CFR §136.12 (1999). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-I/subchapter-M/part-136/subpart-B/section-136.12.

(b) Idaho State Plan

Enhanced Alternative Benefit Plan. Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=2084&dbid=0&repo=PUBLIC-DOCUMENTS.

(c) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(d) State Regulations

"Background Checks," Idaho Code Title 56, Chapter 27 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH27/SECT56-27.

"Human Services Field." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 005.27. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individual Provider Requirements." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individuals Subject to a Background Check." IDAPA 16.05.06, "*Criminal History and Background Checks*," Sec. 100. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Provider." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 007.11. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider Qualifications." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 549.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Transition Services." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 544.20. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Transition Services." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 614.12. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

31.2. Transition Management and Services: Participant Eligibility

Transition management is available to participants aged 18 and older with Enhanced Medicaid benefits. Services are available after 45 consecutive days of a covered stay in a qualified institution when planning to discharge for up to 12 months following discharge. Participants are only eligible to access this service once in a two year cycle. Qualified institutions include nursing facilities (NFs), intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs), hospitals, and institutions for mental diseases (IMDs). Participants receiving transition management are eligible to receive transition services when they meet A&D Waiver Eligibility or DD Waiver Eligibility requirements immediately following discharge.

Before delivery of services, providers must check eligibility on the date of the service to validate coverage. Providers must maintain documentation of the eligibility check. Eligibility can be checked by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website.

See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more detail on eligibility checks.

31.2.1. References: Transition Management and Services – Participant Eligibility

(a) Federal Regulations

Persons to Whom Services will be Provided, 42 CFR §136.12 (1999). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-I/subchapter-M/part-136/subpart-B/section-136.12.

(b) Idaho State Plan

Enhanced Alternative Benefit Plan. Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=2084&dbid=0&repo=PUBLIC-DOCUMENTS.

(c) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(d) State Regulations

"A&D Waiver Services: Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 541. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Adult DD Waiver Services: Participant Eligibility." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 611. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Transition Management." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 549. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Transition Services." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 542.18. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Transition Services." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 612.14. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

31.3. Transition Management and Services: Covered Services and Limitations

31.3.1. Transition Management

Transition management provides relocation assistance and intensive service coordination activities to assist nursing facility (NF), institutions of mental disease (IMD) and intermediate care facilities for individuals with intellectual disabilities (ICF/IID) residents to transition to community settings of their choice. Transition managers function as a liaison between the participant, institutional or facility discharge staff, and other individuals as designated by the participant and the department to support a successful and sustainable transition to the community. Services include the following activities:

- A comprehensive assessment of health, social, and housing needs;
- Development of housing options, including assistance with housing choices, applications, waitlist follow-up, roommate selection, and introductory visits;
- Assistance with tasks necessary to accomplish a move from the institutional setting;
- Securing Transition Services to arrange as necessary to move, including:
    - Obtaining durable medical equipment, assistive technology, and medical supplies;
    - Arranging for home modifications;
    - Applying for public assistance; and
    - Arranging household preparations such as movers, cleaning services, utility setup, purchasing furniture and household supplies;
- Coordinating with others involved in plan development for the participant to ensure successful transition and establishment in a community setting; and
- Providing post-transition support, including assistance with problem solving, dependency and isolation concerns, consumer-directed services and supports, post-secondary educational institutions and proprietary schools when applicable, and community inclusion.

Transition management is limited to 72 hours per participant, per qualifying transition. Additional units may be authorized for participants through the month of their 21st birthday under Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefits.

(a) References: Transition Management

(i) Idaho State Plan

Enhanced Alternative Benefit Plan. Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=2084&dbid=0&repo=PUBLIC-DOCUMENTS.

(ii) State Regulations

"Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 005.21. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Limitations." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 549.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Transition Management." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 549. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

31.3.2. Transition Services

Transition services benefits are provided in conjunction with Transition Management under Enhanced State Plan Adult Developmental Disabilities (DD) Waiver or Aged and Disabled (A&D) Waiver benefits. Transition services include goods and services that enable a participant residing in a qualifying facility to transition to a community-based setting. Transition services may include the following:

- Security deposits that are required to obtain a lease on an apartment or home;
- Cost of essential household furnishings including furniture, window coverings, food preparation items, and bed/bath linens;
- Set-up fees or deposits for utility or service access, including telephone, electricity, heating, and water;
- Services necessary for the participant's health and safety such as pest eradication and one-time cleaning prior to occupancy;
- Moving expenses; and
- Activities to assess need, arrange for, and procure transition services.

Transition services do not include ongoing expenses, real property, ongoing utility charges, décor, monthly rent or mortgage expenses, food, household appliances, or diversion/recreational items such as televisions, movies, and computers.

Transition services are limited to $2,000 per participant, which does not include Transition Management. This service can only be accessed once every two years upon a transition from a qualifying institution as detailed in Participant Eligibility. Services are only available when the participant is unable to meet the expense, or the support cannot be obtained through other sources. Transition services must meet federal home and community-based services (HCBS) requirements as outlined in the Home and Community Based Services (HCBS) section.

(a) References: Transition Services

(i) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(ii) State Regulations

"HCBS." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Transition Services." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 542.18. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Transition Services." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 612.14. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

31.4. Transition Management and Services: Documentation

All documentation must follow standard retention requirements including, but not limited to, those listed in the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook.

Delivery of transition management and services must be documented and include the following:

- The name of the participant;
- The dates of the transition management and services;
- The name of the provider agency and the transition manager;
- The nature, content, and units of the transition management and services received, and whether goals specified in the service care have been achieved;
- Whether the participant has declined services in the service plan;
- The need for, and occurrences of, coordination with other service coordinators;
- A timeline for obtaining needed services; and
- A timeline for reevaluation of the plan.

Transition managers must meet all documentation requirements listed in the Adult DD Services section of this handbook, or the A&D Waiver Services section of this handbook, based on which waiver the participant is receiving services from. Providers must follow the requirements of the Documentation section in addition to the ones presented here.

31.4.1. References: Transition Management and Services – Documentation

(a) Idaho State Plan

Enhanced Alternative Benefit Plan. Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=2084&dbid=0&repo=PUBLIC-DOCUMENTS.

(b) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(c) State Regulations

"Documentation Required." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 613.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider Records." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 542.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Records." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 035. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

31.5. Transition Management and Services: Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Providers have the burden of proof to establish entitlement to payment. Idaho Medicaid reimburses transition management and transition services are reimbursed on a fee-for-service basis and must be prior authorized. Rate updates require legislative approval.

All transition management is prior authorized by the Bureau of Long-Term Care (BLTC). Transition services provided to Aged and Disabled (A&D) Waiver participants are prior authorized by BLTC.Transition services provided to Developmental Disability (DD) Waiver participants are prior authorized by the Bureau of Developmental Disability Services (BDDS).

Enter the appropriate ICD-10-CM: Z74.2, "Need for assistance at home and no other household member able to render care," code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

The Adult DD Services Reimbursement section and the A&D Waiver Services Reimbursement section detail the reimbursement requirements for transition management and services. Transition services can only be provided in the following place of service (POS):

12 Home
33 Custodial Care Facility (certified family homes, assisted living facilities, residential care facility, and other living situations where care is furnished commercially) when the service plan does not identify this service as the responsibility of the facility.
99 Other (Community)

Transition management can be provided in the POS above, or in the qualifying institution prior to a participant's discharge. Transition services may only be billed once a participant is eligible for waiver services after discharge from the institution or facility.

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Transition Management and Service Billing Codes		
HCPCS	**Modifier**	**Description**
T2022	**UD**	**Transition Management – 1 unit = 15 minutes**
T2038		**Transition Services – Prior authorized goods and services not to exceed $2,000.**

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third-party resources before submitting claims to Medicaid. See the Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable including co-payment.

31.5.1. References: Transition Management and Services – Reimbursement

(a) Idaho State Plan

Enhanced Alternative Benefit Plan. Division of Medicaid, Department of Health and Welfare, State of Idaho,

https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=2084&dbid=0&repo=PUBLIC-DOCUMENTS.

(b) Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

(c) State Regulations

"Adult DD Waiver Services: Provider Reimbursement." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 615. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Burden of Proof – Provider Cases." IDAPA 16.05.03, "*Contested Case Proceedings and Declaratory Rulings,"* Sec. 133. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/2023%20Archive/16/160503.pdf.

"Burden of Proof (Rule 477)." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 477. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"General Payment Procedures." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 030. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Mandatory Application." IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure,"* Sec. 800.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

Provider Payment, Idaho Code 56-265 (2026). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265.

"Rates." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 545.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

32. Appeals

See the General Billing Instructions, Idaho Medicaid Provider Handbook for information on appeals for denied claims using the claim review request process. See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for information on appealing denied prior authorization requests.

33. Documentation

All providers are required to generate records at the time the service is delivered and to maintain documentation that supports reimbursement for services. Individual services may have additional documentation requirements. General requirements for documentation and signatures can be found in General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, including standard retention requirements. Records limited to checklists with attendance/appointments, procedure codes, and units of time are insufficient to meet this requirement. Documentation must be signed and dated by the person delivering the service with their name clearly printed.

Providers must meet all documentation requirements listed in the Adult Developmental Disabilities Services: Additional Documentation section of this handbook, or the Aged and Disabled Waiver: Additional Documentation section of this handbook, based on which waiver the participant is receiving services from.

Providers of Children's DD home and community-based services (HCBS) must maintain records for each participant served. Providers must include written documentation of the service provided during each visit made to the participant, containing the following information:

- Date, time, and location of visit;
- Summary of session and support services provided during the visit;
- Length of visit, including time in and time out; and
- Signature and date of the individual providing the service.

Documentation must be made available immediately upon request by department personnel acting in their official capacity. Services delivered without adequate documentation are not eligible for reimbursement. Providers must only submit records for utilization management when requested by the department. Documentation sent unsolicited, or not for a service requiring prior authorization, will not be reviewed by the department. Unreviewed documentation does not constitute approval or authorization of a service.

33.1. References: Documentation

33.1.1. Federal Regulations

Disclosure of Information by Providers and Fiscal Agents, 42 CFR §455, Subpart B (2023). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-B.

33.1.2. Idaho State Plan

ID-20-0020 1915(i) Home and Community-Based Services (HCBS) State Plan Children Benefit Renewal. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/spa/downloads/ID-20-0020.pdf.

33.1.3. Idaho Waivers

ID Adult Developmental Disabilities Waiver (0076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81466.

ID Aged and Disabled Waiver (1076.R07.00). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81471.

33.1.4. State Regulations

Administrative Remedies, Idaho Code §56-209(h)(3) (2016). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/title56/t56ch2/sect56-209h.

"Documentation." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 584.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Documentation Requirements." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 605.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Documentation Required." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 613.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Documentation of Services and Access to Records." IDAPA 16.05.07, "*The Investigation and Enforcement of Fraud, Abuse, and Misconduct*," Sec. 101. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160507.pdf.

"Provider Implementation Plan (PIP)." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 573.08. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Records." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 035. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Appendix A. A&D Waiver Provider Training Matrix Standards V2.3

PURPOSE

Standards for Direct Care Staff and Allowable Tasks/Activities

Effective training is the foundation of a personal care program. It is imperative that training provides the knowledge and skills that will improve competence and confidence and thereby improve the effectiveness of the care we deliver to those we serve.

In accordance with Idaho Administrative Procedures Act (IDAPA) 16.03.26.544.03 Provider Qualifications, all providers of homemaker services, respite care, adult day health, transportation, chore services, companion services, attendant care, adult residential care, and home delivered meals must meet, either by formal training or demonstrated competency, the training requirements contained in the Provider Training Matrix and the standards for direct care staff and allowable tasks or activities in the Department's Aged and Disabled (A&D) waiver as approved by the Centers for Medicare and Medicaid Services (CMS).

Registered Nurses (RN), Licensed Practical Nurses (LPN), and Certified Nursing Assistants (CNA) who maintain a current active license/certification with the Idaho Board of Nursing are only required to be trained for Participant Specific Endorsements as needed.

Adult Day Health (ADH) providers that are licensed settings in full compliance with one of the following chapters of IDAPA are presumed to meet the Provider Training Matrix standards.

IDAPA 16.03.19 Rules Governing Certified Family Homes (CFH)
IDAPA 16.03.21 Developmental Disabilities Agencies (DDA), Residential Habilitation Agencies, and Adult Residential Care Facilities

PROVIDER TRAINING MATRIX STANDARDS

The following are requirements/procedures regarding the implementation of the Provider Training Matrix and standards.

The Provider Training Matrix is divided into four main categories.

1. General
2. Personal Care and Attendant Care
3. Homemaker
4. Participant Specific Endorsements

Each category identifies what core body of knowledge of skill level is expected, who can verify competency and by what method.

General

This category includes the following Required Competencies; Communication, Infection Control, Confidentiality, Documentation, and Participant Rights and Preferences. The table below identifies who can determine competency and by what method.

Attendant Care and Personal Care Services

This category includes the following Required Competencies; Documentation, Eating Meals, Toileting, Mobility, Transferring, Personal Hygiene, Dressing, Bathing, and Medication. The table below identifies who can determine competency and by what method.

Homemaker
This category includes the following Required Competencies; Meal Preparation, Shopping, Laundry, and Housework. The table below identifies who can determine competency and by what method.

Participant Specific Endorsements
These endorsements are related to participants who have care needs that require specific training, delegation, and/or demonstration. The table below identifies who can determine competency and by what method and includes a list of endorsements.

PROVIDER TRAINING MATRIX REQUIREMENTS

Personal Assistance Agency
1. The Required Verification method for each identified category must be completed. If multiple methods are indicated all must be completed.
2. The written test required under each identified category must be approved by either the Agency RN or Agency Personnel as identified in this Matrix.
3. The Agency RN will determine the minimum standards for a passing grade.
4. All training curriculum and blank written test templates will be maintained in an agency training manual and made available for Department review.
5. Completed written tests should be maintained in the individual employee record.
6. Proof of completion for the Provider Training Matrix and/or Participant Specific Endorsements should be maintained in the individual employee record.

Fiscal Intermediary
1. The written test required under each identified category must be approved by either the Agency RN or Agency Personnel as identified in this Matrix.
2. The Agency RN will determine the minimum standards for a passing grade.
3. All training curriculum and blank written test templates will be maintained in an agency training manual and made available for Department review.
4. Completed written tests should be maintained in the individual employee record.
5. The agency RN and participant are responsible for verification of competency for Participant Specific Endorsements.
6. Proof of completion for the Provider Training Matrix and/or Participant Specific Endorsements should be maintained in the individual employee record.

TRAINING CURRICULUM

Training curriculum is the actual study material utilized to train direct care service providers. The agency must have training curriculum for each of the Required Competencies as identified in the Table of Provider Training Matrix Requirements below.

Online Training Modules
Agencies the elect to utilize the Department approved online training modules via In the Know or Care Academy are not required to maintain training curriculum or training verification per the Provider Training Matrix. **The agency must maintain the certificate of completion for each employee for all required courses via the online training module requirements.**

TABLE OF PROVIDER TRAINING MATRIX REQUIREMENTS

Required Competency	Required Instructor	Required Verification
General		
Communication 1. Basic knowledge of reading and comprehension specific to participant Service Plans. 2. Ability to follow verbal and written instructions. 3. Clear prompting and cueing related to participant service delivery. 4. Basic knowledge of effective communication.	Agency Personnel	☐ Written Test ☐Demonstrated Ability ☒Documentation *(Documentation examples: resume, interview summary)*
Infection Control 1. Basic knowledge of how infections are spread, proper handwashing techniques, and knowledge of Universal Precautions. **2.** Basic knowledge of Personal Protective Equipment (PPE)	RN	☒ Written Test ☒Demonstrated Ability ☐Documentation
Confidentiality 1. Adheres to Health Insurance Portability and Accountability Act (HIPAA) and agency confidentiality guidelines.	Agency Personnel	☒ Written Test ☐Demonstrated Ability ☒Documentation
Documentation 1. Knows basic guidelines and fundamentals of documentation specific to participant Service Plans.	Agency Personnel	☒ Written Test ☐Demonstrated Ability ☒Documentation
Participant Rights and Preferences 1. Knowledge of the limitations regarding participant information including Advanced Directives, Physician Scope of Treatment (POST) or Do Not Resuscitate (DNR) 2. Basic knowledge of Home and Community Based Service (HCBS) participant rights IDAPA 16.03.26.533-534. **3.** Basic knowledge of participant dignity, respect, and preferences.	Agency Personnel	☒ Written Test ☐Demonstrated Ability ☐Documentation
Attendant Care and Personal Care Services		
Documentation 1. Observation: Basic knowledge of, and the ability to, identify the participant's physical and mental factors along with usual daily routines.	RN	☒ Written Test ☐Demonstrated Ability ☐Documentation

2. Reporting: Knowledge of mandatory and incident reporting as well as role in reporting condition changes.		
Eating Meals 1. Basic knowledge of fluid balance/hydration. 2. Strategies to ensure adequate nutritional/fluid intake. *(For feeding tubes or special circumstances, Participant Specific Endorsements are required)*	RN	☒ Written Test ☐Demonstrated Ability ☐Documentation
Toileting 1. Knowledge of elimination, terms, and problems with urinary and bowel function. 2. Knowledge of proper cleansing procedures. **3.** Knowledge of toileting equipment/supplies including care, cleaning, and disposal.	RN	☒ Written Test ☐Demonstrated Ability ☐Documentation
Mobility 1. Knowledge of basic terminology and assistive devices including cane, walker, wheelchair, and crutches. 2. Limitations of caregivers must be identified on the employee health screen. *(For mechanical lifts and maintenance exercises Specific Endorsements are required)*	RN	☒ Written Test ☒Demonstrated Ability ☐Documentation
Transferring 1. Knowledge of proper body mechanics and transfers: Bed to chair/commode, bed to wheelchair and back, and participants with weak or paralyzed side.	RN	☒ Written Test ☒Demonstrated Ability ☐Documentation
Personal Hygiene 1. Basic knowledge of oral care, hair care, skin care, nail care, and basic grooming needs. **2.** Nail care for diabetic or circulatory compromised participants is **limited** to nail filing only.	RN	☒ Written Test ☐Demonstrated Ability ☐Documentation
Dressing 1. Basic knowledge of dressing practices including upper and lower body. *(For compression hose, prosthetics and orthotics Participant Specific Endorsements are required)*	RN	☒ Written Test ☐Demonstrated Ability ☐Documentation
Bathing 1. Basic knowledge of bathing techniques.	RN	☒ Written Test ☐Demonstrated Ability ☐Documentation

Medication 1. Basic knowledge of prompting and cueing self-directed medication and treatment administration. 2. Knowledge of program limitations in accordance with IDAPA 23.01.01 "Rules of the Board of Nursing". *(For participant specific medications, oxygen therapy, and inhalation equipment Participant Specific Endorsements are required)*	RN	☒ Written Test ☒Demonstrated Ability ☐Documentation
Homemaker		
Meal Preparation Basic knowledge of the following: 1. Meal Planning: basic nutrition needs. 2. Preparation: preparation of nutritious foods following diet requirements. 3. Storage and Handling: understanding labels, seasonal foods as well as safe food storage and handling. 4. Safe use of household appliances. *(Special diets require Participant Specific Endorsements)*	Agency Personnel	☒ Written Test ☐Demonstrated Ability ☐Documentation
Shopping 1. Basic knowledge of purchasing items based on participant preference and consideration of a fixed income.	Agency Personnel	☒ Written Test ☐Demonstrated Ability ☐Documentation
Laundry 1. Basic knowledge of accepted practice in laundry procedures including following label and washing machine instructions, folding, and putting away laundry.	Agency Personnel	☒ Written Test ☐Demonstrated Ability ☐Documentation
Housework 1. Basic knowledge of routine housekeeping duties including ability to clean surfaces, furnishings, dishes, floors, and garbage disposal.	Agency Personnel	☒ Written Test ☒Demonstrated Ability ☐Documentation

Participant Specific Endorsements

Participant Specific Endorsements training and subsequent required verification must be conducted by the agency RN. This documentation must be kept in the employee file.

Participant Specific Endorsements		
Maintenance Exercise 1. Formal program established by a PT, RN, or Physician. 2. Passive ROM could be established by RN. *(Delegated by licensed professional)*	RN	☐ Written Test ☒Demonstrated Ability ☐Documentation
Mechanical Lift	RN	☐ Written Test

1. Knowledge of current standards of safe practice for mechanical transfers. *(Delegated by licensed professional)*		☒Demonstrated Ability ☐Documentation
Catheter Care 1. Knowledge of current standards of practice for routine care procedure of indwelling catheter.	RN	☐ Written Test ☒Demonstrated Ability ☐Documentation
Bowel Care 1. Knowledge of current standards of practice for routine bowel program.	RN	☐ Written Test ☒Demonstrated Ability ☐Documentation
Orthotics 1. Knowledge of current standards of practice in applying compression hose/sleeves, prosthetics and orthotics.	RN	☐ Written Test ☒Demonstrated Ability ☐Documentation
Ostomy Care 1. Knowledge of current standards of practice for routine procedure of participant ostomy.	RN	☐ Written Test ☒Demonstrated Ability ☐Documentation
Oxygen Therapy 1. Knowledge of generally accepted practice when dealing with oxygen supplies and equipment. 2. Knowledge of appropriate application of oxygen delivery equipment. 3. Flow meter setting as prescribed by Physician only. *(Delegated by licensed professional)*	RN	☐ Written Test ☒Demonstrated Ability ☐Documentation
Inhalation Equipment 1. Knowledge of generally accepted practice in care of nebulizers or other inhalation equipment.	RN	☐ Written Test ☒Demonstrated Ability ☐Documentation
Gastrostomy Tube Feeding 1. Knowledge of current accepted procedure for gastrostomy tube feedings. 2. Knowledge of current accepted procedure for care of gastrostomy site and tube. *(Monthly performance evaluations must be conducted by the RN. Medications via G-Tube may only be given if authorized by RN)*	RN	☐ Written Test ☒Demonstrated Ability ☐Documentation
Feeding Complications 1. Knowledge of current accepted practices when dealing with a participant with specialized feeding needs. (i.e. difficulty swallowing, frequent aspiration, set-up, and specialized equipment)	RN	☐ Written Test ☒Demonstrated Ability ☐Documentation
Special Diets	RN	☐ Written Test

1. Knowledge of generally accepted practice for special dietary needs.		☒Demonstrated Ability ☐Documentation
Medication Assistance 1. In-home Settings: assisting the participant with Physician-ordered medications that are ordinarily self-administered in accordance with IDAPA 23.01.01 "Rules of the Board of Nursing". *(Delegated by licensed professional)*	RN	☒ Written Test ☐Demonstrated Ability ☒Documentation
Treatments 1. Knowledge of current accepted and prescribed procedure. *(Delegated by licensed professional)*	RN	☐ Written Test ☒Demonstrated Ability ☐Documentation
Cognitive Impairments 1. Knowledge of cognitive impairments, care needs, and techniques when working with cognitively impaired individuals. *(For participants with a developmental disability, the IDHW approved courses, Visions and Pathways must be completed)*	RN	☒ Written Test ☐Demonstrated Ability ☒Documentation
Psychological or Social Disorders 1. General knowledge of mental illness/behaviors and basic interventions for Alzheimer's, dementia, depression, and generalized anxiety.	RN	☒ Written Test ☐Demonstrated Ability ☐Documentation

VERSION HISTORY

Date	Version	Comment
02/2026	v2.3	Added version history, accessibility update, IDAPA update.

The information outlined herein is not new law but is an agency interpretation of existing law, except as authorized by law or as incorporated into a contract. To seek additional information or provide input on the agency guidance document please reach out to BLTCQA@dhw.idaho.gov.

Appendix B. Additional Terms: Adult Day Health

State of Idaho

Medicaid Provider Agreement

Additional Terms – Adult Day Health

The DEPARTMENT reserves the right to amend the following conditions in accordance with the Medicaid Provider Agreement, as amended.

A-1. Purpose. The purpose of this agreement is to provide adult day health services in accordance with 16.03.26.544 and 16.03.26.612, "Medicaid Plan Benefits" and 16.03.22 "Residential Assisted Living Facilities." The provider will only bill Medicaid for Adult Day Health services that are provided to community-based adults with functional and/or cognitive limitations, and who meet institutional eligibility criteria. Services are to be delivered in a structured program outside of the home of the participant that provides a variety of health, social and other related support services in a safe and protective setting during any part of a day, but not more than:

A-1.1. Fourteen (14) hours in any twenty-four (24) hour period for an Aged and Disabled (A&D) Waiver participant;

A-1.2. Thirty (30) hours per week;

A-1.3. Thirty (30) hours per week in combination with developmental therapy; or

A-1.4. Forty (40) hours per week in combination with supported employment and developmental therapy.

A-2. Fire/life/safety Standards. Adult day health may be provided in Certified Family Homes, Licensed Residential and Assisted Living Facilities, Developmental Disability Agencies, Nursing Facilities and Hospitals settings and must meet all applicable fire/life/safety requirements according to their licensure or certification. Adult Day Health providers who are not one of the above provider types must at a minimum meet the fire/life safety requirements of a Certified Family Home if the Adult Day Health is provided in a home (IDAPA 16.03.26.610) If the provider does not meet one of the above provider types and provides Adult Day Health in a facility, the provider must at a minimum meet the building and health standards of a Developmental Disability Agency (IDAPA 16.03.21). The provider shall also comply with any city, county, or state requirements which apply to the operation of an Adult Day Health for that area including the requirements of IDAPA 16.03.02.204, except to the reimbursable hours stated in A.1 above.

A-3. Training. The Provider shall ensure that staff has sufficient training to maintain qualifications and competence as required in IDAPA 16.03.26.544.10. Providers shall also have training in 1) infection control; 2) CPR; and 3) First Aid. The Provider acknowledges that training is not a reimbursable activity. In addition, the provider must demonstrate the ability to provide services according to the service plan.

A-4. Criminal History Check. The Provider shall ensure that all service providers have satisfactorily completed a criminal history check prior to providing Adult Day Health as required by IDAPA 16.05.06. If Adult Day Health is provided in a home where other adults are living, all adults living in the home must satisfactorily complete a criminal history check. Adult Day Health or Certified Family Home participants are exempt from having to complete a criminal history check.

A-5. Enrollment Agreement. Prior to the provision of Adult Day Health services to any participant, the provider and the participant or legal guardian shall enter into an Enrollment Agreement. This written agreement must be signed by the participant or guardian and shall include at a minimum the following:

A-5.1. Name and social security number;

A-5.2. Permanent address;

A-5.3. Marital status and gender;

A-5.4. Date of birth;

A-5.5. Name and address of individual(s) to contact in the event of an emergency;

A-5.6. Names of personal physician and dentist;

A-5.7. Admission date and name of individual who completed enrollment form;

A-5.8. A list of medications, diets, allergies, services and treatments prescribed for the participant;

A-5.9. A description of the services to be provided, reflecting that Adult Day Health includes, but is not limited to, recreational activities, maintenance of self-help skills, assistance with activities of daily living, provisions for trips to social functions (transportation costs to social functions are not a Medicaid reimbursable service), and special diets;

A-5.10. The termination notice policy, reflecting that a minimum fifteen (15) calendar days written notice by either party is required unless waived by mutual written agreement.

A-5.11. Notice that services may be terminated on notice shorter than fifteen (15) days under emergency or urgent circumstances, such as termination of this provider agreement; a condition endangering the health, safety or welfare of the participant; or if the participant presents a danger to self or others.

A-6. Enrollment Criteria. The Provider shall enroll participants under the following conditions:

A-6.1. Accept only participants when they can provide the level or type of service the participant requires and an adequate number of skilled and/or licensed staff are available on site to deliver the service.

A-6.2. Participants who require skilled nursing may be enrolled when the care is within the licensed authority of the provider and a nurse is on site to perform the nursing service.

A-6.3. No participant shall be enrolled who has pressure ulcers or open wounds that are not healing.

A-6.4. No participant shall be enrolled who requires continuous nursing assessment and intervention.

A-6.5. No participant shall be enrolled who has draining wounds for which the drainage cannot be contained.

A-6.6. No participant shall be enrolled whose needs are beyond the level of fire safety provided by the facility.

A-6.7. No participant shall be enrolled whose physical, emotional, or social needs are not compatible with the other participants in the facility.

A-6.8. Adult Day Health services may only be provided in a Certified Family Home when authorized by the Department after review and approval of the appropriateness of the arrangement and its subsequent impact on the residents in that home.

A-7. Medications. Adult Day Health may be provided in Certified Family Homes, Licensed Residential and Assisted Living Facilities, Developmental Disabilities Agencies, Nursing Facilities and Hospital settings and must meet all applicable medication standards and requirements according to their licensure or certification. Adult Day Health providers who are not one of the above provider types must at a minimum meet the following medication requirements.

A-7.1. Medications may only be administered by licensed nurses or other licensed healthcare professionals operating within their scope of practice. Any staff who assists with medications must be licensed to do so or must successfully complete a Board of Nursing approved course on assistance with medication, as the delegate of a licensed nurse.

A-7.2. Each hourly participant shall be responsible for bringing his/her own medications for the time spent in Adult Day Health.

A-7.3. The Provider shall be responsible for safeguarding Adult Day Health participants' medications while they are at the facility/home.

A-8. Space and Accommodations Requirements. Adult Day Health may be provided in Certified Family Homes, Licensed Residential and Assisted Living Facilities, Developmental Disabilities Agencies, Nursing Facilities and Hospital settings and must meet all applicable space and accommodation requirements according to their licensure or certification. The following space and accommodation requirements will serve as a guideline for the facilities listed above. Adult Day Health providers who are not one of the above provider types must at a minimum meet the following space and accommodation requirements in addition to meeting the minimum standards listed in A-2:

A-8.1. Provide at least sixty (60) square feet of space per participant that is usable for Adult Day Health program purposes. In addition to space for program activities, the facility shall have a rest area and designated areas to permit privacy and to isolate participants who become ill, disruptive, or require rest. Such rest area shall be located away from activity areas and near a restroom.

A-8.2. Furniture for napping, such as lounge chairs, recliners and couches, shall be made available for the participants' use during daytime hours, 6 a.m. through 10 p.m. The facility shall maintain a space of at least three (3) feet adjacent to each piece of furniture used for napping that is in use, as an entry and exit space from that piece of furniture.

A-8.3. Beds and bedrooms of persons not enrolled in Adult Day Health shall not be utilized for Adult Day Health participants.

A-8.4. There must be at a minimum 1 bathroom for every 8 persons, including staff, and other individuals present at the location. Bathrooms with more than one stall may count towards the 1:8 ratio.

A-8.5. The temperature of the location must be kept at a comfortable temperature. Minimum temperature must not be less than seventy (70) degrees and the maximum temperature must not be more than eighty-five (85) degrees.

A.9. Sufficient Personnel. The following conditions shall be met:

A-9.1. The provider shall employ sufficient personnel to assure the safe and proper care of participants, taking into account the physical and cognitive status of each participant, as well as the size and layout of the facility.

A-9.2. The staff participant ratio shall be a minimum of one (1) staff to six (6) participants (1:6).

A-9.3. As the number and severity of participants with functional impairments increases, the staff participant ratio shall be adjusted accordingly. Additional staff must be added, as necessary, to meet the needs of each individual served. Programs serving a high percentage of participants who are severely impaired should have a staff-participant ratio of one to four (1:4).

A-9.4. The provider shall have a written emergency procedures and disaster preparedness plan and sufficient staff available to implement the written emergency procedures, including evacuation of the participants, if required, in accordance with the provider's disaster preparedness plan.

A-10. Food Preparation Requirements.

A-10.1. If the provider prepares and serves food, it shall be prepared by sanitary methods that conserve nutritional value, flavor and appearance. The facility shall be inspected and licensed by applicable inspection entities in the city, county or region. If no inspection or licensing entity is available a waiver to the inspection requirement may be requested. If a waiver is granted, the provider must still comply with food preparation requirements outlined in IDAPA 16.02.19. "Idaho Food Code".

A-10.2. Intervals between breakfast and lunch and lunch and dinner shall not be less than four (4) hours nor more than six (6) hours between each.

A-10.3. Foods shall be served in a manner to meet the eating needs of each participant, including special diets or portion control.

A-10.4. The participant cannot be required to purchase food from the provider.

A-11. Records. The provider shall maintain the following records:

A-11.1. A current record for each Adult Day Health participant, which includes all information listed in the Enrollment section of this "Additional Terms" agreement.

A-11.2. A log of dates, times, and duration of the services provided to each participant on a daily basis, which shall be maintained for a period of not less than five (5) years from the date of the service delivery.

A-12. Quality Improvement. The Provider is responsible for assuring that it provides quality services in compliance with applicable rules. Results of quality improvement reviews conducted by the Department shall be transmitted to the Provider within forty-five (45) days after the review is completed. The Provider shall respond within forty-five (45) days after the results are received. If problems are identified, the Provider shall implement a quality improvement corrective action plan and report the results to the Department upon request. Quality of services shall be evaluated according to the following criteria:

A-12.1. The outcomes for activities identified on each participant's enrollment agreement are achieved or are modified due to changes in circumstances, abilities, or re-assessment and public funds are expended for appropriate services in the most cost-effective manner.

A-12.2. All enrollment agreements for this service shall be signed by the participant or legal guardian.

A-12.3. The Provider informs each participant or guardian of the services to be received, the expected benefits and attendant risks of receiving those services, of the right to refuse services, and alternative forms of services available.

A-12.4. The Provider, its employees and subcontractors interact with participants in a respectful manner.

A-12.5. Provider interventions promote participant empowerment and choice, within the programmatic confines of safe and effective services that do not endanger the participant or others in implementation. Participants are recognized as primary decision-makers in accessing services, unless a court has established an appropriate guardianship.

A-12.6. Services are provided at a time and location that is convenient, acceptable and suitable for the participant and are coordinated and consistent with all other services the participant is receiving.

A-12.7. The Provider's decision to accept or continue services for a participant should be based on their ability to meet the needs of the participant.

A-12.8. The Provider schedules services to ensure that the enrollment agreement for this service is developed and implemented effectively.

A-12.9. The Provider conducts a quality improvement program which includes sufficient training sessions to ensure staff qualifications and competence, quarterly audits of services, site visits, participant satisfaction, and annual professional credential and competency review. Provider shall implement a Quality Improvement Plan for any deficiencies noted.

A-12.10. The Provider informs the participant about the participant's rights and the availability of protection and advocacy services.

A-12.11. The Provider ensures that the setting in which services are delivered meets the required Home and Community-Based Services setting qualities described in 42 CFR § 441.300(c)(4).

A-13. Reports. The Provider shall:

A-13.1. Maintain a list of all participants being served, and all employees, subcontractors, volunteers or other agents, and provide it to the Department upon request. The report shall indicate what training they have obtained or provided to their staff in meeting the needs of the participants.

A-13.2. Report any suspected or observed charges of fraudulent, negligent, or abusive conduct to the appropriate legal authority as required by rule or law.

A-13.3. Inform the Department within forty-eight (48) hours of any charges of criminal conduct, any accusation of fraudulent, negligent or abusive conduct, and any termination for poor performance by an employee, subcontractor or agent.

A-14. Appeals and Administrative Review.

Providers that disagree with the Department's decision may request in writing for an administrative review pursuant to Idaho Code §56-133. If the provider disagrees with the administrative review decision, it may request an administrative appeal within twenty-eight (28) days of such decision.

FOR THE PROVIDER:

_____

Administrator

_____

Date

Name of Provider:_____

Address of Provider:_____

Phone: _____

Idaho Medicaid Provider Number:_____

Appendix C. Additional Terms: Behavioral Consultation

State of Idaho

Medicaid Provider Agreement
Additional Terms – Behavioral Consultation

The DEPARTMENT reserves the right to amend the following conditions outlined in this document in accordance with the Medicaid Provider Agreement, as amended.

A-1. Purpose. The purpose of this Agreement is to implement the provision of behavior consultation or crisis intervention services to eligible Medicaid participants who meet the criteria for persons with developmental disabilities as defined in Idaho Code § 66-402, who are eighteen (18) years of age or older and who meet Adult DD waiver eligibility in accordance with IDAPA 16.03.26.610-615, "Medicaid Plan Benefits."

A-2. Training. The Provider shall ensure staff participation in any training required by the Department. The Provider shall ensure that direct service providers receive orientation and training to meet the specific needs of the participant(s) to whom they are assigned work duties.

A-3. Criminal History Check. The Provider shall ensure that all direct care staff subject to IDAPA 16.05.06 have satisfactorily completed a criminal history check. The Provider shall ensure that a self-declaration form and fingerprinting are completed for individuals who are subject to a criminal history check before the individual provides unsupervised direct care or services to children or vulnerable adults.

A-4. Restraints. All restraint/restrictive intervention(s) must be identified on a Plan of Service and prior authorized by the Department prior to implementation. The Provider shall not use restraints or restrictive interventions, other than physical restraint in an emergency, prior to the use of positive behavior interventions. Chemical restraint shall be authorized by an attending physician. Mechanical restraint may be used for medical purposes only when authorized by the attending physician. Non-emergency physical restraint and seclusionary time out may be used only when a written behavior change Implementation Plan is developed by the participant, their team, and the behavior consultant as qualified in IDAPA 16.03.26. Written informed consent is required for all use of restraint.

A-5. Quality Improvement. The Provider is responsible for the development and implementation of a quality assurance program which assures service delivery consistent with applicable rules. Results of quality improvement reviews conducted by the Department shall be transmitted to the Provider within forty-five (45) days after the review is completed. If deficiencies have been identified by the review, the Provider shall submit to the Department a corrective action plan for addressing the identified deficiencies. This corrective action plan shall be submitted to the Department within forty-five (45) days of receiving the results of a quality assurance review. Upon request, a provider shall also forward to the Department the results of any implemented corrective action plan. At a minimum quality of services shall be evaluated according to the following criteria:

> **A-5.1.** A participant's implementation plan must be modified when there are changes in circumstances, abilities, or a re-assessment to ensure that public funds are expended for appropriate services in the most cost-effective manner.

A-5.2. The Provider informs each participant or guardian of the services to be received, the expected benefits and risks of receiving those services, of the right to refuse services, and alternative forms of services available.

A-5.3. The Provider, its employees and subcontractors interact with participants in a respectful manner.

A-5.4. Provider interventions promote participant empowerment and choice, within the programmatic confines of safe and effective services that do not endanger the participant or others in implementation. Participants are recognized as primary decision-makers in accessing any and all services, unless a court has established an appropriate guardianship.

A-5.5. Services are provided at a time and location that is convenient, acceptable and suitable for the participant and are coordinated and consistent with all other services the participant is receiving.

A-5.6. The Provider's decision to accept or continue services for a participant is based on the provider's ability to meet the needs of the participant.

A-5.7. The Provider schedules services to ensure that the implementation plan for this service is developed and implemented effectively.

A-5.8. The Provider conducts a quality improvement program which includes sufficient training sessions to ensure staff qualifications and competence, quarterly audits of services, site visits, participant satisfaction, and annual professional credential and competency review. The provider shall implement a Quality Improvement Plan for any deficiencies noted.

A-5.9. The Provider informs the participant about the participant's rights and the availability of protection and advocacy services.

A-5.10. The Provider gives the participant and targeted service coordinator copies of the Provider's implementation plan(s).

A-6. Transition of Participants. The agency must develop a transition plan to terminate service delivery to a participant if, as a result of a person-centered planning process conducted by the person-centered planning team, it is demonstrated that the participant is no longer in need of or desires Behavior Consultation services. The agency must notify the participant in writing that the termination of services will occur. The agency may not terminate services when to do so would pose a threat of endangerment to the participant or others.

A-7. Reports. The Provider shall:

A-7.1. Maintain a list of all participants being served, and all employees, subcontractors or agents, and provide it to the Department upon request. The report shall indicate which providers of services have received Department-approved training.

A-7.2. Keep progress notes/records of time, and tasks/activities performed by direct service providers and have them available to the Department during QA reviews.

A-7.3. Keep annual evaluation reports and have them available to the Department during QA reviews.

A-7.4. Inform the Department within forty-eight (48) hours of any charges of criminal conduct, any accusation of fraudulent, negligent or abusive conduct, and any termination for poor performance by an employee, subcontractor or agent.

A-7.5. Report any suspected or observed fraudulent, negligent, or abusive conduct to the appropriate legal authority as required by rule or law.

A-8. Appeals and Administrative Review.

Providers that disagree with the Department's decision may request in writing for an administrative review pursuant to Idaho Code §56-133. If the provider disagrees with the administrative review decision, it may request an administrative appeal within twenty-eight (28) days of such decision.

FOR THE PROVIDER:

_____

Administrator

_____

Date

Name of Provider:_____

Address of Provider:_____

Phone: _____

Idaho Medicaid Provider Number:_____

Appendix D. Additional Terms: Nursing Facilities

State of Idaho

Medicaid Provider Agreement

Additional Terms – Nursing Facilities
Part I: Private Nursing Facilities

The DEPARTMENT reserves the right to amend the following definitions, applicability, methodology components, and payment formulas outlined in this document titled, "Additional Terms – Nursing Facilities" in accordance with the Medicaid Provider Agreement, as amended. PROVIDER shall comply with all applicable provisions of the Idaho Administrative Code, as amended, including but not limited to: IDAPA 16.03.26 - "Medicaid Plan Benefits."

A-1. Allowable Costs

The following definitions and explanations apply to allowable costs:

A-1.1. Accounts Collection. The costs related to the collection of past due program related accounts, such as legal and bill collection fees, are allowable.

A-1-2. Auto and Travel Expense. Maintenance and operating costs of a vehicle used for patient care purposes and travel expense related to patient care are reimbursable. The allowance for mileage reimbursement cannot exceed the amount determined reasonable by the Internal Revenue Service for the period being reported. Meal reimbursement is limited to the amount that would be allowed by the state for a state employee.

A-1.3. Bad Debts. Payments for efforts to collect past due Title XIX and Title XXI accounts are reimbursable. This may include the fees for lawyers and collection agencies. Other allowances for bad debt and bad debt write-off are not allowable. However, Title XIX and Title XXI coinsurance amounts are one hundred percent (100%) reimbursable under PRM, Section 300.

A-1.4. Bank and Finance Charges. Charges for routine maintenance of accounts are allowable. Penalties for late payments, overdrafts, etc., are not allowable.

A-1.5. Compensation of Owners. An owner may receive reasonable compensation for services subject to the limitations in this chapter, to the extent the services are actually performed, documented, reasonable, ordinary, necessary, and related to patient care. Allowable compensation cannot exceed the amount necessary to attract assistance from parties not related to the owner to perform the same services. The nature and extent of services must be supported by adequate documentation including hours performing the services. Where an average industry wide rate for a particular function can be determined, reported allowable owner compensation cannot exceed the average rate. Compensation to owners, or persons related to owners, providing administrative services is further limited by provisions in IDAPA 16.03.26.050. NF AND ICF/IID REIMBURSEMENT. In determining the reasonableness of compensation for services paid to an owner or a person related to an owner, compensation is the total of all benefits or remuneration paid to or primarily for the benefit of the owner regardless of form or characterization. It includes, but is not limited to, the following:

a. Salaries wages, bonuses and benefits that are paid or are accrued and paid for the reporting period within one (1) month of the close of the reporting period.

b. Supplies and services provided for the owner's personal use.

c. Compensation paid by the facility to employees for the sole benefit of the owner.

d. Fees for consultants, directors, or any other fees paid regardless of the label.

e. Keyman life insurance.

f. Living expenses, including those paid for related persons.

A-1.6. Contracted Service. All services that are received under contract arrangements are reimbursable to the extent that they are related to patient care or the sound conduct and operation of the facility.

A-1.7. Depreciation. Depreciation on buildings and equipment is an allowable property expense subject to Idaho Code §56-108. Depreciation expense is not allowable for land. Lease-hold improvements may be amortized. Generally, depreciation and amortization must be calculated on a straight-line basis and prorated over the estimated useful life of the asset.

A-1.8. Dues, Licenses and Subscriptions. Subscriptions to periodicals related to patient care and for general patient use are allowable. Fees for professional and business licenses related to the operation of the facility are allowable. Dues, tuition, and educational fees to promote quality health care services are allowable when the provisions of PRM, Section 400, are met.

A-1.9. Employee Benefits. Employee benefits including health insurance, vacation, and sick pay are allowable to the extent of employer participation. See PRM, Chapter 21 for specifics.

A-1.10. Employee Recruitment. Costs of advertising for new employees, including applicable entertainment costs, are allowable.

A-1.11. Entertainment Costs Related to Patient Care. Entertainment costs related to patient care are allowable only when documentation is provided naming the individuals and stating the specific purpose of the entertainment.

A-1.12. Food. Costs of raw food are allowable. The provider is only reimbursed for costs of food purchased for patients. Costs for nonpatient meals are nonreimbursable. If the costs for nonpatient meals cannot be identified, the revenues from these meals are used to offset the costs of the raw food.

A-1.13. Home Office Costs. Reasonable costs allocated by related entities for home office services are allowable in their applicable cost centers.

A-1.14. Insurance. Premiums for insurance on assets or for liability purposes, including vehicles, are allowable to the extent that they are related to patient care.

A-1.15. Interest. Interest on working capital loans is an allowable administrative expense. When property is reimbursed based on cost, interest on related debt is allowable. However, interest payable to related entities is not normally an allowable expense. Penalties are not allowable.

A-1.16. Lease or Rental Payments. Payments for the property cost of the lease or rental of land, buildings, and equipment are allowable according to Medicare

reasonable cost principles when property is reimbursed based on cost for leases entered into before March 30, 1981. Such leases entered into on or after March 30, 1981, will be reimbursed in the same manner as an owned asset. The cost of leases related to home offices cannot be reported as property costs, but will be allowable based on reasonable cost principles subject to other limitations contained herein.

A-1.17. Malpractice and Public Liability Insurance. Premiums for malpractice and public liability insurance must be reported as administrative costs.

A-1.18. Payroll Taxes. The employer's portion of payroll taxes is reimbursable.

A-1.19. Property Costs. Property costs related to patient care are allowable subject to other provisions of this chapter. Property taxes and reasonable property insurance are allowable for all facilities. For free-standing nursing facilities, the property rental rate is paid as described in Idaho Code §56-108. Hospital-based nursing facilities are paid based on property costs.

a. Amortization of leasehold improvements will be included in property costs.

i. Straight line depreciation on fixed assets is included in property costs.

ii. Depreciation of moveable equipment is an allowable property cost.

b. Interest costs related to the purchase of land, buildings, fixtures or equipment related to patient care are allowable property costs only when the interest costs are payable to unrelated entities.

A-1.20. Property Insurance. Property insurance per licensed bed is limited to no more than two (2) standard deviations above the mean of the most recently reported property insurance costs, as used for rate setting purposes, per licensed bed of all facilities in the reimbursement class of the end of a facility's fiscal year.

A-1.21. Repairs and Maintenance. Costs of maintenance and minor repairs are allowable when related to the provision of patient care.

A-1.22. Salaries. Salaries and wages of all employees engaged in patient care activities or operation and maintenance are allowable costs. However, non-nursing home wages are not an allowable cost.

A-1.23. Supplies. Cost of supplies used in patient care or providing services related to patient care is allowable.

A-1.24. Taxes. The cost of property taxes on assets used in providing patient care are allowable. Other taxes are allowable costs as provided in the PRM, Chapter 21. Tax penalties are nonallowable costs.

A-2. Nonallowable Costs

The following definitions and explanations apply to nonallowable costs:

A-2.1. Accelerated Depreciation. Depreciation in excess of calculated straight line depreciation, except as otherwise provided is nonallowable.

A-2.2. Acquisitions. Costs of corporate acquisitions, such as purchase of corporate stock as an investment, are nonallowable.

A-2.3. Barber and Beauty Shops. All costs related to running barber and beauty shops are nonallowable.

A-2.4. Charity Allowances. Cost of free care or discounted services are nonallowable.

A-2.5. Fees. Franchise fees are nonallowable, see PRM, Section 2133.1.

A-2.6. Fund Raising. Certain fund raising expenses are nonallowable, see PRM, Section 2136.2.

A-2.7. Goodwill. Costs associated with goodwill as defined in Idaho Code §56-101 are nonallowable.

A-2.8. Holding Companies. All home office costs associated with holding companies are nonallowable see PRM, Section 2150.2A.

A-2.9. Interest. Interest to finance nonallowable costs are nonallowable.

A-2.10. Medicare Costs. All costs of Medicare Part A or Part B services incurred by Medicare certified facilities, including the overhead costs relating to these services are nonallowable.

A-2.11. Nonpatient Care Related Activities. All activities not related to patient care are nonallowable.

A-2.12. Organization. Organization costs are nonallowable, see PRM, Section 2134.

A-2.13. Pharmacist Salaries. Salaries and wages of pharmacists are nonallowable.

A-2-14. Prescription Drugs. Prescription drug costs are nonallowable.

A-2.15. Related Party Interest. Interest on related party loans are nonallowable, see PRM, Sections 218.1 and 218.2.

A-2.16. Related Party Nonallowable Costs. All costs nonallowable to providers are nonallowable to a related party, whether or not they are allocated.

A-2.17. Related Party Refunds. All refunds, allowances, and terms, will be deemed to be allocable to the members of related organizations, on the basis of their participation in the related purchases, costs, etc.

A-2.18. Self-Employment Taxes. Self-employment taxes, as defined by the Internal Revenue Service, that apply to facility owners are nonallowable.

A-2-19. Telephone Book Advertising. Telephone book advertising costs in excess of the base charge for a quarter column advertisement for each telephone book advertised in are nonallowable.

A-2-20. Vending Machines. Costs of vending machines and cost of the product to stock the machine are nonallowable costs.

A-3. Property and Utility Costs

A-3.1. Whether or not each of these cost items is allowed will be determined in accordance with other provisions of IDAPA 16.03.26 or these additional terms, or the PRM in those cases where IDAPA 16.03.26 rules are silent or not contradictory. Total property and utility costs are defined as being made up of the following cost categories. The Department may require and utilize an appraisal to establish those components of property costs that are identified as an integral part of an appraisal.

A-3-2. Depreciation. All allowable depreciation expense.

A-3.3. Interest. All allowable interest expense relating to financing building and equipment purchases.

A-3-4. Property Insurance. All allowable property insurance. Malpractice insurance, workmen's compensation and other employee-related insurances will not be considered to be property costs.

A-3.5. Lease Payments. All allowable lease or rental payments.

A-3.6. Property Taxes. All allowable property taxes.

A-3.7. Utility Costs. All allowable expenses for heat, electricity, water and sewer.

A-4. Components of Nursing Facility Rate Methodology

A-4.1. Applicable Case Mix Index (CMI). The Medicaid CMI used in establishing each facility's rate is calculated based on the most recent assessment for each Medicaid resident in the nursing facility on the first day of the month of the preceding quarter (for example, assessments as of April 1 are used to establish the CMI needed to establish rates for the quarter beginning July 1st). Facility-wide CMI is calculated based on the most recent assessment for all residents in the nursing facility. The CMI is recalculated quarterly and each nursing facility's rate is adjusted accordingly. A facility-wide CMI is also established each year by averaging four (4) calendar quarter CMIs for the cost reporting period from historical data to represent each fiscal quarter in the cost reporting period (for example, an October 1 CMI would represent the fiscal quarter ended September 30th).

A-4.2. Applicable Cost Data. The cost data used in establishing the cost components of the rate calculation are from the audited cost report that ended in the calendar year two (2) years prior (for example, cost reports ending during the period from January 1, 2019 - December 31, 2019 are used in setting rates effective July 1, 2021). The draft audit of a cost report submitted by a facility will be issued by the Department no later than five (5) months after the date all information required for completion of the audit is filed with the Department.

A-4.3. Direct Care Cost Component. The direct care cost component of a nursing facility's rate is determined as follows:

a. The direct care per diem price applicable to the rate period for a nursing facility type (free- standing and urban hospital-based nursing facility, rural hospital-based nursing facility, free-standing and urban hospital-based behavioral care unit, or rural hospital-based behavioral care unit) is identified.

b. A calculated reimbursement floor is calculated for each provider. To calculate the reimbursement floor, the identified direct care price is multiplied by (1 - a margin cap percentage). The margin cap percentage applied to the price for each facility is based on the quality payment tier, as determined through the Quality Payment Program. The margin cap percentages were established at the time of the rate system development and will be periodically reviewed for reasonableness, effectiveness, and efficiency. The higher the tier a provider falls in, with tier one (1) being the highest, the higher the margin percent. The difference between the calculated direct care price and the calculated reimbursement floor is the maximum margin payment available to the facility.

c. The provider’s calculated direct care case mix neutral cost is compared to the calculated reimbursement floor. The case mix neutral cost is derived from the facility’s calculated direct care cost per day divided by the facility wide case mix index for the cost reporting period. If the case mix neutral cost is less than the floor, then the difference between the provider’s calculated floor and case mix neutral cost is calculated.

d. If the facility’s calculated case mix neutral direct care cost is less than the direct price, a margin component is calculated. The calculated margin for each facility is the lessor of the following:

i. The difference between the direct care price for the nursing facility type minus the calculated floor, as described in b. above; or

ii. The difference between the direct care price for the nursing facility type minus the facility's calculated case mix neutral direct care cost.

e. The direct care component will be established at the lessor of the following:

i. The direct care price for the nursing facility type;

ii. The facility's case mix neutral direct cost plus the margin calculated in d. above.

f. Exceptions for cases of lower direct care price:

i. If the direct care price for the nursing facility type is lower, the price, minus the raw food and Medicaid related ancillary portion of the calculated direct care price, is multiplied by the nursing facility's most recent quarterly Medicaid CMI for the rate period. The raw food and Medicaid related ancillary portion of the price is then added back to arrive at the direct care cost component.

ii. If the direct care case mix neutral cost plus margin is lower, these costs, minus raw food and Medicaid related ancillary costs, are multiplied by the nursing facility's most recent quarterly Medicaid CMI for the rate period. Raw food and Medicaid related ancillary costs are then added back to arrive at the direct care cost component.

A-4.4. Indirect Care Cost Component. The indirect care cost component of a nursing facility's rate is determined as follows:

a. The indirect per diem price is applicable to the rate period for a nursing facility type, free- standing and urban hospital-based nursing facilities including behavioral care unit nursing facility providers, or rural hospital-based nursing facilities including behavioral care unit nursing facility providers is identified.

b. A calculated reimbursement floor is calculated for each facility. To calculate the reimbursement floor, the identified indirect care price is multiplied by (1 - a margin cap percentage). The margin cap percentage applied for each facility is the same for all nursing facility types. The margin cap percentage was established at the time of the rate system development and will be periodically reviewed for reasonableness, effectiveness, and efficiency. The difference between the calculated indirect care price and the calculated reimbursement floor is the maximum margin payment available to the facility.

c. The facility's calculated indirect care cost is compared to the calculated reimbursement floor. If the cost is less than the floor, then the difference between the facility's calculated floor and cost is calculated.

d. If the facility's calculated indirect cost is less than the indirect price, a margin component is calculated. The calculated margin for each facility is the lessor of the following:

i. The difference between the indirect care price for the nursing facility type minus the calculated floor, as described in b. above; or

ii. The difference between the indirect care price for the nursing facility type minus the facility's calculated indirect care cost.

e. The indirect care component will be established at the lessor of the following:

i. The indirect price for the nursing facility type;

ii. The facility's indirect cost plus the margin calculated in d. above.

A-4.5. Costs Exempt From Limitation. Costs exempt from cost limits are property taxes, property insurance, utilities and costs related to new legal mandates.

A-4.6. Property Reimbursement. The property reimbursement component is calculated in accordance with Idaho Code §56-108 and section A. 19. of these additional terms.

A-4.7. Revenue Offset. Revenues from products or services provided to nonpatients will be offset from the corresponding rate component(s) as described in Section IDAPA 16.03.26. 484. NF: RATE DEVELOPMENT.

A-4.8. Budget Adjustment Factor (BAF). A total budget for nursing facility reimbursement will be established by legislature and will be effective on July 1 of each year. The budget will be compared to the annual expected Medicaid reimbursement rates for the same rate year. A budget adjustment factor will be established to adjust the expected Medicaid reimbursement rates to meet the approved budget. The BAF may be positive or negative and will apply to all nursing facility rates calculated under the established prospective rate system. The BAF will not be applied to the calculated customary charge for each nursing facility and will not apply to any nursing facility that is retrospectively settled.

A-4.9. NURSING FACILITY: PRICE LIMITS BASED ON COST REPORT. Each July 1st, cost price limitations will be established for nursing facilities based on the audited cost reports for the periods ending in the calendar year two (2) years prior to each July 1 (July 1, 2021 price limits will use cost reports ended in calendar year 2019 and so forth), including inflation adjustments from the mid-point of the cost report period to the mid-point of the rate period. the most recent audited cost report with an end date of June 30th of the previous year or before. Calculated limitations will be effective for a one (1) year period, from July 1 through June 30th of each year, which is the rate year.

a. Percentage Above Bed-Weighted Median.

i. Prior to establishing the first rates at July 1, 2021, the estimated Medicaid payments under the previous prospective system for the period from July 1, 2018, through June 30, 2019, were calculated. This amount was used to model the estimated payments under the case mix system set forth in IDAPA 16.03.26.482 NF: RATE SETTING, IDAPA 16.03.26.483 NF: PRINCIPLE FOR RATE SETTING, and IDAPA 16.03.26.484 NF: RATE DEVELOPMENT. The percentages above the bed-weighted median, for direct and indirect costs, were established at a level that approximated the same amount of Medicaid expenditures as would have been produced by the previous prospective system. The percentages were established to approximate the same distribution of total Medicaid dollars between the hospital-based and freestanding nursing facilities as existed under the previous prospective system.

ii. Once the percentages were established, it they were used to calculate the limit by multiplying the bed- weighted median per diem cost times the calculated percentage for that class of provider. There will be a direct and indirect percentage that is applied to freestanding

and urban hospital-based nursing facilities, and a higher direct and indirect percentage that is applied to rural hospital-based nursing facilities.

iii. Beginning with rates effective October 1, 2012, additional direct care cost limit categories will be added for free-standing and urban hospital-based behavioral care units and rural hospital-based behavioral care units.

iv. The percentages used for each class of nursing facilities was determined and agreed upon during the rate system workgroup meetings. These percentages will be evaluated periodically for reasonableness, effectiveness, and efficiency.

b. Direct Price Limits. The direct price limitation will be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be normalized and arrayed from high to low, with all nursing facilities included in the same array, and the bed-weighted median will be computed.

c. Indirect Price Limits. The indirect price limitation will be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be arrayed, with all nursing facilities included in the same array, and the bed-weighted median will be computed.

d. Costs Exempt From Limitations. Costs exempt from limitations include property taxes, property insurance, and utilities. These costs will be reimbursed on a per diem basis and will not be included in the calculation of the direct or indirect care component. However, property taxes and property insurance will be subject to minimum occupancy levels as defined in IDAPA 16.03.26.492. NF: OCCUPANCY ADJUSTMENT FACTOR.

A-4.11. Calculation of New Beds.

a. Limitation of Facility's Rate.

i. Starting with rates effective July 1, 2021, the facility's rate will be limited to the bed-weighted average of the following two (2) rates:

a. The facility's current prospective rate calculated in accordance with IDAPA 16.03.26.484. NF: RATE DEVELOPMENT; and

b. The lesser of the following:

i. The current median rate for nursing facilities of that type, free-standing, free-standing with a BCU, rural hospital-based, rural hospital-based with a BCU or urban hospital-based, established each July 1st, reduced by ten percent (10%); or .

ii. The nursing facility's current prospective rate calculated in accordance with IDAPA 16.03.26.484. NF: RATE DEVELOPMENT of these rules, reduced by ten percent (10%).

ii. For any beds added prior to July 1, 2021, the Limitation of Facility's Rate will be limited to the bed-weighted average of the following two (2) rates:

a. The facility's current prospective rate calculated in accordance with IDAPA 16.03.26.484. NF: RATE DEVELOPMENT; and

b. The current median rate for nursing facilities of that type, free-standing, free-standing with a BCU, rural hospital-based, rural hospital-based with a BCU, or urban hospital-based, established each July 1st.

b. Calculation of the Bed-Weighted Average. The current calculated facility rate is multiplied by the number of beds in existence prior to the addition. The median rate is multiplied by the number of added beds, weighted for the number of days in the cost reporting period for which they were in service. These two (2) amounts are added together and divided by the total number of beds, with the new beds being weighted if they were only in service for a portion of the year. The resulting per diem amount represents an overall limitation on the facility's reimbursement rate. Providers with calculated rates that do not exceed the limitation receive their calculated rate.

c. Exception to New Bed Rate. The following situations will not be treated as new beds for reimbursement purposes:

i. Any beds converted from nursing facility beds to assisted living beds, can be converted back to nursing facility beds within three (3) years and not be classified as new nursing facility beds. When a nursing facility bed has been converted to an assisted living bed for three (3) or more concurrent years and the bed is converted back to a nursing facility bed, it must be treated as a new nursing facility bed.

ii. Beds added as a result of expansion plans, that the Department was aware of prior to July 1, 1999, will not be treated as new beds. The facility must have already expended significant resources on the purchase of land, site planning, site utility planning, and development. The existence of adequate land or space at the nursing facility does not by itself constitute a significant expenditure of resources for the purposes of expansion. A written request with adequate supporting documentation for an exception under this provision must have been received by the Department no later than December 31, 1999. In no case will beds added after July 1, 2003, qualify for this exception to the new bed criteria.

iii. Beds that are decertified as a requirement of survey and certification due to deficiencies at the facility can be re-certified as existing beds with the approval of the Department.

iv. When a facility can demonstrate to the Department that adding beds is necessary to meet the needs of an underserved area, these beds will not be treated as new beds. For an existing facility the new beds are reimbursed at the same reimbursement rate for that facility's existing beds. For a new facility, the reimbursement rate is negotiated with the Department.

A-4.12. Treatment of a Change of Ownership. New providers resulting from a change in ownership of an existing facility will receive the previous owner's rate, inflated forward to the appropriate cost reporting year, until such time as the new owner has a cost report that qualifies for the rate setting criteria established under these rules. If a new owner is subject to receiving the prior owner rate for a third-rate year, the calculated rate for the third rate year will be the higher of the prior owner rate, inflated to the appropriate cost reporting year or the statewide median rate calculated for that nursing facility class. If the Department determines that such a facility is operationally or financially unstable, the Department may negotiate a reimbursement rate different than the rate then in effect for the facility.

A-4.13. New Facility Grandfather Provision. Any new facilities that were in the planning stages prior to July 1, 2021 or who were qualified to receive the New Facility Rate on July 1, 2021, will be grandfathered in for rate setting purposes. These facilities will be reimbursed at the median rate for the skilled care facilities of that type (freestanding or hospital-based) for the first four (4) full years of operation. During the period of limitation, the facility's rate will be modified each July 1st to reflect the current median rate for skilled care facilities of that type. After the first four (4) full years, the facility will have its rate established at the next July 1st with the existing facilities in accordance with IDAPA 16.03.26.484. NF: RATE DEVELOPMENT.

a. The Year Four (4) calculation will allow for a 4% increase to the BAF adjusted non-property rate components. Providers whose rate is at the median and has a building age other than zero (0), the property rate will be replaced to reflect a building age of zero (0). The property rate will be replaced with a building age of zero (0), including the BAF adjustment.

A-4.14. Occupancy Adjustment Factor. In order to equitably allocate fixed costs to the Medicaid patients in cases where a facility is not maintaining reasonable occupancy levels, an adjustment will be made. No occupancy adjustment will be made against the costs that are used to calculate the property rental rate; however adjustment will be made against all other property costs. The adjustment will be made as follows:

a. Occupancy Levels. If a facility maintains an average occupancy of less than eighty percent (80%) of a facility's capacity, the total property costs not including cost paid under the property rental rate, will be prorated based upon an eighty percent (80%) occupancy rate. Property costs and property rental rates are defined in Idaho Code §56-101. The facility's average occupancy percentage will be subtracted from eighty percent (80%) and the resultant percentage will be taken times the total fixed costs to determine the nonallowable fixed costs.

b. Occupancy Adjustment. For purposes of an occupancy adjustment, facility capacity will be computed based upon the greater of the largest number of beds for which the facility was licensed during the period being reported on or the largest number of beds for which the facility was licensed during calendar year 1981, except where a portion of the facility has been converted to use for nonroutine nursing home activities or the facility is newly constructed and has entered the Medicaid Program subsequent to January 1, 1982. If the facility's designed capacity has been changed, the number of beds used to determine occupancy will be lowered by the amount of capacity being converted to nonroutine nursing home activities. Facility capacity for a new facility will be based on the number of beds approved by the certificate of

need process less any capacity converted to nonroutine nursing home activities.

c. Fixed Costs. For purposes of an occupancy adjustment fixed costs will be considered all allowable and reimbursable costs reported under the property cost categories.

d. Change in Designed Capacity. In cases where a provider changes the designed capacity of a facility, the average occupancy for the period prior to the change and subsequent to the change will be computed and each period will be adjusted separately. If the designed capacity is increased, the increased number of beds will not be subject to this adjustment for the first six (6) months following their licensure.

e. New Facility. In the case of a new facility being licensed and occupied, the first six (6) months occupancy level will not be subject to this adjustment.

A-4-15. Reporting System. The objective of the reporting requirements is to provide a uniform system of periodic reports that will allow:

a. Basis for Reimbursement. A basis of provider reimbursement approximating actual costs.

b. Disclosure. Adequate financial disclosure.

c. Statistical Resources. Statistical resources, as a basis for measurement of reasonable cost and comparative analysis.

d. Criteria. Criteria for evaluating policies and procedures.

A-4.16. Reporting System Principle and Application. The provider will be required to file mandatory annual cost reports.

a. Cost Report Requirements. The fiscal year end cost report filing must include:

i. Annual income statement (two (2) copies);

ii. Balance sheet;

iii. Statement of ownership;

iv. Schedule of patient days;

v. Schedule of private patient charges;

vi. Statement of additional charges to residents over and above usual monthly rate; and

vii. Other schedules, statements, and documents as requested.

b. Special Reports. Special reports may be required. Specific instructions will be issued, based upon the circumstance.

c. Criteria of Reports. All reports must meet the following criteria:

i. State-approved formats used.

ii. Presented on accrual basis.

iii. Prepared in accordance with generally accepted accounting principles and principles of reimbursement.

iv. Appropriate detail provided on supporting schedules or as requested.

d. Preparer. It is not required that any statement be prepared by an independent, licensed or certified public accountant.

e. Reporting by Chain Organizations or Related Party Providers. PRM, Section 2141.7, prohibits the filing of combined or consolidated cost reports as a basis for cost reimbursement. Each facility so related must file a separate set of reports. These cost reports will be required for each level of organization that allocates expenses to the provider. Consolidated financial statements will be considered supplementary information and are not acceptable as fulfilling the primary reporting requirements.

f. Change of Management or Ownership. To properly pay separate entities or individuals when a change of management or ownership occurs, the following requirements must be met:

i. Outgoing management or administration must file an adjusted-period cost report if they are being reimbursed on a retrospective basis at the time of the charge. This report must meet the criteria for annual cost reports, except that it is not filed later than sixty (60) days after the change in management or ownership for the purpose of computing a final program settlement. Outgoing management or administration of a facility being reimbursed on a prospective basis at the time of change will not be required to file a closing cost report. The Department reserves the right to not initiate an audit of a cost report filed by a prior owner if the ownership change occurs between the fiscal period end date of the last cost report filed and the first date of the applicable rate period.

ii. The Department may require an appraisal at the time of a change in ownership.

iii. Providers who are receiving a new provider rate or being reimbursed on a prospective basis, when the change of management or ownership occurs, will not be required to file a closing cost report.

A-4.17. Reporting Period. For purposes of nursing facility rate setting, cost report periods of less than one hundred and eighty-four days (184) days will not be used. If a provider changes their fiscal year-end or experiences a change in ownership, the last cost report filed by that facility that is one hundred and eighty-four days (184) days or more will be used until a cost report that includes one hundred and eighty-four days (184) days or more is received from the new owner, or is based on the new fiscal year.

A-5. Appeals and Administrative Review

Providers that disagree with the Department's calculation may request in writing for an administrative review pursuant to Idaho Code §56-133. If the provider disagrees with the administrative review decision, it may request an administrative appeal within twenty-eight (28) days of such decision.

State of Idaho
Medicaid Provider Agreement

Additional Terms – Nursing Facilities

Part II: Behavioral Care Units

The DEPARTMENT reserves the right to amend the following definitions, applicability, methodology components, and payment formulas outlined in this document titled, "Additional Terms – Behavioral Care Units" in accordance with the Medicaid Provider Agreement, as amended.

A-1. Determination. The Behavioral Care Unit (BCU) must have a qualifying program and have been providing care in the BCU to behavior residents as of July 1, 2011. Nursing facility providers that meet the BCU criteria will have BCU direct care costs included in direct care costs subject to the cost limit. The direct care cost limitation may be higher than a non-BCU nursing facility.

A-2. BCU Routine Customary Charge. If the cost to operate a BCU is included in a nursing facility's rate calculation, the nursing facility must report its usual and customary charge for semi-private rooms in both the BCU and general nursing facility. A weighted average routine customary charge is computed to represent the composite of all Medicaid nursing facility residents in the nursing facility based on the type of rooms they occupy, including the BCU.

A-3. Prospective Rate Setting. The direct care cost limit calculation for any special rate revenue offsets in the prior year related to one-to-one (1:1) staffing ratios, BCU, or increased staffing, will be reversed before calculating the cost limit. This revenue offset reversal excludes revenues related to special rate add-ons for ventilator-dependent or tracheostomy services. Rates will be calculated using the cost report ended in the calendar year prior to each July 1 rate setting period with the BCU's direct care costs included in direct care costs subject to the higher BCU cost limit.

A-4. Annual Rates. Once an annual rate has been set as provided in Section A-3 of these additional terms, the following process will be used to determine BCU eligibility. A nursing facility must apply for BCU eligibility on an annual basis. Eligibility is determined by:

A-4.1. BCU days, regardless of payer source, are divided by the total occupied days in the nursing facility and that calculation equals or exceeds a minimum of twenty percent (20%). The BCU days as a percentage of total occupied days in the nursing facility must meet or exceed a minimum of thirty percent (30%).

A-4.2. The BCU nursing facility provider must provide a list of all residents they believe were qualified for BCU status for the previous year;

a. The Department will select a sample of Idaho Medicaid participants from the submitted list. The nursing facility provider must send the Minimum Data Set (MDS) for each selected sample participant, along with related census information, and other requested information to the Department.

b. The Department will review this information to determine that the participants meet the requirements of Section A-5 and A-6 of these additional terms and calculate the percentage of BCU days to the total occupied days in

the facility to determine whether the facility meets the BCU eligibility requirement in Section A-5 of these additional terms.

A-5. Participant Characteristics. All participants in a BCU must meet the criteria for nursing facility level of care, and have the following characteristics as provided in documentation requested by the Department:

A-5.1. Medically based behavior disorder that causes a significantly diminished capacity for judgment, retention of information, or decision-making, or medically based mental health disorder of diagnosis and has a high-level resource use; and

A-5.2. Must have a history of need for additional resources to provide for disruptive behaviors requiring enhanced resource use from nursing facility staff; demonstrated by documentation of the frequency of occurrences, and the extra resources required, for a minimum of three (3) consecutive months, Disruptive behaviors are evidenced by three (3) or more of the following within a given week as defined by the Idaho Medicaid Provider Handbook:

a. Wandering behaviors;

b. Verbally abusive behaviors;

c. Physically abusive behaviors;

d. Socially inappropriate or disruptive behaviors, such as verbal or vocal symptoms like disruptive sounds, noises, screaming, physical symptoms like self-abusive acts, public sexual behavior or disrobing in public, smearing or throwing food or bodily wastes, hoarding, rummaging through belongings of other residents;

e. Behaviors that resist care; or

f. Does not meet unit discharge criteria outlined below

A-5.3. A behavior baseline profile must be established for each participant within thirty (30) days of admission;

A-5.4. A behavior intervention program must be in place for each participant, designed to reduce or control the inappropriate behaviors to enhance the participant's quality of life, functional and cognitive status or safety.

A-6. BCU Annual Renewal. The facility must request continuation in the BCU program annually including the following:

A-6.1. A description of the facility's program that includes the required components in Sections A-5 and A-6 of these additional terms; and

A-6.2. A profile of the types of behavior of participants served and any restrictions the facility has adopted.

A-7. Administrative and Staffing Requirements.

A-7.1. Staffing must be at a level necessary for the facility to be able to provide direct supervision of participants as needed.

A-7.2. Psychiatrist or physician extender must be available to consult as needed for initial and on-going assessments and for twenty-four hours a day/seven days a week (24/7) emergency services. Consultants must make at least quarterly site visits and be available to participate in Behavior Management Team meetings as needed.

A-7.3. Licensed Master Social Worker (LMSW), Licensed Professional Counselor (LPC), or Licensed Social Worker (LSW) with behavioral experience must be available

to consult as needed, make periodic site visits and to participate in the assessment, behavioral intervention planning, behavioral intervention implementation and Behavior Management Team meetings as needed.

A-8. Behavior Management Team Meetings. Weekly behavior management team meetings must be conducted that include psychiatrist, physician, facility social services staff, behavior program director, director of nursing services, dietary manager, recreational services or activity director, and selected primary care staff. Physicians, psychiatrists, social services consultants and other off-site specialists are included as needed and may participate in person or by telephone.

A-9. Staff Training. Behavioral training classes for staff that are tailored to the needs of the positions involved, and includes appropriate information on:

A-9.1. Assessment and prevention;

A-9.2. Medication and side effects;

A-9.3. Effects of disease process on mood state;

A-9.4. Safety techniques;

A-9.5. Deflecting aggression or target behaviors;

A-9.6. Comprehensive environmental intervention;

A-9.7. Stress management; and

A-9.8. Documentation and charting.

A-10. Quarterly Training. In addition to annual training requirements as outlined in Section A-1.9 of these additional terms, BCUs will provide quarterly education to direct care staff aimed at enhancing neurocognitive, behavioral health, and behavior management knowledge and skill sets. Examples of such education include but are not limited to: the physiology of neurocognitive diseases and mental illnesses, antipsychotic/antidepressant effects on elderly populations, evidenced based practice behavior management techniques and strategies, and review of the Medicaid BCU program. Quarterly education can be conducted by: a qualified facility staff person, online courses, webinars, conferences, seminars or guest speakers.

A-11. Care Planning, Behavioral Management, and Programming. Individualized care plans, based on assessments of cognitive and functional abilities, along with behavior analysis to create a strategy for prevention and intervention that are documented for each participant and include the following:

A-11.1. Thirty (30) day assessments of progress made by each participant, must be completed, documented, and reviewed by the facility's behavioral management team.

A-11.2. Comprehensive behavior monitoring techniques that track and trend the intensity and daily occurrence of behaviors, successful interventions, and behavior modification techniques used must be documented for each participant.

A-11.3. Attempts to involve family and responsible parties with the participant through visits, training, outings, or appropriate communications, must be documented.

A-11.4. Recreational and activity programming must be targeted to specific needs of each individual participant and the behaviors each participant exhibits must be documented.

A-11.5. Integration for appropriate social interactions must be used when appropriate for each individual participant.

A-11.6. Community for transition must be used when appropriate for each individual participant.

A-11.7. Attempts to meet discharge criteria must be documented for each individual participant when progress shows a decline in the need for special care programming.

A-12. Discharge Criteria. The BCU must maintain, and document discharge criteria as follows:

A-12.1. Document improvement in ability to function that would enable transfer to less-restrictive environment.

A-12.2. Document lack of benefit from specialized programs offered in BCU.

A-12.3. Document consistent refusals by participant or responsible party to allow interventions that are determined to be helpful.

A-12.4. Document acute danger to self or others that cannot be managed by staffing in the BCU.

A-12.5. Document acute physical illness or complications requiring a higher level of medical care than available in the facility.

A-13. Termination of BCU Status.

A-13.1. If a provider opts to leave the BCU program, the Department must be notified so the direct care cap can be adjusted to that of a non-BCU provider, beginning with the next rate year.

A-13.2. If a provider does not meet BCU qualifications during the renewal period, they must wait one year to re-apply for BCU status. If the provider re-applies within one to two (1 – 2) years of the non-qualifying period, they receive their actual direct care cost, subject to the BCU price. If the provider re-applies three (3) years after the non-qualifying period, they will receive the direct care median rate of other BCU providers, reduced by ten percent (10%).

A-14. Refusal of Admissions. The provisions of this agreement do not preclude a nursing facility from refusing to admit a participant whose needs cannot be met by the nursing facility.

A-15. Reimbursement for Years One (1) Through Four (4) of Newly Licensed Facilities with BCUs. Beginning with the first day of the first month following approval of the BCU license and when the provider can demonstrate that BCU days from a minimum of sixty (60) calendar days, regardless of payer source, divided by total census days for that same sixty-day period, equals or exceeds a minimum of thirty percent (30%), the provider's rate will change to reflect BCU services. The provider will be reimbursed at ten percent (10%) below the median rate for BCU facilities of that type, either freestanding or hospital-based, for the remaining period within the first four (4) full years of operation. If there are no facilities of the same type (for example, no other hospital-based BCUs), the provider will receive ten percent (10%) below the median rate for their type, but the direct cost portion of the rate will be revised to the ten percent (10%) below the median rate of existing BCUs. At no time will this rate be set below the median rate for the non-BCU providers of that nursing facility type. The rate change to reflect BCU services will not be retroactive to rate quarters paid prior to meeting the thirty percent (30%) BCU occupancy requirement.

A-15.1. Grandfather Provision. Any new facilities that were in the planning stages prior to July 1, 2021 or who were qualified to receive the New Facility Rate on July 1,

2021, will be grandfathered in for rate setting purposes. These facilities will be reimbursed at the median rate for the skilled care facilities of that type, either freestanding BCU or hospital-based BCU for the first four (4) full years of operation.

A-15.2. A nursing facility must apply for BCU eligibility on an annual basis in accordance with Section A-6 of these additional terms. If the provider did not meet the BCU qualifications described in Sections A-5 through A-14 of these additional terms, for a full cost report year corresponding to the initial application year, the thirty percent (30%) BCU day requirement will apply only to days beginning with the first day of BCU eligibility to the end of the year.

A-15.3. During the period of limitation, the facility's rate will be modified annually on July 1st to reflect ten percent (10%) below the current median rate for skilled care facilities of that type. At no time will that rate be set below the median rate for the non-BCU providers of that nursing facility type. After the first four (4) complete years of operations, the facility will have its rate established at the next July 1st with the existing facilities in accordance with Sections A-3 and A-5 of these additional terms.

A-15.4. For facilities that meet the grandfathered provision above, during the period of limitation, the facility's rate will be modified annually on July 1st to reflect the current median rate for the skilled care facilities of that type. After the first four (4) complete years of operations, the facility will have its rate established at the next July 1st with the existing facilities in accordance with Sections A-3 and A-5 of these additional terms.

A-15.5. During the period of limitation, providers must demonstrate annually that BCU days were equal to or exceeded thirty percent (30%), as described in IDAPA 16.03.26.489. NF: BCU QUALIFICATIONS. Providers must provide a report to the Department with a calculation of BCU days for each month during the period being reviewed. If the twelve-month (12) average falls below thirty percent (30%), then the BCU reimbursement will revert to the median rate. Once the Department has established the provider has met the requirements of IDAPA 16.03.26.489 NF: BCU QUALIFICATIONS they will be eligible for a new rate outlined in these additional terms.

A-15.6. If a nursing facility who previously qualified as a BCU does not meet the minimum requirements upon annual application, they must wait one (1) year from the date of BCU denial before they may apply again for BCU status. The minimum qualifying percent BCU day requirement upon re-application will be set at thirty percent (30%).

A-16. Nursing Facility: Existing Provider Elects to Add Behavioral Care Unit (BCU).

A-16.1. The direct cost portion of the rate will be calculated by determining ten percent (10%) below the median direct cost portion for BCU facilities of that type (freestanding or hospital-based) effective on July 1 of the rate year. If there are no facilities of the same type (for example no other hospital-based BCUs), the direct cost portion of the rate will be set at ten percent (10%) below the median rate of existing BCUs. The direct cost portion of the rate will be updated on July 1 of each rate year until the provider has a qualifying twelve-month (12) cost report, as described in Section A-16.4. of these additional terms. At no time will the direct cost portion be lower than the direct cost median of the non-BCU providers for that nursing facility type.

A-16.2. Any provider who qualified as a BCU prior to the rate year effective July 1, 2021 will have the direct cost portion of the rate calculated by determining the median direct cost portion for BCU facilities of that type (freestanding or hospital-based) effective on July 1 of the rate year. If there are no facilities of the same type (for example no other hospital-based BCUs), the direct cost portion of the rate will be set at the median rate of existing BCUs. The direct cost portion of the rate will be updated on July 1 of each rate year until the provider has a qualifying twelve-month (12) cost report, as described in Section A-16.3 of these additional terms.

A-16.3. The provider's total calculated rate will be subject to customary charge limitations and any other rate reductions implemented for other providers.

A-16.4. Once the provider has a twelve-month (12) cost report that contains a full year of BCU costs, their rate will be calculated in the same manner as other providers in accordance with IDAPA 16.03.26, "Medicaid Plan Benefits" and Medicaid Provider Agreement Additional Terms – Nursing Facilities.

A-16.5. A nursing facility must apply for BCU eligibility on an annual basis in accordance with Sections A-1 through A-14 of these additional terms. If the provider was not a BCU for a full cost report year, the thirty percent (30%) BCU day requirement will apply only to days beginning with the first day of BCU eligibility to the end of the year.

A16-6. If a nursing facility who previously qualified as a BCU does not meet the minimum requirements upon annual application, they must wait one (1) year from the date of BCU denial before they may apply again for BCU status. The minimum qualifying percent BCU day requirement upon re-application will be set at thirty percent (30%).

A-17. Appeals and Administrative Review. Providers that disagree with the Department's calculation may request in writing for an administrative review pursuant to Idaho Code §56-133. If the provider disagrees with the administrative review decision, it may request an administrative appeal within twenty-eight (28) days of such decision.

State of Idaho

Medicaid Provider Agreement

Additional Terms – Nursing Facilities
Part III: State Owned Nursing Facilities

The DEPARTMENT reserves the right to amend the following definitions, applicability, methodology components, and payment formulas outlined in this document titled, "Additional Terms – State Owned Nursing Facilities" in accordance with the Medicaid Provider Agreement, as amended.

A-1 Allowable Costs

The following definitions and explanations apply to allowable costs:

A-1.1. Accounts Collection. The costs related to the collection of past due program related accounts, such as legal and bill collection fees, are allowable.

A-1.2. Auto and Travel Expense. Maintenance and operating costs of a vehicle used for patient care purposes and travel expense related to patient care are reimbursable. The allowance for mileage reimbursement cannot exceed the amount determined reasonable by the Internal Revenue Service for the period being reported. Meal reimbursement is limited to the amount that would be allowed by the state for a state employee.

A-1.3. Bad Debts. Payments for efforts to collect past due Title XIX and Title XXI accounts are reimbursable. This may include the fees for lawyers and collection agencies. Other allowances for bad debt and bad debt write-off are not allowable. However, Title XIX and Title XXI coinsurance amounts are one hundred percent (100%) reimbursable under PRM, Section 300.

A-1.4. Bank and Finance Charges. Charges for routine maintenance of accounts are allowable. Penalties for late payments, overdrafts, etc., are not allowable.

A-1.5. Compensation of Owners. An owner may receive reasonable compensation for services subject to the limitations in this chapter, to the extent the services are performed, documented, reasonable, ordinary, necessary, and related to patient care. Allowable compensation cannot exceed the amount necessary to attract assistance from parties not related to the owner to perform the same services. The nature and extent of services must be supported by adequate documentation including hours performing the services. Where an average industry wide rate for a particular function can be determined, reported allowable owner compensation cannot exceed the average rate. Compensation to owners, or persons related to owners, providing administrative services is further limited by provisions in IDAPA 16.03.26.050. NF AND ICF/IID REIMBURSEMENT. In determining the reasonableness of compensation for services paid to an owner or a person related to an owner, compensation is the total of all benefits or remuneration paid to or primarily for the benefit of the owner regardless of form or characterization. It includes, but is not limited to, the following:

a. Salaries wages, bonuses and benefits that are paid or are accrued and paid for the reporting period within one (1) month of the close of the reporting period.

b. Supplies and services provided for the owner's personal use.

c. Compensation paid by the facility to employees for the sole benefit of the owner.

d. Fees for consultants, directors, or any other fees paid regardless of the label.

e. Keyman life insurance.

f. Living expenses, including those paid for related persons.

A-1.6. Contracted Service. All services that are received under contract arrangements are reimbursable to the extent that they are related to patient care or the sound conduct and operation of the facility.

A-1.7. Depreciation. Depreciation on buildings and equipment is an allowable property expense. Depreciation expense is not allowable for land. Lease-hold improvements may be amortized. Generally, depreciation and amortization must be calculated on a straight line basis and prorated over the estimated useful life of the asset.

A-1.8. Dues, Licenses and Subscriptions. Subscriptions to periodicals related to patient care and for general patient use are allowable. Fees for professional and business licenses related to the operation of the facility are allowable. Dues, tuition, and educational fees to promote quality health care services are allowable when the provisions of PRM, Section 400, are met.

A-1.9. Employee Benefits. Employee benefits including health insurance, vacation, and sick pay are allowable to the extent of employer participation. See PRM, Chapter 21 for specifics.

A-1.10. Employee Recruitment. Costs of advertising for new employees, including applicable entertainment costs, are allowable.

A-1.11. Entertainment Costs Related to Patient Care. Entertainment costs related to patient care are allowable only when documentation is provided naming the individuals and stating the specific purpose of the entertainment.

A-1.12. Food. Costs of raw food are allowable. The provider is only reimbursed for costs of food purchased for patients. Costs for nonpatient meals are nonreimbursable. If the costs for nonpatient meals cannot be identified, the revenues from these meals are used to offset the costs of the raw food.

A-1.13. Home Office Costs. Reasonable costs allocated by related entities for home office services are allowable in their applicable cost centers.

A-1.14. Insurance. Premiums for insurance on assets or for liability purposes, including vehicles, are allowable to the extent that they are related to patient care.

A-1.15. Interest. Interest on working capital loans is an allowable administrative expense. When property is reimbursed based on cost, interest on related debt is allowable. However, interest payable to related entities is not normally an allowable expense. Penalties are not allowable.

A-1.16. Lease or Rental Payments. Payments for the property cost of the lease or rental of land, buildings, and equipment are allowable according to Medicare reasonable cost principles when property is reimbursed based on cost for leases entered into before March 30, 1981. Such leases entered into on or after March 30, 1981, will be reimbursed in the same manner as an owned asset. The cost of leases related to home offices cannot be reported as property costs, but will be allowable based on reasonable cost principles subject to other limitations contained herein.

A-1.17. Malpractice and Public Liability Insurance. Premiums for malpractice and public liability insurance must be reported as administrative costs.

A-1.18. Payroll Taxes. The employer's portion of payroll taxes is reimbursable.

A-1.19. Property Costs. Property costs related to patient care are allowable subject to other provisions of this agreement and applicable regulations. Property taxes and reasonable property insurance are allowable for all facilities. State owned nursing facilities are paid based on property costs.

a. Amortization of leasehold improvements will be included in property costs.

i. Straight line depreciation on fixed assets is included in property costs.

ii. Depreciation of moveable equipment is an allowable property cost.

b. Interest costs related to the purchase of land, buildings, fixtures or equipment related to patient care are allowable property costs only when the interest costs are payable to unrelated entities.

A-1.20. Property Insurance. Property insurance per licensed bed is limited to no more than two (2) standard deviations above the mean of the most recently reported property insurance costs, as used for rate setting purposes, per licensed bed of all facilities in the reimbursement class of the end of a facility's fiscal year.

A-1.21. Repairs and Maintenance. Costs of maintenance and minor repairs are allowable when related to the provision of patient care.

A-1.22. Salaries. Salaries and wages of all employees engaged in patient care activities or operation and maintenance are allowable costs. However, non-nursing home wages are not an allowable cost.

A-1.23. Supplies. Cost of supplies used in patient care or providing services related to patient care is allowable.

A-1.24. Taxes. The cost of property taxes on assets used in providing patient care are allowable. Other taxes are allowable costs as provided in the PRM, Chapter 21. Tax penalties are nonallowable costs.

A-2. Nonallowable Costs

The following definitions and explanations apply to nonallowable costs:

A-2.1. Accelerated Depreciation. Depreciation in excess of calculated straight line depreciation, except as otherwise provided is nonallowable.

A-2.2. Acquisitions. Costs of corporate acquisitions, such as purchase of corporate stock as an investment, are nonallowable.

A-2.3. Barber and Beauty Shops. All costs related to running barber and beauty shops are nonallowable.

A-2.4. Charity Allowances. Cost of free care or discounted services are nonallowable.

A-2.5. Fees. Franchise fees are nonallowable, see PRM, Section 2133.1.

A-2.6. Fund Raising. Certain fund raising expenses are nonallowable, see PRM, Section 2136.2.

A-2.7 Goodwill. Costs associated with goodwill as defined in Idaho Code §56-101 are nonallowable.

A-2.8. Holding Companies. All home office costs associated with holding companies are nonallowable see PRM, Section 2150.2A.

A-2.9. Interest. Interest to finance nonallowable costs are nonallowable.

A-2.10. Medicare Costs. All costs of Medicare Part A or Part B services incurred by Medicare certified facilities, including the overhead costs relating to these services are nonallowable.

A-2.11. Nonpatient Care Related Activities. All activities not related to patient care are nonallowable.

A-2.12. Organization. Organization costs are nonallowable, see PRM, Section 2134.

A-2.13. Pharmacist Salaries. Salaries and wages of pharmacists are nonallowable.

A-2-14. Prescription Drugs. Prescription drug costs are nonallowable.

A-2.15. Related Party Interest. Interest on related party loans are nonallowable, see PRM, Sections 218.1 and 218.2.

A-2.16. Related Party Nonallowable Costs. All costs nonallowable to providers are nonallowable to a related party, whether or not they are allocated.

A-2.17. Related Party Refunds. All refunds, allowances, and terms, will be deemed to be allocable to the members of related organizations, on the basis of their participation in the related purchases, costs, etc.

A-2.18. Self-Employment Taxes. Self-employment taxes, as defined by the Internal Revenue Service, that apply to facility owners are nonallowable.

A-2-19. Telephone Book Advertising. Telephone book advertising costs in excess of the base charge for a quarter column advertisement for each telephone book advertised in are nonallowable.

A-2-20. Vending Machines. Costs of vending machines and cost of the product to stock the machine are nonallowable costs.

A-3. Property and Utility Costs

A-3.1. Whether or not each of these cost items is allowed will be determined in accordance with other provisions of IDAPA 16.03.26 or these additional terms, or the PRM in those cases where IDAPA 16.03.26 rules are silent or not contradictory. Total property and utility costs are defined as being made up of the following cost categories. The Department may require and utilize an appraisal to establish those components of property costs that are identified as an integral part of an appraisal.

A-3-2. Depreciation. All allowable depreciation expense.

A-3.3. Interest. All allowable interest expense relating to financing building and equipment purchases.

A-3-4. Property Insurance. All allowable property insurance. Malpractice insurance, workmen's compensation and other employee-related insurances will not be considered to be property costs.

A-3.5. Lease Payments. All allowable lease or rental payments.

A-3.6. Property Taxes. All allowable property taxes.

A-3.7. Utility Costs. All allowable expenses for heat, electricity, water and sewer.

A-4. Components of Nursing Facility Rate Methodology

A-4.1. Applicable Cost Data. The cost data used in establishing the cost components of the rate calculation are from the audited cost report that matches the service dates to be cost settled. The draft audit of a cost report submitted by a facility will be issued by the Department no later than five (5) months after the date all information required for completion of the audit is filed with the Department.

A-4.2. Retrospective Settlement. State owned nursing facilities will be subject to a retrospective cost settlement. The cost settlement will be based on the total audited allowable nursing facility costs divided by the total audited days for the same reporting period. The Medicaid payments received for the same reporting period will be adjusted to the calculated allowable Medicaid costs.

A-4.3. Revenue Offset. Revenues from products or services provided to nonpatients will be offset from the corresponding cost center.

A-4-4. Reporting System. The objective of the reporting requirements is to provide a uniform system of periodic reports that will allow:

a. Basis for Reimbursement. A basis of provider reimbursement approximating actual costs.

b. Disclosure. Adequate financial disclosure.

c. Statistical Resources. Statistical resources, as a basis for measurement of reasonable cost and comparative analysis.

d. Criteria. Criteria for evaluating policies and procedures.

A-4.5. Reporting System Principle and Application. The provider will be required to file mandatory annual cost reports.

a. Cost Report Requirements. The fiscal year end cost report filing must include:

i. Annual income statement (two (2) copies);

ii. Balance sheet;

iii. Statement of ownership;

iv. Schedule of patient days;

v. Schedule of private patient charges;

vi. Statement of additional charges to residents over and above usual monthly rate; and

vii. Other schedules, statements, and documents as requested.

b. Special Reports. Special reports may be required. Specific instructions will be issued, based upon the circumstance.

c. Criteria of Reports. All reports must meet the following criteria:

i. State-approved formats used.

ii. Presented on accrual basis.

iii. Prepared in accordance with generally accepted accounting principles and principles of reimbursement.

iv. Appropriate detail provided on supporting schedules or as requested.

d. Preparer. It is not required that any statement be prepared by an independent, licensed or certified public accountant.

e. Reporting by Chain Organizations or Related Party Providers. PRM, Section 2141.7, prohibits the filing of combined or consolidated cost reports as a basis for cost reimbursement. Each facility so related must file a separate set of reports. These cost reports will be required for each level of organization that allocates expenses to the provider. Consolidated financial statements will be considered supplementary information and are not acceptable as fulfilling the primary reporting requirements.

f. Change of Management or Ownership. To properly pay separate entities or individuals when a change of management or ownership occurs, the following requirements must be met:

i. Outgoing management or administration must file an adjusted-period cost report if they are being reimbursed on a retrospective basis at the time of the charge. This report must meet the criteria for annual cost reports, except that it is not filed later than sixty (60) days after the change in management or ownership for the purpose of computing a final program settlement. Outgoing management or administration of a facility being reimbursed on a prospective basis at the time of change will not be required to file a closing cost report. The Department reserves the right to not initiate an audit of a cost report filed by a prior owner if the ownership change occurs between the fiscal period end date of the last cost report filed and the first date of the applicable rate period.

ii. The Department may require an appraisal at the time of a change in ownership.

iii. Providers who are receiving a new provider rate or being reimbursed on a prospective basis, when the change of management or ownership occurs, will not be required to file a closing cost report.

A-4.6. Reporting Period. For purposes of nursing facility rate setting, cost report periods of less than one hundred and eighty-four (184) days will not be used. If a provider changes their fiscal year-end or experiences a change in ownership, the last cost report filed by that facility that is one hundred and eighty-four (184) days or more will be used until a cost report that includes one hundred and eighty-four (184) days or more is received from the new owner, or is based on the new fiscal year.

A-5. Appeals and Administrative Review

Providers that disagree with the Department's calculation may request in writing for an administrative review pursuant to Idaho Code §56-133. If the provider disagrees with the administrative review decision, it may request an administrative appeal within twenty-eight (28) days of such decision.

FOR THE PROVIDER:

_____

Administrator

_____

Date

Name of Provider:_____

Address of Provider:_____

Phone: _____

Idaho Medicaid Provider Number:_____

Appendix E. Additional Terms: Personal Care Services

State of Idaho

Medicaid Provider Agreement

Additional Terms –
Aged And Disabled Waiver Personal Care Services

The DEPARTMENT reserves the right to amend the conditions outlined in this document in accordance with the Medicaid Provider Agreement, as amended.

A-1. Purpose. The purpose of this agreement is to provide Personal Care Services (PCS) and Aged and Disabled Waiver services to eligible Medicaid participants in accordance with IDAPA 16.03.26, "Medicaid Plan Benefits." PCS and Aged and Disabled Waiver services function to prevent unnecessary institutional placement, to provide for the greatest degree of independence possible, to enhance quality of life, to encourage individual choice, and to maintain community integration.

A-2. Training. The Provider shall ensure that direct service providers receive orientation and training to meet the specific needs of the participant(s) to whom they are assigned work duties in accordance with the Skills Training Matrix prior to furnishing services.

A-3. Quality Improvement. The provider is responsible for the development and implementation of a quality improvement program which assures service delivery consistent with applicable rules.

A-3.1. The provider conducts a quality improvement program which includes sufficient training sessions to ensure staff qualifications and competence, quarterly audits of services, site visits, participant satisfaction, and annual professional credential and competency review. Provider shall implement a Quality Improvement Plan for any deficiencies noted.

A-3.2. Keep annual evaluation reports and have them available to the Department during Quality Assurance reviews.

A.3.3. The provider informs the participant about the participant's rights, the availability of protection and advocacy services.

A-3.4. The provider gives the participant copies of the provider's implementation plan(s).

A-4. Provider Reviews and Corrective Action

Results of individual quality assurance reviews shall be transmitted to the provider within fifteen (15) business days of a review being completed. If deficiencies have been identified, the provider will have fifteen (15) business days to remediate all deficiencies. If the provider elects not to remediate deficiencies, the Department will request the provider complete and submit a Corrective Action Plan. A Corrective Action Plan must be submitted to the Department within forty-five (45) calendar days of receiving the Corrective Action Plan Request. The provider shall also submit documentation to the Department to verify implementation of the Corrective Action Plan within forty-five (45) calendar days of the Department's acceptance of the Corrective Action Plan.

A-5. Policies and Procedures. The provider shall provide to the Department policies and procedures that address the following:

A-5.1. Personnel, including employee qualifications, duties, compensations, benefits, training and conduct;

A-5.2. Standards for acceptance of participants, intake and admission procedures, and termination of services;

A-5.3. Participants rights and confidentiality;

A-5.4. Participant choice, including how the provider will maximize participant choice and involvement in the selection, scheduling, direction, and evaluation of direct service providers;

A-5.5. Participant and employee grievance procedures;

A-5.6. Service Delivery, including scope of services provided and procedures for delivering services;

A-5.7. Emergency response to ensure participant health and safety. The provider must have a plan which demonstrates the capability of providing emergency back up and relief services to cover the essential service needs within a reasonable time frame;

A-5.8. Home and Community-Based Services (HCBS), including how the provider will ensure that services are delivered consistent with the required HCBS setting requirements;

A-5.9. Electronic Visit Verification, including how service delivery verification will be provided to the participant;

A-5.10. Quality Assurance, including quarterly audits of services, site visits, participant satisfaction, and annual professional credential and competency review as well as annual evaluation practices.

A-6. Subcontractors. The provider shall describe the extent to which subcontractors will be used, submit to the Department for review all contracts between the agency and its subcontractors, and have procedures in place to assure the work performed by the subcontractor is of high quality.

A-7. Service Delivery.

A-7.1. The provider will not bring children or other third persons into the participant's home while providing services.

A-7.2. The provider will not become involved in the participant’s personal/financial affairs unless the participant is a family member or the provider’s involvement is part of a service coordination plan.

A-7.3. The provider will not smoke in the residence of a participant non-smoker, nor without written permission of a participant smoker.

A-7.4. The provider will not use the participant’s telephone for personal calls except as authorized by the participant and any long-distance charges are to be reimbursed immediately to the participant and/or other individuals responsible for paying phone charges.

A-7.5. When terminating services to a participant, the provider will give fourteen (14) days written notice to the participant.

A-7.6. The provider will not consume the food or beverages of the participant without the written permission of the participant, nor require the participant to provide food or beverage as a condition for providing services.

A-8. Registered Nurse (RN) and Qualified Intellectual Disability Professional (QIDP) Supervisors. The supervisor's service must be of such quality that the overall program is enhanced. The Department may review the supervisor's delivery of services to ensure quality care is being provided. Quality care includes, but is not limited to, assuring:

A-8.1. Assessments accurately reflect and address the participant's medical condition, medical treatments, functional abilities, living environment, and formal and informal supports available to the eligible participant.

A-8.2. The supervisor will oversee the development of care plans which reflect and address eligible participant's personal care needs which can only be met by the provision of personal care services by a qualified personal care attendant. To the maximum extent possible, the development of the plan will be a collaborative process involving the eligible participant, family, and other support systems. Complete, accurate and understandable care plans are completed within reasonable time frames allowing for earliest approval of services - not to exceed thirty (30) days from request.

A-8.3. Care plans are placed and maintained in the eligible participant's home on or before the first day of service which give adequate direction to the provider.

A-8.4. Care plans for eligible participants with developmentally disabilities reflect coordination with the QIDP.

A-8.5. The RN or QIDP supervisors are responsible for assuring that the Personal Care Assistant (PCA) understands and is capable of implementing the plan of care.

A-8.6. The provider will make on-site supervisory visits at intervals of at least ninety (90) days, or as authorized by the Department. The provider shall ensure that the care plan is being followed, provide instruction to the personal care attendant, assess and document the general health status of the eligible participant, and assess and document the effectiveness of the care plan, and the provision of PCS in meeting the eligible participant's needs. If service documentation is absent, the care plan is not being followed, or the eligible participant exhibits indications of abuse or neglect, the Supervisor will immediately notify the Department.

A-8.7. A copy of the RN and QIDP visit form will be provided to the Department within five (5) working days of each visit.

A-8.8. RN and QIDP supervisor services are reasonably accessible to participants, personal care attendant and the Department, to respond when care issues arise. Prior to a scheduled absence the supervisor will make alternative arrangements for coverage with another qualified supervisor.

A-8.9. If needs are identified, the RN and QIDP supervisor may initiate an application for service coordination.

A-9. Reports. The provider shall:

A-9.1. Maintain a list of all participants being served, and all employees, subcontractors, volunteers or other agents, and provide it to the Department upon request. The report shall indicate what training they have obtained or provided to their staff in meeting the needs of the participants.

A-9.2. Report any suspected or observed fraudulent, negligent, or abusive conduct to the appropriate legal authority as required by rule or law.

A-10. Appeals and Administrative Review. Providers that disagree with the Department's decision may request in writing for an administrative review pursuant to Idaho Code §56-133. If the provider disagrees with the administrative review decision, it may request an administrative appeal within twenty-eight (28) days of such decision.

FOR THE PROVIDER:

_____

Administrator

_____

Date

Name of Provider:_____

Address of Provider:_____

Phone: _____

Idaho Medicaid Provider Number:_____

Appendix F. Additional Terms: Residential Habilitation

State of Idaho

Medicaid Provider Agreement

Additional Terms – Residential Habilitation

The DEPARTMENT reserves the right to amend the following conditions outlined in this document in accordance with the Medicaid Provider Agreement, as amended.

A-1. Purpose. The purpose of this Agreement is to provide residential habilitation services in accordance with IDAPA 16.03.26.610-615, "Medicaid Plan Benefits" and IDAPA 16.04.17, "Residential Habilitation Agencies" for persons who have a developmental disability (DD) as defined in Section 66-402, Idaho Code, and who are home and community-based service (HCBS)/DD Waiver participants.

A-2. Training. The Provider shall ensure staff participation in any training required by the Department. The Provider shall ensure that direct service providers receive orientation and training to meet the specific needs of the participant(s) to whom they are assigned work duties.

A-3. Background Check. The Provider shall ensure that all direct staff subject to IDAPA 16.05.06 have satisfactorily completed a criminal history check. The Provider shall ensure that a self-declaration form and fingerprinting are completed for any individual who is subject to a criminal history check before the individual provides unsupervised direct care or services to children or vulnerable adults.

A-4. Prohibitions. The Provider shall ensure the following:

A-4.1. Participants are not compelled to work for the agency, independent provider, employee or contractor.

A-4.2. Service providers do not withhold food or hydration that is necessary for a nutritionally adequate diet.

A-4.3. Service providers do not bring children or other third persons into the participant's home while providing residential habilitation services.

A-4.4. Service providers do not become involved in the participant's personal or financial affairs unless the provider's involvement is defined on the implementation plan.

A-4.5. Service providers do not consume the food or beverages of the participant without written permission, or require the participant to provide food or beverages.

A-4.6. Service providers follow all laws relating to the operation of motor vehicles used to transport participants, and maintain liability insurance that covers participants. Seat belts or other proper seat restraints must be available and used in both the front and back seats.

A-4.7. Service providers do not smoke in the residence of a participant or in a vehicle if the participant does not smoke. Service providers may smoke in the presence of a participant who also smokes, with written permission from the participant.

A-4.8. Service providers do not work while under the influence of illegal drugs, alcohol, or prescription drugs that may affect performance.

A-4.9. Service providers do not use the participant's telephone for personal calls except as prior authorized by the participant. Any long-distance charges shall be reimbursed immediately to the individual who pays for telephone service.

A-5. Restraints. All restraint(s) must be identified, agreed to, and documented on a Plan of Service through the person-centered planning process. Written consent and a behavior change plan is also necessary for the use of restraints. A written behavior change implementation plan is developed by the participant, their team, Qualified Intellectual Disabilities Professional (QIDP) or the behavior consultant/crisis management provider, as qualified in IDAPA Section 16.03.26.610-615. The written behavior change plan must describe how the restraint will be used. The Provider shall use positive behavior interventions prior to the use of restraints, other than physical restraint in an emergency, as documented in the written behavior change plan. Restraints may only be used when documented in the written behavior change plan to be the least restrictive option for the participant to live safely in the community. Personnel involved in restraints must be trained to meet any health, behavioral or medical requirements of the participant and have appropriate supervision and oversight of a provider with the qualifications of a QIDP or higher. All restraint plans must be prior authorized by the Department prior to implementation. At a minimum the use of restraints must follow these criteria:

A-5.1. Chemical restraint shall be used only when authorized by an attending physician.

A-5.2. Mechanical restraint may be used for medical purposes only when authorized by the attending physician. Mechanical restraints may only be used for non-medical purposes when authorized by a QIDP or behavior consultant/crisis management provider.

A-5.3. Non-emergency physical restraint may be used only when authorized by a QIDP or behavior consultant/crisis management provider. Emergency physical restraint may be used without a written and approved behavior change plan in isolated incidents to prevent injury to the participant or others. Documentation is required of any emergency use.

A-5.5. Time out seclusion may be used only when authorized by a QIDP or behavior consultant/crisis management provider.

A-6. Restrictive Interventions. All restrictive intervention(s) must be identified, agreed to, and documented on a Plan of Service through the person-centered planning process. If the HCBS quality poses a health or safety risk to the participant or others, goals must be identified with strategies to mitigate the risk in the person-centered plan and agreed to by the participant or their guardian. The restrictive intervention shall be unique to the participant based on their needs. Written consent and a behavior change plan is also necessary for the use of restrictive interventions. A written behavior change implementation plan is developed by the participant, their team, and the QIDP, or behavior consultant/crisis management provider as qualified in IDAPA Section 16.03.26.610-615. The written behavior change plan must describe how the restrictive intervention will be used. The Provider shall use positive behavior interventions prior to the use of restrictive interventions. Restrictive interventions may only be used when documented in the written behavior change plan to be the least restrictive option for the participant to live safely in the community. Personnel involved in restrictive interventions must be trained to meet any health, behavioral or medical requirements of the participant and have appropriate supervision and oversight of a provider with the qualifications of a Qualified Intellectual Disabilities Professional (QIDP) or

higher. All restrictive intervention plans must be prior authorized by the Department prior to implementation. Setting qualities warranting risk mitigation include full integration and access to the community, including:

A-6.1. Freedom to control personal resources,

A-6.2. Freedom to work in competitive integrated settings,

A-6.3. Freedom to engage in community life,

A-6.5. Freedom to receive services in the community,

A-6.6. Right to privacy,

A-6.7. Autonomy in making choices, including daily activities, physical environment, and with whom to interact, and

A-6.8. Opportunities for choice regarding services and supports.

Setting qualities that may warrant an exception include:

A-6.9. Lockable bedroom or living unit doors,

A-6.10. Choice of roommate,

A-6.11. Freedom to furnish and decorate living spaces,

A-6.12. Freedom and support to control schedules and activities,

A-6.13. Access to food,

A-6.14. Ability to have visitors at any time, and

A-6.15. Physically accessible setting.

A-7. Seclusion. The use of seclusion must be identified, agreed to, and documented on a Plan of Service through the person-centered planning process. Written consent and a behavior change plan is also necessary for the use of seclusion. A written behavior change implementation plan is developed by the participant, their team, and the QIDP or behavior consultant/crisis management provider as qualified in IDAPA Section 16.03.26.610-615. The written behavior change plan must describe how seclusion will be used. The Provider shall use positive behavior interventions prior to the use of seclusion as documented in the written behavior change plan. Seclusion may only be used when documented in the written behavior change plan to be the least restrictive option for the participant to live safely in the community. Personnel involved in seclusion must be trained to meet any health, behavioral or medical requirements of the participant and have appropriate supervision and oversight of a provider with the qualifications of a Qualified Intellectual Disabilities Professional (QIDP) or higher. All seclusion plans must be prior authorized by the Department prior to implementation.

A-8. Quality Improvement. The Provider is responsible for the development and implementation of a quality improvement program which assures service delivery consistent with applicable rules. Results of individual quality improvement reviews conducted by the Department shall be transmitted to the Provider within forty-five (45) days after the review is completed. If deficiencies have been identified by the review, the Provider shall submit to the Department a corrective action plan for addressing the identified deficiencies. This corrective action plan shall be submitted to the Department within forty-five (45) days of receiving the results of a quality assurance review. Upon request, a provider shall also forward to the Department the results of any implemented corrective action plan. At a minimum quality of services shall be evaluated according to the following criteria:

A-8.1. A participant's implementation plan must be modified when there are changes in circumstances, abilities, or a re-assessment to ensure that public funds are expended for appropriate services in the most cost-effective manner.

A-8.2. The Provider informs each participant or guardian of the services to be received, the expected benefits and attendant risks of receiving those services, of the right to refuse services, and alternative forms of services available.

A-8.3. The Provider, its employees and subcontractors interact with participants in a respectful manner.

A-8.4. Provider interventions promote participant empowerment and choice, within the programmatic confines of safe and effective services that do not endanger the participant or others in implementation. Participants are recognized as primary decision-makers in accessing any and all services, unless a court has established an appropriate guardianship.

A-8.5. Services are provided at a time and location that is convenient, acceptable and suitable for the participant and the participant's team, and are coordinated and consistent with all other services the participant is receiving.

A-8.6. The Provider's decision to accept or continue services for a participant is based on the Provider's ability to meet the needs of the participant.

A-8.7. The Provider schedules services to ensure that the implementation plan for this service is developed and implemented effectively.

A-8.8. The Provider conducts a quality improvement program which includes sufficient training sessions to ensure staff qualifications and competence, quarterly audits of services, site visits, participant satisfaction, and annual professional credential and competency review. The provider shall implement a Quality Improvement Plan for any deficiencies noted.

A-8.9. The Provider informs the participant about the participant's rights and the availability of protection and advocacy services.

A-8.10. The Provider discusses the implementation plan(s) with the participant and provides him/her a copy of each plan.

A-8.11. The provider must furnish a written status update at least every six (6) months to the Department and annually to the Person Centered Planning Team.

A-8.12. The Provider ensures that the setting in which services are delivered meets the required Home and Community-Based Services setting qualities described in 42 CFR § 441.300(c)(4).

A-9. Transition of Participants. The agency must develop a transition plan to terminate service delivery to a participant if, as a result of a person-centered planning process conducted by the person-centered planning team, it is demonstrated that the participant is no longer in need of or desires Residential Habilitation services. The agency must notify the participant in writing that the termination of services will occur. The agency may not terminate services when to do so would pose a threat of endangerment to the participant or others.

A-10. Reports. The Provider shall:

A-10.1. Maintain a list of all participants being served, and all employees, subcontractors or agents, and provide it to the Department upon request. The report shall indicate which providers of services have received Department-approved training.

A-10.2. Keep progress notes/records of time, and tasks/activities performed by direct service providers and have them available to the Department during QA reviews.

A-10.3. Keep annual evaluation reports and have them available to the Department during QA reviews.

A-10.4. Inform the Department within forty-eight (48) hours of any criminal conduct, any accusation of fraudulent, negligent or abusive conduct, and any termination for poor performance by any employee, subcontractor or agent.

A-10.5. Report any suspected or observed fraudulent, negligent, or abusive conduct to the appropriate legal authority as required by rule or law.

A-11. Appeals and Administrative Review.

Providers that disagree with the Department's decision may request in writing for an administrative review pursuant to Idaho Code §56-133. If the provider disagrees with the administrative review decision, it may request an administrative appeal within twenty-eight (28) days of such decision.

FOR THE PROVIDER:

_____

Administrator

_____

Date

Name of Provider:_____

Address of Provider:_____

Phone: _____

Idaho Medicaid Provider Number:_____

Appendix G. Additional Terms: Supported Employment

State of Idaho

Medicaid Provider Agreement

Additional Terms – Supported Employment

The DEPARTMENT reserves the right to amend the following conditions outlined in this document in accordance with the Medicaid Provider Agreement, as amended.

A-1. Purpose. The purpose of this Agreement is to provide supported employment services for eligible Medicaid participants who meet the criteria for persons with developmental disabilities as defined in Idaho Code § 66-402, who are eighteen (18) years of age or older, and who meet criteria for Intermediate Care Facility for the Individuals with Intellectual Disabilities (ICF/IID) level of care in accordance IDAPA 16.03.26.610-615, "Medicaid Plan Benefits." Supported employment does not include services provided by the Idaho Division of Vocational Rehabilitation, such as evaluation, work adjustment, and job site selection.

A-2. Training. The Provider shall ensure staff participation in any training required by the Department. The Provider shall ensure that direct service providers receive orientation and training to meet the specific needs of the participant(s) to whom they are assigned work duties.

A-3. Criminal History Check. The Provider shall ensure that all direct care staff subjected to IDAPA 16.05.06 providers have satisfactorily completed a criminal history check. The Provider shall ensure that a self-declaration form and fingerprinting are completed for any individual who is subject to a criminal history check before the individual provides unsupervised direct care or services to children or vulnerable adults.

A-4. Quality Improvement. The Provider is responsible for the development and implementation of a quality assurance program which assures service delivery consistent with applicable rules. Results of quality improvement reviews conducted by the Department shall be transmitted to the Provider within forty-five (45) days after the review is completed. If deficiencies have been identified by the review, the Provider shall submit to the Department a corrective action plan for addressing the identified deficiencies. This corrective action plan shall be submitted to the Department within forty-five (45) days of receiving the results of a quality assurance review. Upon request, a provider shall also forward to the Department the results of any implemented corrective action plan. At a minimum quality of services shall be evaluated according to the following criteria:

A-4.1. A participant's implementation plan must be modified when there are changes in circumstances, abilities, or a re-assessment to ensure that public funds are expended for appropriate services in the most cost-effective manner.

A-4.2. The Provider informs each participant or guardian of the services to be received, the expected benefits and attendant risks of receiving those services, of the right to refuse services, and alternative forms of services available.

A-4.3. The Provider, its employees and subcontractors interact with participants in a respectful manner.

A-4.4. Provider interventions promote participant empowerment and choice, within the
programmatic confines of safe and effective services that do not endanger the

participant or others in implementation. Participants are recognized as primary decision-makers in
accessing any and all services, unless court has established an appropriate guardianship.

A-4.5. Services are provided at a time and location that is convenient, acceptable and suitable for the participant and are coordinated and consistent with all other services the participant is receiving.

A-4.6. The Provider's decision to accept or continue services for a participant is based on that provider's ability to meet the needs of the participant.

A-4.7. The Provider schedules services to ensure that the implementation plan for this service is developed and implemented effectively.

A-4.8. The Provider conducts a quality improvement program which includes sufficient training sessions to ensure staff qualifications and competence, quarterly audits of services, site visits, participant satisfaction, and annual professional credential and competency review. The provider shall implement a Quality Improvement Plan for any deficiencies noted.

A-4.9. The Provider informs the participant about the participant's rights and the availability of protection and advocacy services.

A-4.10. The Provider gives the participant copies of the Provider's implementation plan(s).

A-4.11. The Provider ensures that the setting in which services are delivered meets the required Home and Community-Based Services setting qualities described in CFR § 441.300(c)(4).

A-5. Transition of Participants. The agency must develop a transition plan to terminate service delivery to a participant if, as a result of a person-centered planning process conducted by the person-centered planning team, it is demonstrated that the participant is no longer in need of or desires Supported Employment services. The agency must notify the client in writing that the termination of services will occur. The agency may not terminate services when to do so would pose a threat of endangerment to the participant or others.

A-6. Reports. The Provider shall:

A-6.1. Maintain a list of all participants being served, and all employees, subcontractors or agents, and provide it to the Department upon request. The report shall indicate which providers of services have received Department-approved training.

A-6.2. Inform the Department within forty-eight (48) hours of any criminal conduct, any accusation of fraudulent, negligent or abusive conduct, and any termination for poor performance by an employee, subcontractor or agent.

A-6.3. Report any suspected or observed fraudulent, negligent, or abusive conduct to the appropriate legal authority as required by rule or law.

A-7. Payment for Services. Supported Employment providers shall not use Medicaid reimbursement for job coaching for payment for work completed by the participant.

A-8. Appeals and Administrative Review.

Providers that disagree with the Department's decision may request in writing for an administrative review pursuant to Idaho Code §56-133. If the provider disagrees with the

administrative review decision, it may request an administrative appeal within 28 days of such decision.

FOR THE PROVIDER:

_____

Administrator

_____

Date

Name of Provider:_____

Address of Provider:_____

Phone: _____

Idaho Medicaid Provider Number:_____

Appendix H. Provider Handbook Modifications

This table lists the last three years of changes to this handbook as of the publication date. Changes to references or of a non-substantive technical nature are not captured.

Provider Handbook Modifications				
Version	**Section/Column**	**Modification Description**	**Date**	**SME**
2.0	All	Published version	08/17/2026	TQD
1.142	Appendix H. Provider Handbook Modifications	Added that insubstantial changes will not be captured and log will only retain three years.	08/17/2026	K Lolofie W Deseron
1.141	Appendix G. Additional Terms: Supported Employment	New section.	08/17/2026	K Lolofie W Deseron
1.140	Appendix F. Additional Terms: Residential Habilitation	New section.	08/17/2026	K Lolofie W Deseron
1.139	Appendix E. Additional Terms: Personal Care Services	New section.	08/17/2026	K Lolofie W Deseron
1.138	Appendix D. Additional Terms: Nursing Facilities	New section.	08/17/2026	K Lolofie W Deseron
1.137	Appendix C. Additional Terms: Behavioral Consultation	New section.	08/17/2026	K Lolofie W Deseron
1.136	Appendix B. Additional Terms: Adult Day Health	New section.	08/17/2026	K Lolofie W Deseron
1.135	Appendix A. Provider Training Matrix Standards V2.3	New section.	08/17/2026	K Lolofie W Deseron
1.134	33. Documentation	New section.	08/17/2026	K Lolofie W Deseron
1.133	32. Appeals	New section.	08/17/2026	K Lolofie W Deseron
1.132	31.5. Transition Management and Services: Reimbursement	Added burden of proof, place of services and resources.	08/17/2026	K Lolofie W Deseron
1.131	31.4. Transition Management and Services: Documentation	Added direction to general requirements.	08/17/2026	K Lolofie W Deseron
1.130	31.3.2. Transition Services	Added waiver coverage and services reimbursed.	08/17/2026	K Lolofie W Deseron
1.129	31.2. Transition Management and Services: Participant Eligibility	Clarified requirement to check eligibility, and added resources.	08/17/2026	K Lolofie W Deseron
1.128	31.1. Transition Management and Services: Provider Qualifications	Add A&D transition managers must be employees of agencies, a spouse cannot provide services and point to general requirements.	08/17/2026	K Lolofie W Deseron
1.127	30.5. Supported Employment: Reimbursement	Added burden of proof, legislative approval of rates and resources.	08/17/2026	K Lolofie W Deseron
1.126	30.4. Supported Employment: Documentation	Added direction to general section.	08/17/2026	K Lolofie W Deseron
1.125	30.3. Supported Employment: Covered Services and Limitations	Updated that exception for budget is DD, and A&D quality assurance.	08/17/2026	K Lolofie W Deseron
1.124	30.2. Supported Employment: Participant Eligibility	Clarified requirement to check eligibility, and added resources.	08/17/2026	K Lolofie W Deseron

Provider Handbook Modifications				
Version	**Section/Column**	**Modification Description**	**Date**	**SME**
1.123	30.1. Supported Employment: Provider Qualifications	Added language around additional provider agreement and general qualifications.	08/17/2026	K Lolofie W Deseron
1.122	27.8. Service Coordination: Reimbursement	Added burden of proof, legislative approval of rates and resources.	08/17/2026	K Lolofie W Deseron
1.121	27.6. Service Coordination: Documentation	Added reminder to see general requirements.	08/17/2026	K Lolofie W Deseron
1.120	27.5. Service Coordination: Prior Authorization: Children	Removed inaccurate request process. Pointed to general requirements.	08/17/2026	K Lolofie W Deseron
1.119	27.3. Service Coordination: Covered Services and Limitations	Added mandatory reporting requirement.	08/17/2026	K Lolofie W Deseron
1.118	27.2.3. Service Coordination for Children	Added duplicative service clarification.	08/17/2026	K Lolofie W Deseron
1.117	27.2.2. Service Coordination for Adults	Added duplicative service clarification.	08/17/2026	K Lolofie W Deseron
1.116	27.2. Service Coordination: Provider Qualifications	Section deleted. See general section requirements.	08/17/2026	K Lolofie W Deseron
1.115	27.2. Service Coordination: Participant Eligibility	Clarified requirement to check eligibility, and added resources.	08/17/2026	K Lolofie W Deseron
1.114	26.4. Respite Care: Reimbursement	Added EVV info, CFH info, A&D info, burden of proof, legislative approval of rates and resources.	08/17/2026	K Lolofie W Deseron
1.113	26.4. Documentation	Section Deleted. See general requirements.	08/17/2026	K Lolofie W Deseron
1.112	26.3. Respite Care: Covered Services and Limitations	Removed information about RALFs. RALF content is in the Long-Term Care Facility handbook.	08/17/2026	K Lolofie W Deseron
1.111	26.2. Respite Care: Participant Eligibility	Clarified requirement to check eligibility, and added resources.	08/17/2026	K Lolofie W Deseron
1.110	26.1. Respite Care: Provider Qualifications	Updated A&D participant requirements. Pointed to general requirements.	08/17/2026	K Lolofie W Deseron
1.109	25.5. Supported Living: Reimbursement	Section rewrite.	08/17/2026	K Lolofie W Deseron
1.108	25.4. Supported Living: Additional Documentation	Add info on deviation from plans. Pointed to general requirements.	08/17/2026	K Lolofie W Deseron
1.107	25.3. Supported Living: Covered Services and Limitations	Reminder added to meet quality assurance requirements.	08/17/2026	K Lolofie W Deseron
1.106	25.2. Supported Living: Participant Eligibility	Clarified requirement for policies and procedures, to check eligibility, and added resources.	08/17/2026	K Lolofie W Deseron
1.105	25.1. Supported Living: Provider Qualifications	Moved some content to ResHab agency section. Pointed to general qualifications.	08/17/2026	K Lolofie W Deseron
1.104	22.5. Personal Care Services: Reimbursement	Added burden of proof, legislative approval of rates and resources.	08/17/2026	K Lolofie W Deseron
1.103	22.4. Personal Care Services: Documentation	Added to follow general requirements.	08/17/2026	K Lolofie W Deseron
1.102	22.3. Personal Care Services: Covered Services and Limitations	Clarified RN is supervisor. Updated information on attendant care.	08/17/2026	K Lolofie W Deseron
1.101	22.2. Personal Care Services: Participant Eligibility	Clarified requirement to check eligibility, and added resources.	08/17/2026	K Lolofie W Deseron

Provider Handbook Modifications				
Version	**Section/Column**	**Modification Description**	**Date**	**SME**
1.100	22.1. Personal Care Services: Provider Qualifications	Updated requirements and moved majority of content to PAA section.	08/17/2026	K Lolofie W Deseron
1.99	20.4. Homemaker Services: Reimbursement	Added information on EVV, burden of proof, legislative approval of rates and resources.	08/17/2026	K Lolofie W Deseron
1.98	20.4. Documentation	Section Deleted. See general requirements.	08/17/2026	K Lolofie W Deseron
1.97	20.2. Homemaker Services: Participant Eligibility	Clarified requirement for no other able person to perform task and to check eligibility, and added resources.	08/17/2026	K Lolofie W Deseron
1.96	20.1. Homemaker Services: Provider Qualifications	Added prohibition against spouses and pointed to general requirements.	08/17/2026	K Lolofie W Deseron
1.95	19.4. Home Delivered Meals: Reimbursement	Added burden of proof, legislative approval of rates and resources.	08/17/2026	K Lolofie W Deseron
1.94	19.4 Documentation	Section Deleted. See general requirements.	08/17/2026	K Lolofie W Deseron
1.93	19.3. Home Delivered Meals: Covered Services and Limitations	Some content moved to participant eligibility.	08/17/2026	K Lolofie W Deseron
1.92	19.2. Home Delivered Meals: Participant Eligibility	Clarified requirements and to check eligibility, and added resources.	08/17/2026	K Lolofie W Deseron
1.91	19.1. Home Delivered Meals: Provider Qualifications	Clarify direct service and general requirements.	08/17/2026	K Lolofie W Deseron
1.90	17.5. Developmental Therapy: Reimbursement	Added legislative approval of rates and resources.	08/17/2026	K Lolofie W Deseron
1.89	17.4.2. Developmental Therapy Service Plans	Some content removed as duplicative.	08/17/2026	K Lolofie W Deseron
1.88	17.4. Prior Authorization	Section Deleted. See general requirements.	08/17/2026	K Lolofie W Deseron
1.87	17.4. Developmental Therapy: Additional Documentation	Added requirement to follow general section.	08/17/2026	K Lolofie W Deseron
1.86	17.2. Developmental Therapy: Participant Eligibility	Clarified requirement to check eligibility, BDDS authorization and added resources.	08/17/2026	K Lolofie W Deseron
1.85	17.1. Developmental Therapy: Provider Qualifications	Moved content to DDA section.	08/17/2026	K Lolofie W Deseron
1.84	16.4. Documentation	Section Deleted. See general requirements.	08/17/2026	K Lolofie W Deseron
1.83	16.4. Day Habilitation: Reimbursement	Added enrollment requirement, legislative approval of rates and resources.	08/17/2026	K Lolofie W Deseron
1.82	16.2. Day Habilitation: Participant Eligibility	Clarified requirement to check eligibility and added resources.	08/17/2026	K Lolofie W Deseron
1.81	16.1. Day Habilitation: Provider Qualifications	Added requirement to follow general section.	08/17/2026	K Lolofie W Deseron
1.80	16.1. Day Habilitation: Provider Qualifications	Added to see general requirements.	08/17/2026	K Lolofie W Deseron
1.79	15.4. Documentation	Section Deleted. See general requirements.	08/17/2026	K Lolofie W Deseron
1.78	15.4. Consultation (Self Direction): Reimbursement	Added legislative approval of rates and resources.	08/17/2026	K Lolofie W Deseron
1.77	15.3. Consultation Services(Self Direction): Covered Services and Limita	Clarified agency must be acting as fiscal intermediary.	08/17/2026	K Lolofie W Deseron

Provider Handbook Modifications				
Version	**Section/Column**	**Modification Description**	**Date**	**SME**
1.76	15.2. Consultation Services (Self Direction): Participant Eligibility	Clarified requirement to check eligibility and added resources.	08/17/2026	K Lolofie W Deseron
1.75	15.1. Consultation (Self Direction): Provider Qualifications	Added requirements. Clarified cannot be performed by spouse and to see general requirements.	08/17/2026	K Lolofie W Deseron
1.74	14.4. Documentation	Section Deleted. See general requirements.	08/17/2026	K Lolofie W Deseron
1.73	14.4. Companion Services: Reimbursement	Added enrollment requirement, legislative approval of rates and resources.	08/17/2026	K Lolofie W Deseron
1.72	14.2. Companion Services: Participant Eligibility	Clarified requirement to check eligibility and added resources.	08/17/2026	K Lolofie W Deseron
1.71	14.1. Companion Services: Provider Qualifications	Clarified cannot be performed by spouse and to see general requirements.	08/17/2026	K Lolofie W Deseron
1.70	13.5. Documentation	Section Deleted. See general section.	08/17/2026	K Lolofie W Deseron
1.69	13.5. Community Crisis Supports: Reimbursement	Added enrollment requirement, legislative approval of rates and resources.	08/17/2026	K Lolofie W Deseron
1.68	13.2. Community Crisis Supports: Participant Eligibility	Clarified requirement to check eligibility and added resources.	08/17/2026	K Lolofie W Deseron
1.67	13.1. Community Crisis Supports: Provider Qualifications	Added requirement to also use general section.	08/17/2026	K Lolofie W Deseron
1.66	12.4. Documentation	Section Deleted. See general section.	08/17/2026	K Lolofie W Deseron
1.65	12.4. Chore Services: Reimbursement	Added enrollment requirement, legislative approval of rates and resources.	08/17/2026	K Lolofie W Deseron
1.64	10. Attendant Care: Provider Qualifications	Clarified provider requirements.	08/17/2026	K Lolofie W Deseron
1.63	10. Children's Habilitation Intervention Services	Sections deleted. Content moved into its own handbook.	08/17/2026	K Lolofie W Deseron
1.62	10.2. Attendant Care: Participant Eligibility	Added information on participant requirements and provider expectations.	08/17/2026	K Lolofie W Deseron
1.61	10.3. Attendant Care: Covered Services and Limitations	Added requirement to exhaust state plan PCS.	08/17/2026	K Lolofie W Deseron
1.60	10.4. Attendant Care Services – Reimbursement	Added information about EVV and provider resources.	08/17/2026	K Lolofie W Deseron
1.59	10.4. Documentation	Section deleted.	08/17/2026	K Lolofie W Deseron
1.58	11.1. Behavior Consultation/Crisis Management: Provider Qualifications	Added direction to general qualifications.	08/17/2026	K Lolofie W Deseron
1.57	11.2. Behavior Consultation/Crisis Management: Participant Eligibility	Clarified requirement to check eligibility, BDDS authorizations and added resources.	08/17/2026	K Lolofie W Deseron
1.56	11.4. Behavior Consultation/Crisis Management: Reimbursement	Added enrollment requirement, legislative approval of rates and resources.	08/17/2026	K Lolofie W Deseron
1.55	11.4. Prior Authorization	Section Deleted. See general section.	08/17/2026	K Lolofie W Deseron
1.54	11.5. Documentation	Section Deleted. See general section.	08/17/2026	K Lolofie

Provider Handbook Modifications				
Version	**Section/Column**	**Modification Description**	**Date**	**SME**
				W Deseron
1.53	12.1. Chore Services: Provider Qualifications	Clarified requirement to be employee of agency and prohibitions.	08/17/2026	K Lolofie W Deseron
1.52	12.2. Chore Services: Participant Eligibility	Clarified requirement to check eligibility and added resources.	08/17/2026	K Lolofie W Deseron
1.51	9.4. Aged & Disabled Case Management: Reimbursement	Added standard reimbursement language.	08/17/2026	K Lolofie W Deseron
1.50	9.4. Documentation	Section Deleted.	08/17/2026	K Lolofie W Deseron
1.49	9.3. Aged & Disabled Case Management: Covered Services and Limitations	Noted services can't be duplicative and RALF eligibility.	08/17/2026	K Lolofie W Deseron
1.48	9.2. Aged & Disabled Case Management: Participant Eligibility	Added information on Aged & Disabled Case Management and basic eligibility information.	08/17/2026	K Lolofie W Deseron
1.47	9.1. A&D Case Management: Provider Qualifications	Revised language to account for correct provider types.	08/17/2026	K Lolofie W Deseron
1.46	8. Adult Residential Care	New section.	08/17/2026	K Lolofie W Deseron
1.45	7.5. Adult Day Health: Reimbursement	Added standard reimbursement language.	08/17/2026	K Lolofie W Deseron
1.44	7.4. Documentation	Section deleted.	08/17/2026	K Lolofie W Deseron
1.43	7.3. Adult Day Health: Covered Services and Limitations	Removed notification language. Added language to follow general requirements.	08/17/2026	K Lolofie W Deseron
1.42	7.2. Adult Day Health: Participant Eligibility	Added basic eligibility requirements.	08/17/2026	K Lolofie W Deseron
1.41	7.1. Adult Day Health: Provider Qualifications	Added the potential providers of the service and training requirements.	08/17/2026	K Lolofie W Deseron
1.40	6.8.2 Adult Developmental Disability Services: Cost Survey Procedures	Section deleted.	08/17/2026	K Lolofie W Deseron
1.39	6.8. Adult Developmental Disability Services: Reimbursement	Added reimbursement language. Removed cost survey language.	08/17/2026	K Lolofie W Deseron
1.38	6.6. Adult Developmental Disability Services: Additional Documentation	Added requirement to follow general documentation.	08/17/2026	K Lolofie W Deseron
1.37	6.5. Adult Developmental Disability Services: Covered Services and Limit	Added language about place of service, and observations as a reason to report.	08/17/2026	K Lolofie W Deseron
1.36	6.1.3. DD Waiver Services	Changed September to March for application processing.	08/17/2026	K Lolofie W Deseron
1.35	6. Adult Developmental Disability (DD) Services – General Information	Added standard eligibility language.	08/17/2026	K Lolofie W Deseron
1.34	5.9.2. Cost Survey Procedures	Section deleted.	08/17/2026	K Lolofie W Deseron
1.33	5.9. Aged and Disabled Waiver: Reimbursement	Rewrite section.	08/17/2026	K Lolofie W Deseron
1.32	5.8. Aged and Disabled Waiver: Quality Assurance and Improvement	Added information around corrective action plan.	08/17/2026	K Lolofie W Deseron
1.31	5.7. Aged and Disabled Waiver: Additional Documentation	Provide reference to resources.	08/17/2026	K Lolofie W Deseron

Provider Handbook Modifications				
Version	**Section/Column**	**Modification Description**	**Date**	**SME**
1.30	5.6. Aged and Disabled Waiver: Covered Services and Limitations	Updated service list.	08/17/2026	K Lolofie W Deseron
1.29	5.5. Aged &and Disabled Waiver: Individual Service Plan	Added contributors A&D Waiver Case Manager and Dual Plan Care Coordinator/Specialist. Provided reference to resources. Updated eligible supervisors and service plan requirements. Added prohibitions on restraints and seclusion.	08/17/2026	K Lolofie W Deseron
1.28	5.3. Aged and Disabled Waiver: Participant Eligibility	Added standard participant eligibility language.	08/17/2026	K Lolofie W Deseron
1.27	5.2. Aged and Disabled Waiver: Provider Qualifications	Removed content and directed to general provider qualifications section.	08/17/2026	K Lolofie W Deseron
1.26	4.6. Children's Support Services: Reimbursement	Updated to require enrollment, burden of proof and usual and reimbursement determinations.	08/17/2026	K Lolofie W Deseron
1.25	4.5. Children's Support Services: Additional Documentation	Removed content and directed to general documentation section.	08/17/2026	K Lolofie W Deseron
1.24	4.3.5. Family Education	New section.	08/17/2026	K Lolofie W Deseron
1.23	4.3.8. Family-Directed Community Supports	Section deleted.	08/17/2026	K Lolofie W Deseron
1.22	4.2. Children's Support Services: Participant Eligibility	Added standard eligibility language. Added Vineland information.	08/17/2026	K Lolofie W Deseron
1.21	4.1.6. Community Supports Worker	Section deleted.	08/17/2026	K Lolofie W Deseron
1.20	4.1.5. Support Broker	Section deleted.	08/17/2026	K Lolofie W Deseron
1.19	4.1.3. Community-Based Supports	Removed independent respite provider prohibition for meeting experience requirement.	08/17/2026	K Lolofie W Deseron
1.18	3.5. HCBS Participant Eligibility	Clarified participants won't be disenrolled if unable to find a provider.	08/17/2026	K Lolofie W Deseron
1.17	3.4. Home and Community-Based Person-Centered Planning Requirements	Clarified state plan PCS for plan distribution.	08/17/2026	K Lolofie W Deseron
1.16	3.3.2. Residential Provider-Owned or Controlled Setting Quality Requirements	Defined assessed need.	08/17/2026	K Lolofie W Deseron
1.15	3.2. HCBS Decision-Making Authority	Clarified who submits the request for restrictive intervention and coordination requirement.	08/17/2026	K Lolofie W Deseron
1.14	2.5. Service Coordination	New section.	08/17/2026	K Lolofie W Deseron
1.13	2.4.3. Residential Habilitation Agency: Aged & Disabled Waiver Requirements	New section.	08/17/2026	K Lolofie W Deseron
1.12	2.4.2. Residential Habilitation Agency: Developmental Disability Waiver Requirements	New section.	08/17/2026	K Lolofie W Deseron

Provider Handbook Modifications				
Version	**Section/Column**	**Modification Description**	**Date**	**SME**
1.11	2.4. Residential Habilitation – Agency	Added information on provider agreements. Moved content to General Provider Qualifications.	08/17/2026	K Lolofie W Deseron
1.10	2.3. Personal Assistance Agency	New section. Adds the requirements for provider qualifications.	08/17/2026	K Lolofie W Deseron
1.9	2.2. Developmental Disability Agency	New section. Adds the requirements for provider qualifications.	08/17/2026	K Lolofie W Deseron
1.8	2. General Provider Qualifications	New section. Contains standard requirements.	08/17/2026	K Lolofie W Deseron
1.7	1.3. Medicaid	Revised contact sections.	08/17/2026	K Lolofie W Deseron
1.6	1.1. Gainwell Technologies	Clarified Gainwell does not serve managed care plans.	08/17/2026	K Lolofie W Deseron
1.5	Home and Community-Based Services (HCBS) and Long-Term Support Services (LTSS)	Added information about the State Plan and Waivers.	08/17/2026	K Lolofie W Deseron
1.4	All-Participant Eligibility	Participant eligibility sections incorporated rule requirements to check eligibility.	08/17/2026	K Lolofie W Deseron
1.3	All-Reimbursement	Reimbursement sections incorporated language on burden of proof and legislative approval for rate changes as required by regulations.	08/17/2026	K Lolofie W Deseron
1.2	All-Documentation	Many documentation sections were deleted or reduced and replaced with a General Documentation section.	08/17/2026	K Lolofie W Deseron
1.1	All	Section headings were updated to reflect the service provided.	08/17/2026	K Lolofie W Deseron
1.0	All	Published version	12/03/2025	TQD
1.0	All	Created due to CR; formerly Agency Professional.	11/26/2025	W Deseron