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August 2010

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# 1. Section Modifications

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<thead>
<tr>
<th>Section/Column</th>
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<td>8/19/2010</td>
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<td>2.5.4.</td>
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<td>All</td>
<td>Replaced member with participant</td>
<td>8/17/2010</td>
<td>C Stickney</td>
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<td>2.3.4.</td>
<td>Updated PA information</td>
<td>8/17/2010</td>
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<td>All</td>
<td>Updated numbering for sections to accommodate Section Modifications</td>
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2. Adult Residential Care

2.1. Overview
This section covers all Medicaid services provided as deemed appropriate by the Idaho Department of Health and Welfare (DHW) for:
- Residential Assisted Living Facility (RALF)
- Certified Family Home (CFH)

2.2. Regional Medicaid Services
Regional Medicaid Services (RMS) is a unit of the Division of Medicaid in the region that acts as the administrative case manager for the Aged and Disabled Waiver, Developmental Disabilities Waiver, or Personal Care Services. They determine participant needs through the Uniform Assessment Instrument (UAI), or Scales of Independent Behavior-Revised (SIB-R), authorize waiver services, and develop an Individual Service Plan (ISP).

2.3. General Information
This section covers all general claim information for waiver services for aged and disabled adults (A&D Waiver), Developmental Disabilities Waiver (DD Waiver), or Personal Care Services (PCS). It addresses the following:
- Provider qualifications
- Record keeping
- Participant eligibility
- Prior authorization (PA)
- Billing information
- Place Of Service delivery and exclusions
- Plan for Services
- Change of provider information

2.3.1. Provider Qualifications
All providers of services must have a valid provider agreement with Medicaid. Providers must meet the qualifications of IDAPA 16.03.10.329 Aged Or Disabled Waiver Services or TBI requirements – Provider Qualifications and Duties for Developmental Disabilities Waiver IDAPA 16.03.10.705 DD Waiver Services–Provider Qualifications and Duties, for Personal Care Services IDAPA 16.03.10.305 Personal Care Services (PCS) The RMS in each region will monitor performance under this agreement.

Adult Residential Care providers must obtain a separate provider number for transportation services, and adult day care services. Non-Medical Transportation services providers must be enrolled as Non-Emergent Transportation providers with the Idaho Medicaid program; see Non-Emergent Transportation, for more information.

2.3.2. Record Keeping
Medicaid requires all providers to meet the documentation requirements listed in the Provider Enrollment Agreement and IDAPA rules. Providers must generate records at the time of service and maintain all records necessary to fully document the extent of services submitted for Medicaid reimbursement. Providers must also retain all medical records to document services submitted for Medicaid reimbursement for at least five years after the date of service.
2.3.3. **Participant Eligibility**
For a participant to be eligible for Medicaid payment of waiver services, the RMS will determine eligibility.

2.3.4. **Prior Authorization (PA)**
The Regional Medicaid Service (RMS) must authorize all services reimbursed by Medicaid before services are rendered. Approved PAs are valid for one year from the date of prior authorization by the RMS unless otherwise indicated. Claims for services requiring PA will be denied if the provider did not obtain a PA from the authorizing authority.

Payment will only be made for actual services rendered. There are no bed-hold payments when a participant is hospitalized, or in a natural support setting.

Services, Supplies, Rent, Utilities and Food (RUF) not disclosed in the written admission agreement can not be charged to the participant.

See General Billing Information, Prior Authorization (PA), for additional billing information.

2.3.5. **Healthy Connections (HC)**
HC referrals are required for services under the DD Waiver.

2.3.6. **Plan of Care (POC)**
All services that are provided must be based on a written Plan of Care (POC). This is developed by the POC team which includes the participant, the family, guardian, service providers, and others identified by the participant.

The Plan of Care (POC) must be based on the Uniform Assessment Instrument (UAI), or SIB-R. It will include:
- Type, amount, frequency, and duration of services with the provider identified.
- Support and service needs to be met by the participant’s family, friends, other community resources, and the providers of services.
- Goals to be addressed.
- Activities to promote progress, maintain functional skills, or delay or prevent regression.
- Includes all Medicaid allowable services and supports, and all natural or non-paid services and supports.
- The plan must be revised and updated by the Plan of Care (POC) team based upon treatment results or a change in the participant’s needs and POC must be updated at least annually.
- The signatures of the POC team participants.

2.4. **Residential Assisted Living Facility (RALF)**

2.4.1. **Overview**
Adult Residential Assisted Living Facility (RALF) consists of a range of services provided in a congregate setting licensed in accordance with IDAPA 16.03.22 that provides commercial care for participants on A&D or PCS Waivers. The service need identified by the Uniform Assessment Instrument (UAI) is negotiated between the facility and the participant and includes:
• Administrative oversight must be provided for all services provided or available in this setting
• Assistance with personal finances if applicable
• Assistance with activities of daily living
• Housekeeping
• Laundry
• Meals (including special diets)
• Medication management
• Opportunities for socialization
• Recreation
• Transportation

A Plan of Care (POC)/Negotiated Service Agreement (NSA) will be developed between the participant, or the participant’s legal representative, and a facility representative. While in this setting, the participant will not be eligible for other waiver services except for nursing services, adult day care, behavior consultation, and assistive technology.

**Note:** Adult residential care services are covered for Medicaid Enhanced Plan participants. See *CMS-1500 Instructions, Appendix A.1.1* for covered services.

2.4.2. **Provider Qualifications**
The facility must meet all applicable state laws and regulations. In addition, the provider must ensure that adequate staff is provided to meet the needs of all participants accepted for admission on a 24 hour, seven days per week basis.

2.4.3. **Payment**
Payment will be made on a *per diem or unit* basis. The daily payment rate will be established by the Regional Medicaid Services. See *CMS-1500 Instructions, Appendix A* for covered services.

2.5. **Certified Family Home (CFH)**
When services are delivered in the home of the provider, the home must be a Certified Family Home (CFH). A Certified Family Home (CFH) is defined in *IDAPA 16.03.19 Rules Governing Certified Family Homes* as:

“A home certified by DHW to provide care to one or two adults, who are unable to reside on their own and require activities of daily living, protection and security, and need encouragement towards independence.”

A Certified Family Home may be granted an exception to the two resident limits if approved by Regional Medicaid Services (RMS). With an approved exception, the Certified Family Home (CFH) may provide care and supervision to three or four residents. These providers are reimbursed to deliver services as outlined on the participant’s plan of care. See *CMS-1500 Instructions, Appendix A.1.2* for covered services.

2.5.1. **CFH Services**
CFH services support the participant in daily living activities, household tasks, and other routine activities the participant is unable to accomplish. Other services could include training to encourage and accelerate development in independent daily living skills, such as housekeeping, meal preparation, dressing and personal hygiene, taking medication, money management, socialization, mobility, and other therapeutic programs.
2.5.2. **Certified Family Home (CFH) Provider Affiliation for DD Waiver**

Certified family home providers caring for DD Waiver participants must be affiliated with a RES/HAB agency. Certified family home providers receive oversight, training, and quality assurance from the RES/HAB agency. A fee is paid to RES/HAB agencies for these services for CFH providers affiliating with the agency.

Agencies must maintain adequate documentation to support the date, times, amounts, and types (including contents) of training, oversight, and quality assurance services provided. This documentation includes telephone contacts and direct contacts with both the provider and participant.

2.5.3. **Change in Participant Status**

It is the responsibility of the RES/HAB provider to notify the plan monitor for DD Waiver participants when there is a significant change in the participant’s circumstances including accident, injuries, and health related activities.

2.5.4. **Change of Provider Information**

If the provider has a change of name, address, or telephone number, immediately notify Idaho Medicaid in writing. Indicating updated provider information on a claim form is not acceptable and the appropriate changes cannot be made. Send corrections to

Idaho Medicaid  
Provider Enrollment  
PO Box 70082  
Boise, ID 83707  
Fax: (877) 517-2041

2.5.5. **Payment**

Payment will be made on a *per diem or unit* basis. The daily payment rate will be established by the Regional Medicaid Services.