Dear Senators HEIDER, Nuxoll, Schmidt, and
Representatives WOOD, Packer, Rusche:

The Legislative Services Office, Research and Legislation, has received the enclosed rules of the Department of Health and Welfare:

IDAPA 16.03.01 - Eligibility for Health Care Assistance for Families and Children - Proposed Rule (Docket No. 16-0301-1501);

IDAPA 16.03.04 - Rules Governing the Food Stamp Program in Idaho - Proposed Rule (Docket No. 16-0304-1501);

IDAPA 16.03.05 - Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD) - Temporary and Proposed Rule (Docket No. 16-0305-1501);

IDAPA 16.03.05 - Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD) - Proposed Rule (Docket No. 16-0305-1502);

IDAPA 16.03.09 - Medicaid Basic Plan Benefits - Proposed Rule (Docket No. 16-0309-1501);

IDAPA 16.03.09 - Medicaid Basic Plan Benefits - Proposed Rule (Docket No. 16-0309-1502);

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits - Proposed Rule (Docket No. 16-0310-1501);

IDAPA 16.03.13 - Consumer-directed Services - Proposed Rule (Docket No. 16-0313-1501).

Pursuant to Section 67-454, Idaho Code, a meeting on the enclosed rules may be called by the cochairmen or by two (2) or more members of the subcommittee giving oral or written notice to Research and Legislation no later than fourteen (14) days after receipt of the rules' analysis from Legislative Services. The final date to call a meeting on the enclosed rules is no later than 11/05/2015. If a meeting is called, the subcommittee must hold the meeting within forty-two (42) days of receipt of the rules' analysis from Legislative Services. The final date to hold a meeting on the enclosed rules is 12/07/2015.

The germane joint subcommittee may request a statement of economic impact with respect to a proposed rule by notifying Research and Legislation. There is no time limit on requesting this statement, and it may be requested whether or not a meeting on the proposed rule is called or after a meeting has been held.

To notify Research and Legislation, call 334-4834, or send a written request to the address on the memorandum attached below.

Eric Milstead
Director

Legislative Services Office
Idaho State Legislature

Serving Idaho's Citizen Legislature

MEMORANDUM

TO: Rules Review Subcommittee of the Senate Health & Welfare Committee and the House Health & Welfare Committee

FROM: Legislative Research Analyst - Elizabeth Bowen

DATE: October 19, 2015

SUBJECT: Department of Health and Welfare

IDAPA 16.03.01 - Eligibility for Health Care Assistance for Families and Children - Proposed Rule (Docket No. 16-0301-1501)

IDAPA 16.03.04 - Rules Governing the Food Stamp Program in Idaho - Proposed Rule (Docket No. 16-0304-1501)

IDAPA 16.03.05 - Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD) - Temporary and Proposed Rule (Docket No. 16-0305-1501)

IDAPA 16.03.05 - Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD) - Proposed Rule (Docket No. 16-0305-1502)

IDAPA 16.03.09 - Medicaid Basic Plan Benefits - Proposed Rule (Docket No. 16-0309-1501)

IDAPA 16.03.09 - Medicaid Basic Plan Benefits - Proposed Rule (Docket No. 16-0309-1502)

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits - Proposed Rule (Docket No. 16-0310-1501)

IDAPA 16.03.13 - Consumer-directed Services - Proposed Rule (Docket No. 16-0313-1501)

The Department of Health and Welfare submits notice of proposed rulemaking at IDAPA 16.03.01, 16.03.04, 16.03.05, 16.03.09, 16.03.10, and 16.03.13.

16.03.01

This proposed rule updates language to conform with the federal Medicare Access and CHIP Reauthorization Act of 2015. Specifically, the proposed rule incorporates transitional Medicaid for adults. Negotiated rulemaking was not conducted due to the nature of the rule change. The anticipated fiscal impact for fiscal year 2017 is $2,842,411 coming from the state general fund and $6,928,649 coming from federal funds. The Department states that this rulemaking is authorized pursuant to Sections 56-202, 56-203, 56-209, 56-236 through 56-240, 56-242, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

16.03.04

This proposed rule conforms food stamp rules to federal requirements pertaining to eligibility. Negotiated rulemaking was not conducted due to the nature of the rule change. There is no anticipated fiscal impact on the

state general fund. The Department states that this rulemaking is authorized pursuant to Section 56-203, Idaho Code.

16.03.05

The first rule, a temporary and proposed rule, updates program rules for Aid to the Aged, Blind, and Disabled in order to align with the current state plan. The effective date of the temporary rule is January 1, 2015. Negotiated rulemaking was not conducted due to the nature of the rule change. The anticipated fiscal impact to the state general fund is $120,960, as the Department expects an increase in the number of requests from participants for preexisting medical expenses. The Department states that this rulemaking is authorized pursuant to Section 56-202, Idaho Code.

The second rule, a proposed rule, updates program rules for Aid to the Aged, Blind, and Disabled in order to align with federal requirements for eligibility. Negotiated rulemaking was not conducted due to the nature of the rule change. There is no anticipated impact on the state general fund. The Department states that this rulemaking is authorized pursuant to Section 56-202, Idaho Code.

16.03.09

The first rule, a proposed rule, updates and clarifies language relating to school-based and therapy services under Medicaid. Negotiated rulemaking was conducted, and there is no anticipated fiscal impact on the state general fund. The Department states that this rulemaking is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

The second rule, also a proposed rule, revises language relating to primary care case management and health homes in order to reflect the state's shift toward an outcome-based health care policy initiative. Negotiated rulemaking was conducted, and there is no anticipated fiscal impact on the state general fund. The Department states that this rulemaking is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

16.03.10

This proposed rule revises and incorporates language relating to home and community based services in order to align IDAPA rule with the state Medicaid plan and new requirements in federal regulations. The purpose of the rule is to provide greater opportunities for participants to receive care while remaining in their homes and communities. Negotiated rulemaking was conducted, and there is no anticipated fiscal impact on the state general fund. The Department states that this rulemaking is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

16.03.13

This proposed rule also relates to home and community based services; its purpose is to ensure that participants live in, and receive services in, environments that comply with quality standards. Negotiated rulemaking was conducted, and there is no anticipated fiscal impact on the state general fund. The Department states that this rulemaking is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

cc: Department of Health and Welfare
Tamara Prisock

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.01 - ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

DOCKET NO. 16-0301-1501

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-209, 56-236 through 56-240, 56-242, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code; also 42 CFR 435.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2015.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Under the Medicare Access and CHIP Reauthorization Act of 2015, changes are being made to align this chapter of rules with federal regulations approved in that act. Transitional Medicaid (TM) previously thought to have a sunset clause was extended, and is being added. A change for eligibility for "authorized employment" is being removed to ensure eligibility determinations are correctly determined. Language is being removed that is not necessary for eligible institutions.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

The anticipated fiscal impact for FY 2017 for Transitional Medicaid will be $9,771,060, with $6,928,649 from federal funds and $2,842,411 from state general funds. The fiscal impact amount was calculated using an estimation of the number of adults with children who will become eligible for Transitional Medicaid in FY 2017 multiplied by the current average monthly Medicaid claim by the Parent/Caretaker eligibility group.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the Department has determined it was not feasible because changes are being made to align with federal regulations and to be in compliance with Idaho's State Plan.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

CONTACT INFORMATION, WEB ADDRESS, ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cheri Bourn at (208) 334-4934.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 31st Day of August, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5564; fax: (208) 334-6558
e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0301-1501
(Only Those Sections With Amendments Are Shown.)

221. U.S. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.
To be eligible, an individual must be a lawfully present member of one (1) of the following groups: (3-20-14)

01. U.S. Citizen. A U.S. Citizen or a "national of the United States." (3-20-14)

02. Child Born Outside the U.S. A child born outside the U.S., as defined in Public Law 106-395, is considered a citizen if all of the following conditions are met: (3-20-14)

a. At least one (1) parent is a U.S. Citizen. The parent can be a citizen by birth or naturalization. This includes an adoptive parent; (3-20-14)

b. The child is residing permanently in the U.S. in the legal and physical custody of a parent who is a U.S. Citizen; (3-20-14)

c. The child is under eighteen (18) years of age; (3-20-14)

d. The child is a lawful permanent resident; and (3-20-14)

e. If the child is an adoptive child, the child was residing in the U.S. at the time the parent was naturalized and was in the legal and physical custody of the adoptive parent. (3-20-14)

03. Full-Time Active Duty U.S. Armed Forces Member. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) who is currently on full-time active duty with the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard, or a spouse or unmarried dependent child of the U.S. Armed Forces member. (3-20-14)

04. Veteran of the U.S. Armed Forces. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) who was honorably discharged from the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy, or U.S. Coast Guard for a reason other than their citizenship status, or a spouse, including a surviving spouse who has not remarried, or an unmarried dependent child of the veteran. (3-20-14)

05. Non-Citizen Entering the U.S. Before August 22, 1996. A non-citizen who entered the U.S. before August 22, 1996, who is currently a qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c), who remained continuously present in the U.S. until he became a qualified non-citizen. (3-20-14)

06. Non-Citizen Entering On or After August 22, 1996. A non-citizen who entered the U.S. on or after August 22, 1996, and who is: (3-20-14)

a. A refugee admitted into the U.S. under 8 U.S.C. 1157, and can be eligible for seven (7) years from the date of entry; (3-20-14)

b. An asylee granted asylum into the U.S. under 8 U.S.C. 1158, and can be eligible for seven (7) years from the date asylee status is assigned; (3-20-14)

c. An individual whose deportation or removal from the U.S. has been withheld under 8 U.S.C. 1253 or 1231(b)(3) as amended by Section 305(a) of Division C of Public Law 104-208, and can be eligible for seven (7) years from the date deportation or removal was withheld; (3-20-14)

d. An Amerasian immigrant admitted into the U.S. under 8 U.S.C. 1612(b)(2)(A)(i)(V), and can be eligible for seven (7) years from the date of entry; or (3-20-14)

e. A Cuban or Haitian entrant to the U.S. under Section 501(e) of the Refugee Assistance Act under Section 501(e) of P.L. 96-422 (1980), and can be eligible for seven (7) years from the date of entry. (3-20-14)

07. Qualified Non-Citizen Entering On or After August 22, 1996. A qualified non-citizen under 8 U.S.C. 1641(b) or (c), who entered the U.S. on or after August 22, 1996, and who has held a qualified non-citizen status for at least five (5) years. (3-20-14)

08. American Indian Born in Canada. An American Indian born in Canada, under 8 U.S.C. 1359. (3-20-14)

09. American Indian Born Outside the U.S. An American Indian born outside of the U.S., who is a member of a U.S. federally recognized tribe under 25 U.S.C. 450 b(e). (3-20-14)

10. Qualified Non-Citizen Child Receiving Federal Foster Care. A qualified non-citizen child as defined in 8 U.S.C. 1641(b) or (c), and receiving federal foster care assistance. (3-20-14)

11. Victim of Severe Form of Trafficking. A victim of a severe form of trafficking in persons, as defined in 22 U.S.C. 7102(13); who meets one (1) of the following: (3-20-14)

a. Is under the age of eighteen (18) years; or (3-20-14)

b. Is certified by the U.S. Department of Health and Human Services as willing to assist in the investigation and prosecution of a severe form of trafficking in persons; and (3-20-14)

i. Has made a bona fide application for a temporary visa under 8 U.S.C. 1104(a)(15)(T), which has not been denied; or (3-20-14)

ii. Is remaining in the U.S. to assist the U.S. Attorney General in the prosecution of traffickers in persons. (3-20-14)

12. Afghan Special Immigrant. An Afghan special immigrant, as defined in Public Law 110-161, who has special immigration status after December 26, 2007. (3-20-14)

13. Iraqi Special Immigrant. An Iraqi special immigrant, as defined in Public Law 110-181, who has special immigration status after January 28, 2008. (3-20-14)

~~***14. Employment Authorized Alien**. An alien granted an employment authorization document (EAD), as defined in 8 CFR Part 274a.12(c).* (3-20-14)~~

1~~5~~4. Individuals not Meeting the Citizenship or Qualified Non-Citizen Requirements. An individual who does not meet the citizenship or qualified non-citizen requirements in Subsections 221.01 through 221.1~~4~~3 of this rule, may be eligible for emergency medical services if he meets all other conditions of eligibility. ~~(3-20-14)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

412. -- 41~~9~~8. (RESERVED)

419. TRANSITIONAL MEDICAID FOR ADULTS.
Participants who no longer qualify for Medicaid due to an increase in earned income or working hours are eligible for an additional twelve (12) months of Medicaid. Participants must have been eligible for Medicaid during at least three (3) of the six (6) months immediately preceding the month in which the participant became ineligible. ( )

(BREAK IN CONTINUITY OF SECTIONS)

532. RESIDENT OF AN ELIGIBLE INSTITUTION.
A resident of an eligible institution must meet all nonfinancial and financial criteria of Title XIX, ~~or~~ Title XXI, or any other applicable program. ~~*Eligible institutions are medical institutions, intermediate care facilities, child care institutions for foster care, or publicly-operated community residences serving no more than sixteen (16) residents.*~~
~~*(3-20-14)*~~( )

42 CFR

§435.406 Citizenship and alienage.

(a) The agency must provide Medicaid to otherwise eligible residents of the United States who are—

(1) Citizens: (i) Under a declaration required by section 1137(d) of the Act that the individual is a citizen or national of the United States; and

(ii) The individual has provided satisfactory documentary evidence of citizenship or national status, as described in §435.407.

(iii) An individual for purposes of the declaration and citizenship documentation requirements discussed in paragraphs (a)(1)(i) and (a)(1)(ii) of this section includes both applicants and beneficiaries under a section 1115 demonstration (including a family planning demonstration project) for which a State receives Federal financial participation in their expenditures, as though the expenditures were for medical assistance.

(iv) Individuals must declare their citizenship and the State must document the individual's citizenship in the individual's eligibility file on initial applications and initial redeterminations effective July 1, 2006.

(v) The following groups of individuals are exempt from the requirements in paragraph (a)(1)(ii) of this section:

(A) Individuals receiving SSI benefits under title XVI of the Act.

(B) Individuals entitled to or enrolled in any part of Medicare.

(C) Individuals receiving disability insurance benefits under section 223 of the Act or monthly benefits under section 202 of the Act, based on the individual's disability (as defined in section 223(d) of the Act).

(D) Individuals who are in foster care and who are assisted under Title IV-B of the Act, and individuals who are beneficiaries of foster care maintenance or adoption assistance payments under Title IV-E of the Act.

(2)(i) Except as specified in 8 U.S.C. 1612(b)(1) (permitting States an option with respect to coverage of certain qualified aliens), qualified aliens as described in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) (including qualified aliens subject to the 5-year bar) who have provided satisfactory documentary evidence of Qualified Alien status, which status has been verified with the Department of Homeland Security (DHS) under a declaration required by section 1137(d) of the Act that the applicant or beneficiary is an alien in a satisfactory immigration status.

(ii) The eligibility of qualified aliens who are subject to the 5-year bar in 8 U.S.C. 1613 is limited to the benefits described in paragraph (b) of this section.

(b) The agency must provide payment for the services described in §440.255(c) of this chapter to residents of the State who otherwise meet the eligibility requirements of the State plan (except for receipt of AFDC, SSI, or State Supplementary payments) who are qualified aliens subject to the 5-year bar or who are non-qualified aliens who meet all Medicaid eligibility criteria, except non-qualified aliens need not present a social security number or document immigration status.

[55 FR 36819, Sept. 7, 1990, as amended at 56 FR 10807, Mar. 14, 1991; 71 FR 39222, July 12, 2006; 72 FR 38691, July 13, 2007]

Transitional Medicaid

Amended Text
The Medicare Access and CHIP Reauthorization ACT of 2015
Sec. 212.Permanent extension of transitional medical assistance (TMA)

(a)In general.—
Section 1925 of the Social Security Act (42 U.S.C. 1396r–6) is amended—

(1)by striking subsection (f); and

(2)by redesignating subsection (g) as subsection (f).

(b)Conforming amendment.—

Section 1902(e)(1) of the Social Security Act (42 U.S.C. 1396a(e)(1)) is amended to read as follows:

(1)Beginning April 1, 1990, for provisions relating to the extension of eligibility for medical assistance for certain families who have received aid pursuant to a State plan approved under part A of title IV and have earned income, see section 1925.

Original Text
(e)(1)(A) Notwithstanding any other provision of this title, effective January 1, 1974, subject to subparagraph (B) each State plan approved under this title must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of title IV in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such aid because of increased hours of, or increased income from, employment, shall, while a member of such family is employed, remain eligible for assistance under the plan approved under this title (as though the family was receiving aid under the plan approved under part A of title IV) for 4 calendar months beginning with the month in which such family became ineligible for aid under the plan approved under part A of title IV because of income and resources or hours of work limitations contained in such plan.

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.04 - RULES GOVERNING THE FOOD STAMP PROGRAM IN IDAHO

DOCKET NO. 16-0304-1501

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 56-203, Idaho Code, 7 CFR 273.2(j), and 7 CFR 273.8(a).

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2015.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This rulemaking aligned the Food Stamp rules with a federal requirement that excludes households from receiving the $5000 resource limit when they are not in compliance with program participation requirements. The chapter is also being amended to clarify the language describing the effected households.

Specifically, this rulemaking reduces the food stamp applicant resource limit from $5,000 to $2,250, or $3,250 for certain households, and clarifies the description of such households.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

There is no anticipated fiscal impact to the state general fund as a result of this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rulemaking is simple in nature and aligns rules with federal limits.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

CONTACT INFORMATION, WEB ADDRESS, ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Malinda Reissig at (208) 334-5779.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 31st Day of August, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5564; fax: (208) 334-6558
e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0304-1501
(Only Those Sections With Amendments Are Shown.)

010. DEFINITIONS A THROUGH D.
For the Food Stamp Program, the following definitions apply: (4-11-06)

01. Adequate Notice. Notice a household must receive on or before the first day of the month an action by the Department is effective. (4-6-05)

02. Administrative Error Claim. A claim resulting from an overissuance caused by the Department's action or failure to act. (6-1-94)

03. Aid to the Aged, Blind and Disabled (AABD). Cash, excluding in-kind assistance, financed by federal, state or local government and provided to cover living expenses or other basic needs. (4-11-06)

04. Applicant. A person applying for Food Stamps. (6-1-94)

05. Application for Participation. The application form filed by the head of the household or authorized representative. (6-1-94)

06. Application for Recertification. When a household applies for recertification within thirty (30) days of the end of the certification period, it is considered an application for recertification even if a partial month of benefits is received. (4-11-06)

07. Authorized Representative. A person designated by the household to act on behalf of the household to apply for or receive and use Food Stamps. Authorized representatives include private nonprofit organizations or institutions conducting a drug addiction or alcoholic treatment and rehabilitation center acting for center residents. Authorized representatives include group living arrangement centers acting for center residents. Authorized representatives include battered women's and children's shelters acting for the shelters' residents. Homeless meal providers may not be authorized representatives for homeless Food Stamp recipients. (4-11-06)

08. Battered Women and Children's Shelter. A shelter for battered women and children which is a public or private nonprofit residential facility. If the facility serves others, a portion of the facility must be set aside on a long-term basis to serve only battered women and children. (6-1-94)

09. Boarder. Any person or group to whom a household, other than a commercial boarding house, furnishes meals and lodging in exchange for an amount equal to or greater than the thrifty food plan. Children, parents and spouses in a household must not be treated as boarders. (6-1-94)

10. Boarding House. A licensed commercial enterprise offering meals and lodging for payment to make a profit. (6-1-94)

11. Broad Based Categorical Eligibility. If a participant meets the eligibility requirements found in 7 CFR Section 273.2(j)(2) as well as all other Food Stamp eligibility criteria, then the participant is eligible for Food Stamps. Participants who are eligible under this definition are also subject to resource, gross, and net income eligibility standards. ( )

1~~1~~2. Categorical Eligibility. If all household members receive or are authorized to receive monthly cash payment through TAFI, AABD or SSI, the household is categorically eligible. Categorically eligible households are exempt from resource, gross and net income eligibility standards. (4-11-06)

1~~2~~3. Certification Determination. Actions necessary to determine household eligibility including interviews, verification, approval, denial, field investigation, analysis and corrective action necessary to insure

prompt, efficient and correct certifications. (6-1-94)

13**.** **Certification Period**. The period of time a household is certified to receive Food Stamp benefits. The month of application counts as the first month of certification. (4-11-06)

14**.** **Contact (Six-Month)**. A six-month contact is a recertification that waives the interview requirement, allowing for written contact and verification of the participant's circumstances in lieu of the interview. (3-29-12)

15**.** **Claim Determination**. The action taken by the Department establishing the household's liability for repayment when an overissuance of Food Stamps occurs. (6-1-94)

16**.** **Client**. A person entitled to or receiving Food Stamps. (6-1-94)

17**.** **Department**. The Idaho Department of Health and Welfare. (6-1-94)

18**.** **Disqualified Household Members**. Individuals required to be excluded from participation in the Food Stamp Program are Disqualified Household Members. These include: (6-1-94)

a. Ineligible legal non-citizen who do not meet the citizenship or eligible legal non-citizen requirements. (7-1-98)

b. Individuals awaiting proof of citizenship when citizenship is questionable. (6-1-94)

c. Individuals disqualified for failure or refusal to provide a Social Security Number (SSN). (6-1-94)

d. Individuals disqualified for Intentional Program Violation (IPV). (6-1-94)

e. Individuals disqualified for receiving three (3) months of Food Stamps in a three (3) year period in which they did not meet the work requirement for able-bodied adults without dependent children. (7-1-98)

f. Individuals disqualified as a fugitive felon or probation or parole violator. (7-1-98)

g. Individuals disqualified for a voluntary quit or reduction of hours of work to less than thirty (30) hours per week. (7-1-98)

h. Individuals disqualified for failure to cooperate in establishing paternity and obtaining support for a child under eighteen (18). (7-1-98)

i. Individuals convicted under federal or state law of any offense classified as a felony involving the possession, use, or distribution of a controlled substance when they do not comply with the terms of a withheld judgment, probation, or parole. The felony must have occurred after August 22, 1996. (3-30-01)

1920**.** **Documentation**. The method used to record information establishing eligibility. The information must sufficiently explain the action taken and the proof and how it was used. (6-1-94)

201**.** **Drug Addiction or Alcoholic Treatment Program**. Any drug addiction or alcoholic treatment rehabilitation program conducted by a private nonprofit organization or institution or a publicly operated community mental health center under Part B of Title XIX of the Public Health Service Act (42 USC 300x, et seq.). Indian reservation based centers may qualify if FCS requirements are met and the program is funded by the National Institute on Alcohol Abuse under Public Law 91-616 or was transferred to Indian Health Service funding. (4-6-05)

(BREAK IN CONTINUITY OF SECTIONS)

181. ***(RESERVED)*** **BROAD BASED CATEGORICALLY ELIGIBLE HOUSEHOLD EXCEPTIONS.**

If a household contains any of the following members, the household is not eligible under Broad Based Categorical Eligibility. ( )

01. IPV. Any household member is disqualified for an Intentional Program Violation (IPV). ( )

02. Drug-Related Felony. Any household member is ineligible because of a drug-related felony. ( )

03. Strike. Any household member is on strike. ( )

04. Transferred Resources. Any household member transferred resources in order to qualify for benefits. ( )

05. Refusal to Cooperate. Any household member refused to cooperate in providing information that is needed to determine initial or ongoing eligibility. ( )

(BREAK IN CONTINUITY OF SECTIONS)

305. RESOURCE LIMIT.
The Food Stamp resource limit is five thousand dollars ($5,000) for Broad Based Categorically Eligible households. Households that do not meet the requirements for Broad Based Categorical Eligibility are subject to resource limits published by the USDA Food and Nutrition Service. ~~(4-7-11)~~( )

CFR citations for Welfare Docket No. 16-0304-1501

§273.2 Office operations and application processing.

(j) *PA, GA and categorically eligible households.* The State agency must notify households applying for public assistance (PA) of their right to apply for food stamp benefits at the same time and must allow them to apply for food stamp benefits at the same time they apply for PA benefits. The State agency must also notify such households that time limits or other requirements that apply to the receipt of PA benefits do not apply to the receipt of food stamp benefits, and that households which cease receiving PA benefits because they have reached a time limit, have begun working, or for other reasons, may still qualify for food stamp benefits. If the State agency attempts to discourage households from applying for cash assistance, it shall make clear that the disadvantages and requirements of applying for cash assistance do not apply to food stamps. In addition, it shall encourage applicants to continue with their application for food stamps. The State agency shall inform households that receiving food stamps will have no bearing on any other program's time limits that may apply to the household. The State agency may process the applications of such households in accordance with the requirements of paragraph (j)(1) of this section, and the State agency must base their eligibility solely on food stamp eligibility criteria unless the household is categorically eligible, as provided in paragraph (j)(2) of this section. If a State has a single Statewide GA application form, households in which all members are included in a State or local GA grant may have their application for food stamps included in the GA application form. State agencies may use the joint application processing procedures described in paragraph (j)(1) of this section for GA recipients in accordance with paragraph (j)(3) of this section. The State agency must base eligibility of jointly processed GA households solely on food stamp eligibility criteria unless the household is categorically eligible as provided in paragraph (j)(4) of this section. The State agency must base the benefit levels of all households solely on food stamp criteria. The State agency must certify jointly processed and categorically eligible households in accordance with food stamp procedural, timeliness, and notice requirements, including the 7-day expedited service provisions of paragraph (i) of this section and normal 30-day application processing standards of paragraph (g) of this section. Individuals authorized to receive PA, SSI, or GA benefits but who have not yet received payment are considered recipients of benefits from those programs. In addition, individuals are considered recipients of PA, SSI, or GA if their PA, SSI, or GA benefits are suspended or recouped. Individuals entitled to PA, SSI, or GA benefits but who are not paid such benefits because the grant is less than a minimum benefit are also considered recipients. The State agency may not consider as recipients those individuals not receiving GA, PA, or SSI benefits who are entitled to Medicaid only.

(1) *Applicant PA households.* (i) If a joint PA/food stamp application is used, the application may contain all the information necessary to determine a household's food stamp eligibility and level of benefits. Information relevant only to food stamp eligibility must be contained in the PA form or must be an attachment to it. The joint PA/food stamp application must clearly indicate that the household is providing information for both programs, is subject to the criminal penalties of both programs for making false statements, and waives the notice of adverse action as specified in paragraph (j)(1)(iv) of this section.

(ii) The State agency may conduct a single interview at initial application for both public assistance and food stamp purposes. A household's eligibility for food stamp out-of-office interview provisions in paragraph (e)(2) of this section does not relieve the household of any responsibility for a face-to-face interview to be certified for PA.

(iii) For households applying for both PA and food stamps, the State agency must follow the verification procedures described in paragraphs (f)(1) through (f)(8) of this section for those factors of eligibility which are needed solely for purposes of determining the household's eligibility for food stamps. For those factors of eligibility which are needed to determine both PA eligibility and food stamp eligibility, the State agency may use the PA verification rules. However, if the household has provided the State agency sufficient verification to meet the verification requirements of paragraphs (f)(1) through (f)(8) of

this section, but has failed to provide sufficient verification to meet the PA verification rules, the State agency may not use such failure as a basis for denying the household's food stamp application or failing to comply with processing requirements of paragraph (g) of this section. Under these circumstances, the State agency must process the household's food stamp application and determine eligibility based on its compliance with the requirements of paragraphs (f)(1) through (f)(8) of this section.

(iv) In order to determine if a household will be eligible due to its status as a recipient PA/SSI household, the State agency may temporarily postpone, within the 30-day processing standard, the food stamp eligibility determination if the household is not entitled to expedited service and appears to be categorically eligible. However, the State agency shall postpone denying a potentially categorically eligible household until the 30th day in case the household is determined eligible to receive PA benefits. Once the PA application is approved, the household is to be considered categorically eligible if it meets all the criteria concerning categorical eligibility in §273.2(j)(2). If the State agency can anticipate the amount and the date of receipt of the initial PA payment, but the payment will not be received until a subsequent month, the State agency shall vary the household's food stamp benefit level according to the anticipated receipt of the payment and notify the household. Portions of initial PA payments intended to retroactively cover a previous month shall be disregarded as lump sum payments under §273.9(c)(8). If the amount or date of receipt of the initial PA payment cannot be reasonably anticipated at the time of the food stamp eligibility determination, the PA payments shall be handled as a change in circumstances. However, the State agency is not required to send a notice of adverse action if the receipt of the PA grant reduces, suspends or terminates the household's food stamp benefits, provided the household is notified in advance that its benefits may be reduced, suspended, or terminated when the grant is received. The case may be terminated if the household is not categorically eligible in accordance with §273.12(c). The State agency shall ensure that the denied application of a potentially categorically eligible household is easily retrievable. For a household filing a joint application for food stamps and PA benefits or a household that has a PA application pending and is denied food stamps but is later determined eligible to receive PA benefits and is otherwise categorically eligible, the State agency shall provide benefits using the original application and any other pertinent information occurring subsequent to that application. Except for residents of public institutions who apply jointly for SSI and food stamp benefits prior to their release from a public institution in accordance with §273.1(e)(2), benefits shall be paid from the beginning of the period for which PA or SSI benefits are paid, the original food stamp application date, or December 23, 1985 whichever is later. Residents of public institutions who apply jointly for SSI and food stamp benefits prior to their release from the institution shall be paid benefits from the date of their release from the institution. In situations where the State agency must update and reevaluate the original application of a denied case, the State agency shall not reinterview the household, but shall use any available information to update the application. The State agency shall then contact the household by phone or mail to explain and confirm changes made by the State agency and to determine if other changes in household circumstances have occurred. If any information obtained from the household differs from that which the State agency obtained from available information or the household provided additional changes in information, the State agency shall arrange for the household or it authorized representative to initial *all* changes, re-sign and date the updated application and provide necessary verification. In no event can benefits be provided prior to the date of the original food stamp application filed on or after December 23, 1985. Any household that is determined to be eligible to receive PA benefits for a period of time within the 30-day food stamp processing time, shall be provided food stamp benefits back to the date of the food stamp application. However, in no event shall food stamp benefits be paid for a month for which such household is ineligible for receipt of any PA benefits for the month, unless the household is eligible for food stamp benefits and an NPA case. Benefits shall be prorated in accordance with §273.10(a)(1)(ii) and (e)(2)(ii)(B). Household that file joint applications that are found categorically eligible after being denied NPA food stamps shall have their benefits for the initial month prorated from the date from which the PA benefits are payable, or the date of the original food stamp application, whichever is later. The State agency shall act on reevaluating the original application either at the household's request or when it becomes otherwise aware of the household's PA and/or SSI eligibility. The household shall be informed on the notice of denial required by §273.10(g)(1)(ii) to notify the State agency if its PA or SSI benefits are approved.

(v) The State agency may not require households which file a joint PA/food stamp application and whose PA applications are denied to file new food stamp applications. Rather, the State agency must determine or continue their food stamp eligibility on the basis of the original applications filed jointly for PA and food stamp purposes. In addition, the State agency must use any other documented information obtained subsequent to the application which may have been used in the PA determination and which is relevant to food stamp eligibility or level of benefits.

(2) *Categorically eligible PA and SSI households.* (i) The following households are categorically eligible for food stamps unless the entire household is institutionalized as defined in §273.1(e) or disqualified for any reason from receiving food stamps.

(A) Any household (except those listed in paragraph (j)(2)(vii) of this section) in which all members receive or are authorized to receive cash through a PA program funded in full or in part with Federal money under Title IV-A or with State money counted for maintenance of effort (MOE) purposes under Title IV-A;

(B) Any household (except those listed in paragraph (j)(2)(vii) of this section) in which all members receive or are authorized to receive non-cash or in-kind benefits or services from a program that is more than 50 percent funded with State money counted for MOE purposes under Title IV-A or Federal money under Title IV-A and that is designed to forward purposes one and two of the TANF block grant, as set forth in Section 401 of P.L. 104-193.

(C) Any household (except those listed in paragraph (j)(2)(vii) of this section) in which all members receive or are authorized to receive non-cash or in-kind benefits or services from a program that is more than 50 percent funded with State money counted for MOE purposes under Title IV-A or Federal money under Title IV-A and that is designed to further purposes three and four of the TANF block grant, as set forth in Section 401 of P.L. 104-193, and requires participants to have a gross monthly income at or below 200 percent of the Federal poverty level.

(D) Any household in which all members receive or are authorized to receive SSI benefits, except that residents of public institutions who apply jointly for SSI and food stamp benefits prior to their release from the institution in accordance with §273.1(e)(2), are not categorically eligible upon a finding by SSA of potential SSI eligibility prior to such release. The State agency must consider the individuals categorically eligible at such time as SSA makes a final SSI eligibility and the institution has released the individual.

(E) Any household in which all members receive or are authorized to receive PA and/or SSI benefits in accordance with paragraphs (j)(2)(i)(A) through (j)(2)(i)(D) of this section.

(ii) The State agency, at its option, may extend categorical eligibility to the following households only if doing so will further the purposes of the Food Stamp Act:

(A) Any household (except those listed in paragraph (j)(2)(vii) of this section) in which all members receive or are authorized to receive non-cash or in-kind services from a program that is less than 50 percent funded with State money counted for MOE purposes under Title IV-A or Federal money under Title IV-A and that is designed to further purposes one and two of the TANF block grant, as set forth in Section 401 of P.L. 104-193. States must inform FNS of the TANF services under this paragraph that they are determining to confer categorical eligibility.

(B) Subject to FNS approval, any household (except those listed in paragraph (j)(2)(vii) of this section) in which all members receive or are authorized to receive non-cash or in-kind services from a program that is less than 50 percent funded with State money counted for MOE purposes under Title IV-A or Federal money under Title IV-A and that is designed to further purposes three and four of the TANF block grant, as set forth in Section 401 of P.L 104-193, and requires participants to have a gross monthly income at or below 200 percent of the Federal poverty level.

(iii) Any household in which one member receives or is authorized to receive benefits according to paragraphs (j)(2)(i)(B), (j)(2)(i)(C), (j)(2)(ii)(A) and (j)(2)(ii)(B), of this section and the State agency determines that the whole household benefits.

(iv) For purposes of paragraphs (j)(2)(i), (j)(2)(ii),and (j)(2)(iii) of this section, “authorized to receive” means that an individual has been determined eligible for benefits and has been notified of this determination, even if the benefits have been authorized but not received, authorized but not accessed, suspended or recouped, or not paid because they are less than a minimum amount.

(v) The eligibility factors which are deemed for food stamp eligibility without the verification required in paragraph (f) of this section because of PA/SSI status are the resource, gross and net income limits; social security number information, sponsored alien information, and residency. However, the State agency must collect and verify factors relating to benefit determination that are not collected and verified by the other program if these factors are required to be verified under paragraph (f) of this section. If any of the following factors are questionable, the State agency must verify, in accordance with paragraph (f) of this section, that the household which is considered categorically eligible:

(A) Contains only members that are PA or SSI recipients as defined in the introductory paragraph (j) of this section;

(B) Meets the household definition in §273.1(a);

(C) Includes all persons who purchase and prepare food together in one food stamp household regardless of whether or not they are separate units for PA or SSI purposes; and

(D) Includes no persons who have been disqualified as provided for in paragraph (j)(2)(vi) of this section.

(vi) Households subject to retrospective budgeting that have been suspended for PA purposes as provided for in Temporary Assistance for Needy Families (TANF) regulations, or that receive zero benefits shall continue to be considered as authorized to receive benefits from the appropriate agency. Categorical eligibility shall be assumed at recertification in the absence of a timely PA redetermination. If a recertified household is subsequently terminated from PA benefits, the procedures in §273.12(f)(3), (4), and (5) shall be followed, as appropriate.

(vii) Under no circumstances shall any household be considered categorically eligible if:

(A) Any member of that household is disqualified for an intentional Program violation in accordance with §273.16 or for failure to comply with monthly reporting requirements in accordance with §273.21;

(B) The entire household is disqualified because one or more of its members failed to comply with workfare in accordance with §273.22; or

(C) The head of the household is disqualified for failure to comply with the work requirements in accordance with §273.7.

(D) Any member of that household is ineligible under §273.11(m) by virtue of a conviction for a drug-related felony.

(viii) These households are subject to all food stamp eligibility and benefits provisions (including the provisions of §273.11(c)) and cannot be reinstated in the Program on the basis of categorical eligibility provisions.

(ix) No person shall be included as a member in any household which is otherwise categorically eligible if that person is:

(A) An ineligible alien as defined in §273.4;

(B) Ineligible under the student provisions in §273.5;

(C) An SSI recipient in a cash-out State as defined in §273.20; or

(D) Institutionalized in a nonexempt facility as defined in §273.1(e).

(E) Ineligible because of failure to comply with a work requirement of §273.7.

(x) For the purposes of work registration, the exemptions in §273.7(b) shall be applied to individuals in categorically eligible households. Any such individual who is not exempt from work registration is subject to the other work requirements in §273.7.

(xi) When determining eligibility for a categorically eligible household all provisions of this subchapter except for those listed below shall apply:

(A) Section 273.8 except for the last sentence of paragraph (a).

(B) Section 273.9(a) except for the fourth sentence in the introductory paragraph.

(C) Section 273.10(a)(1)(i).

(D) Section 273.10(b).

(E) Section 273.10(c) for the purposes of eligibility.

(3) *Applicant GA households.* (i) State agencies may use the joint application processing procedures in paragraph (j)(1) of this section for GA households, except for the effective date of categorical eligibility, when the criteria in paragraphs (j)(3)(i) (A) and (B) of this section are met. Benefits for GA households that are categorically eligible, as provided in paragraph (j)(4) of this section, shall be provided from the date of the original food stamp application, the beginning of the period for which GA benefits are authorized, or the effective date of State GA categorical eligibility (February 1, 1991) or local GA categorical eligibility (August 1, 1992), whichever is later:

(A) The State agency administers a GA program which uses formalized application procedures and eligibility criteria that test levels of income and resources; and,

(B) Administration of the GA program is integrated with the administration of the PA or food stamp programs, in that the same eligibility workers process applications for GA benefits and PA or food stamp benefits.

(ii) State agencies in which different eligibility workers process applications for GA benefits and PA or food stamp benefits, but procedures otherwise meet the criteria in paragraph (j)(3)(i) of this section may, with FNS approval, jointly process GA and food stamp applications. If approved, State agencies shall adhere to the joint application processing procedures in paragraph (j)(1) of this section, except for the effective date of categorical eligibility for GA households. Benefits shall be provided GA households that are categorically eligible, as provided in paragraph (j)(4) of this section, from the date of the original food stamp application, the beginning of the period for which GA benefits are authorized, or the effective

date of State GA categorical eligibility (February 1, 1992) or local GA categorical eligibility (August 1, 1992), whichever is later.

(4) *Categorically eligible GA households.* Households in which each member receives benefits from a State or local GA program which meets the criteria for conferring categorical eligibility in paragraph (j)(4)(i) of this section shall be categorically eligible for food stamps unless the individual or household is ineligible as specified in paragraph (j)(4)(iv) and (j)(4)(v) of this section.

(i) *Certification of qualifying programs.* Recipients of benefits from programs that meet the criteria in paragraphs (j)(4)(i)(A) through (j)(4(i)(C) of this section shall be considered categorically eligible to receive benefits from the Food Stamp Program. If a program does not meet all of these criteria, the State agency may submit a program description to the appropriate FNS regional office for a determination. The description should contain, at a minimum, the type of assistance provided, the income eligibility standard, and the period for which the assistance is provided.

(A) The program must have income standards which do not exceed the gross income eligibility standard in §273.9(a)(1). The rules of the GA program apply in determining countable income.

(B) The program must provide GA benefits as defined in §271.2 of this part.

(C) The program must provide benefits which are not limited to one-time emergency assistance.

(ii) *Verification requirements.* In determining whether a household is categorically eligible, the State agency shall verify that each member receives PA benefits, SSI, or GA from a program that meets the criteria in paragraph (j)(4)(i) section or that has been certified by FNS as an appropriate program and that it includes no individuals who have been disqualified as provided in paragraph (j)(4)(iv) or (j)(2)(v) of this section. The State agency shall also verify household composition if it is questionable, in accordance with §273.2(f), in order to determine that the household meets the definition of a household in §273.1(a).

(iii) *Deemed eligibility factors.* When determining eligibility for a categorically eligible household, all Food Stamp Program requirements apply except the following:

(A) *Resources.* None of the provisions of §273.8 apply to categorically eligible households except the second sentence of §273.8(a) pertaining to categorical eligibility and §273.8(i) concerning transfer of resources. The provision in §273.10(b) regarding resources available the time of the interview does not apply to categorically eligible households.

(B) *Gross and net income limits.* None of the provisions in §273.9(a) relating to income eligibility standards apply to categorically eligible households, except the fourth sentence pertaining to categorical eligibility. The provisions in §§273.10(a)(1)(i) and 273.10(c) relating to the income eligibility determination also do not apply to categorically eligible households.

(C) *Zero benefit households.* All eligible households of one or two persons must be provided the minimum benefit, as required by §273.10(e)(2)(ii)(C).

(D) Residency.

(E) Sponsored alien information.

(iv) *Ineligible household members.* No person shall be included as a member of an otherwise categorically eligible household if that person is:

(A) An ineligible alien, as defined in §273.4;

(B) An ineligible student, as defined in §273.5;

(C) Disqualified for failure to provide or apply for an SSN, as required by §273.6;

(D) A household member, not the head of household, disqualified for failure to comply with a work requirement of §273.7;

(E) Disqualified for intentional program violation, as required by §273.16;

(F) An SSI recipient in a cash-out State, as defined in §273.20; or

(G) An individual who is institutionalized in a nonexempt facility, as defined in §273.1(e).

(v) *Ineligible households.* A household shall not be considered categorically eligible if:

(A) It refuses to cooperate in providing information to the State agency that is necessary for making a determination of its eligibility or for completing any subsequent review of its eligibility, as described in §§273.2(d) and 273.21(m)(1)(ii);

(B) The household is disqualified because the head of household fails to comply with a work requirement of §273.7;

(C) The household is ineligible under the striker provisions of §273.1(g); or

(D) The household is ineligible because it knowingly transferred resources for the purpose of qualifying or attempting to qualify for the Program, as provided in §273.8(i).

(vi) *Combination households.* Households consisting entirely of recipients of PA, SSI and/or GA from a program that meets the requirements of §273.2(j)(4)(i) shall be categorically eligible in accordance with the provisions for paragraphs (j)(2)(iii) and (j)(2)(v) of this section for members receiving PA and SSI or provisions of paragraphs (j)(4) (iv) and (v) of this section for members receiving GA.

(5) *Households with some PA or GA recipients.* State agencies that use the joint application processing procedures in paragraphs (j)(1) and (j)(3) of this section may apply these procedures to a food stamp applicant household in which some, but not all, members are in the PA/GA filing unit, except for procedures concerning categorical eligibility. If the State agency decides not to use the joint application procedures for these households, the households shall file separate applications for PA/GA and food stamp benefits. This decision shall not be made on a case-by-case basis, but shall be applied uniformly to all households of this type in a project area.

§273.8 Resource eligibility standards.

(a) *Uniform standards.* The State agency shall apply the uniform national resource standards of eligibility to all applicant households, including those households in which members are recipients of federally aided public assistance, general assistance, or supplemental security income. Households which are categorically eligible as defined in §273.2(j)(2) or 273.2(j)(4) do not have to meet the resource limits or definitions in this section.

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND AND DISABLED (AABD)

DOCKET NO. 16-0305-1501

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2015.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2015.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The Aid to the Aged, Blind, and Disabled (AABD) program rules are being updated and aligned with the current State Plan that was approved by the Centers for Medicare and Medicaid Services (CMS) in January 2015. This change adds additional types of allowable pre-existing medical expenses towards a participant’s liability.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reason:

CMS approved amendments to the State Plan that were effective in January 2015, and these changes provide a benefit to participants that adds additional pre-existing medical expenses allowed towards a participant's liability.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year.

The Department anticipates that the annual fiscal impact for changes to the pre-existing medical expenses will be $403,600, with $252,240 from federal funds and $120,960 from state general funds. The fiscal impact amount is due to the Department's anticipation of an increase in the number of requests from participants for pre-existing medical expenses.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not feasible because these changes update the rules for amendments made to the State Plan that were approved in January 2015, by the Centers for Medicare and Medicaid Services (CMS) and not negotiable by the Department.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Callie Harrold (208) 334-0663.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 1st Day of September, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5564; fax: (208) 334-6558
e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING IS THE TEMPORARY RULE AND PROPOSED TEXT OF DOCKET NO. 16-0305-1501
(Only Those Sections With Amendments Are Shown.)

723. PATIENT LIABILITY FOR PERSON WITH NO COMMUNITY SPOUSE.
For a participant with no community spouse, patient liability is computed as described in Subsections 723.01 through 723.03 of this rule. (5-3-03)

01. Income of Participants in Long-Term Care. For a single participant, or participant whose spouse is also in long-term care and chooses the SSI method of calculating the amount of income and resources, the patient liability is his total income less the deductions in Subsection 723.03 of this rule. (5-3-03)

02. Community Property Income of Long-Term Care Participant with Long-Term Care Spouse. Patient liability income for a participant, whose spouse is also in long-term care, choosing the community property method, is one-half (1/2) his share of the couple's community income, plus his own separate income. The deductions in Table 723.03 are subtracted from his income. (7-1-99)

03. Income of Participant in Facility. A participant residing in the long-term care facility at least one (1) full calendar month, beginning with his most recent admission, must have the deductions in Subsection 723.03 subtracted from his income, after the AABD exclusions are subtracted from the income. Total monthly income includes income paid into an income (Miller) trust that month. The income deductions must be subtracted in the order listed. Remaining income is patient liability. (3-15-02)

a. AABD Income Exclusions. Subtract income excluded in determining eligibility for AABD cash. (7-1-99)

b. Aid and Attendance and UME Allowances. Subtract a VA Aid and Attendance allowance and Unusual Medical Expense (UME) allowance for a veteran or surviving spouse, unless the veteran lives in a state operated veterans' home. (3-30-01)

c. SSI Payment Two (2) Months. Subtract the SSI payment for a participant entitled to receive SSI at his at-home rate for up to two (2) months, while temporarily in a long-term care facility. (7-1-99)

d. AABD Payment. Subtract the AABD payment, and income used to compute the AABD payment, for a participant paid continued AABD payments up to three (3) months in long-term care. (7-1-99)

e. First Ninety ($90) Dollars of VA Pension. Subtract the first ninety ($90) dollars of a VA pension for a veteran in a private long-term care facility or a State Veterans Nursing Home. (5-3-03)

f. Personal Needs. Subtract forty dollars ($40) for the participant's personal needs. For a veteran or surviving spouse in a private long-term care facility or a State Veterans Nursing Home the first ninety ($90) dollars of VA pension substitutes for the forty dollar ($40) personal needs deduction. (5-3-03)

g. Employed and Sheltered Workshop Activity Personal Needs. For an employed participant or

participant engaged in sheltered workshop or work activity center activities, subtract the lower of the personal needs deduction of two hundred dollars ($200) or his gross earned income. The participant's total personal needs allowance must not exceed two hundred and thirty dollars ($230). For a veteran or surviving spouse with sheltered workshop or earned income, and a protected VA pension, the total must not exceed two hundred dollars ($200). This is a deduction only. No actual payment can be made to provide for personal needs. (3-30-01)

h. Home Maintenance. Subtract two hundred and twelve dollars ($212) for home maintenance cost if the participant had an independent living situation, before his admission for long-term care. His physician must certify in writing the participant is likely to return home within six (6) months, after the month of admission to a long-term care facility. This is a deduction only. No actual payment can be made to maintain the participant's home. (7-1-99)

i. Maintenance Need. Subtract a maintenance need deduction for a family member, living in the long-term care participant's home. A family member is claimed, or could be claimed, as a dependent on the Federal Income Tax return of the long-term care participant. The family member must be a minor or dependent child, dependent parent, or dependent sibling of the long-term care participant. The maintenance need deduction is the AFDC payment standard for the dependents, computed according to the AFDC State Plan in effect before July 16, 1996. (7-1-99)

j. Medicare and Health Insurance Premiums. Subtract expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, not subject to payment by a third party. Deduction of Medicare Part B premiums is limited to the first two (2) months of Medicaid eligibility. Medicare Part B premiums must not be subtracted, if the participant got SSI or AABD cash the month prior to the month for which patient liability is being computed. (7-1-99)

k. Mandatory Income Taxes. Subtract taxes mandatorily withheld from unearned income for income tax purposes. To qualify for deduction of mandatory taxes, the tax must be withheld from income before the participant receives the income. (7-1-99)

l. Guardian Fees. Subtract court-ordered guardianship fees of the lesser of ten percent (10%) of the monthly benefit handled by the guardian, or twenty-five dollars ($25). Where the guardian and trustee is the same person, the total deduction for guardian and trust fees must not exceed twenty-five dollars ($25) monthly. (3-20-14)

m. Trust Fees. Subtract up to twenty-five dollars ($25) monthly paid to the trustee for administering the participant's trust. (7-1-99)

n. Impairment Related Work Expenses. Subtract impairment-related work expenses for an employed participant who is blind or disabled under AABD criteria. Impairment-related work expenses are purchased or rented items and services that are purchased or rented to perform work. The items must be needed because of the participant's impairment. The actual monthly expense of the impairment-related items is subtracted. Expenses must not be averaged. (3-20-14)

o. Income Garnished for Child Support. Subtract income garnisheed for child support to the extent the expense is not already accounted for in computing the maintenance need standard. (3-30-01)

p. Incurred Medical Expenses. Subtract amounts for certain limited medical or remedial care expenses that have current balances owed and are deemed medically necessary as defined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." Current medical expenses that are not covered by the Idaho Medicaid Plan, or by a third party, may be deducted from the base participation amount. (4-11-15)

q. Pre-existing Medical Expenses. Subtract amounts for medical and remedial care expenses incurred within the three (3) months prior to the month of application. The deductions for medical and remedial care expenses are limited to those medically necessary expenses incurred by the participant for the participant's care. The deduction for medical and remedial care expenses is limited to the amount of liability owed by the participant, and if applicable, after any third-party insurance has been applied. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero. (1-1-15)T

(BREAK IN CONTINUITY OF SECTIONS)

725. PATIENT LIABILITY FOR PARTICIPANT WITH COMMUNITY SPOUSE.
After income ownership is decided, patient liability is determined using steps in Table 725.

TABLE 725 - INCOME DEDUCTIONS FOR PARTICIPANT IN FACILITY

	Step	Procedure
01.	AABD Income Exclusions	Subtract income excluded in determining eligibility for AABD cash.
02.	Aid and Attendance and UME Allowances	Subtract a VA Aid and Attendance allowance and Unusual Medical Expense (UME) allowance for a veteran or surviving spouse, unless the veteran lives in a state operated veterans' home.
03.	SSI Payment Two (2) Months	Subtract the SSI payment for a participant entitled to receive SSI at his at-home rate for up to two (2) months, while temporarily in a long-term care facility.
04.	AABD Cash	Subtract the AABD cash payment and income used to compute AABD cash, for a participant eligible to have his AABD cash continued up to three (3) months, while he is in long-term care.
05.	VA Pension	Subtract the first ninety (90$) of the VA pension for a veteran.
06.	Personal Needs	Subtract forty dollars ($40) for the participant's personal needs. Do not allow this deduction for a veteran.
07.	Employed and Sheltered Workshop Activity Needs	For an employed participant or participant engaged in sheltered workshop or work activity center activities subtract the lower of two hundred dollars ($200) or his earned income.
08.	Community Spouse Allowance: Step a.	Compute the Community Spouse Allowance (CSA) using Step a. through Step c. Compute the Shelter Adjustment. Add the current Food Stamp Program Standard Utility Allowance to the community spouse's shelter costs. Shelter costs include rent, mortgage principal and interest, homeowner's taxes, insurance, and condominium or cooperative maintenance charges. The Standard Utility Allowance must be reduced by the value of any utilities included in maintenance charges for a condominium or cooperative. Subtract the Shelter Standard from the shelter and utilities. The Shelter Standard is thirty percent (30%) of one hundred fifty percent (150%) of one-twelfth (1/12) of the income official poverty line defined by the Federal Office of Management and Budget (OMB) for a family of two (2) persons. The Shelter Adjustment is the positive balance remaining.

TABLE 725 - INCOME DEDUCTIONS FOR PARTICIPANT IN FACILITY		
	Step	**Procedure**
09.	Community Spouse Allowance: Step b.	Compute the Community Spouse Need Standard (CSNS). Add the Shelter Adjustment to the minimum CSNS. The minimum CSNS equals one hundred fifty percent (150%) of one-twelfth (1/12) of the income official poverty line defined by the OMB for a family unit of two (2) members. The minimum CSNS is revised annually in July. The total CSNS may not exceed the maximum CSNS. The maximum CSNS is computed by multiplying one thousand five hundred dollars ($1,500) by the percentage increase in the consumer price index for all urban Consumers (all items; U.S. city average) between September 1988 and the September before the current calendar year. The maximum CSNS is revised annually in January.
10.	Community Spouse Allowance: Step c.	Compute the Community Spouse Allowance. Subtract the community spouse's gross income from the CSNS. The community spouse's income includes income produced by his resources. Round any remaining cents to the next higher dollar. Any positive balance remaining is the CSA. The CSA is subtracted as actually paid to the community spouse, up to the computed maximum. A larger spouse support amount must be used as the CSA, if court-ordered. The CSA ordered by a court is not subject to the CSA limit.
11.	Family Member Allowance (FMA)	Compute the family member's gross income. Subtract the family member's gross income from the minimum CSNS. Divide the difference by three (3). Round cents to the next higher dollar. Any remainder is the FMA for that family member. The FMA is allowed, whether or not it is actually paid by the participant. A family member is, or could be claimed, as a dependent on the Federal income tax return of either spouse. The family member must be a minor or dependent child, dependent parent or dependent sibling of either spouse. The family member must live in the community spouse's home.
12.	Medicare and Health Insurance Premiums	Subtract expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, not subject to payment by a third party. Deduction of Medicare Part B premiums is limited to the first two (2) months of Medicaid eligibility. Do not subtract the Medicare Part B premiums if the participant got SSI or AABD cash the month prior to the month for which patient liability is being computed.
13.	Mandatory Income Taxes	Subtract taxes mandatorily withheld from unearned income for income tax purposes. To qualify for deduction of mandatory taxes, the tax must be withheld from income before the participant receives the income.
14.	Guardian Fees	Subtract court-ordered guardianship fees of the lesser of ten percent (10%) of the monthly benefit handled by the guardian, or twenty-five dollars ($25). Where the guardian and trustee are the same person, the total deduction for guardian and trust fees must not exceed twenty-five dollars ($25) monthly.

TABLE 725 - INCOME DEDUCTIONS FOR PARTICIPANT IN FACILITY		
	Step	**Procedure**
15.	Trust Fees	Subtract up to twenty-five dollars ($25) monthly paid to the trustee for administering the participant's trust.
16.	Impairment Related Work Expenses	Subtract impairment-related work expenses for an employed participant who is blind or disabled under AABD criteria. Impairment-related work expenses are purchased or rented items and services, purchased or rented to perform work. The items must be needed because of the participant's impairment. The actual monthly expense of the impairment-related items is subtracted. Expenses must not be averaged.
17.	Income Garnisheed for Child Support	Subtract income garnisheed for child support to the extent the expense is not already accounted for in computing the Family Member Allowance.
18.	Incurred Medical Expenses	Subtract amounts for certain limited medical or remedial care expenses that have current balances owed and are deemed medically necessary as defined in IDAPA 16.03.09, “Medicaid Basic Plan Benefits.” Current medical expenses that are not covered by the Idaho Medicaid Plan, or by a third party, may be deducted from the base participation amount.
19.	Pre-existing Medical Expenses	Subtract amounts for medical and remedial care expenses incurred within the three (3) months prior to the month of application. The deductions for medical and remedial care expenses are limited to those medically necessary expenses incurred by the participant for the participant’s care. The deduction for medical and remedial care expenses is limited to the amount of liability owed by the participant, and if applicable, after any third-party insurance has been applied. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero.

~~(4-11-15)~~(1-1-15)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND AND DISABLED (AABD)

DOCKET NO. 16-0305-1502

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2015.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

These rule changes are needed to amend and align with the federal requirements for eligibility and the Department's current business practice for determining countable self-employment income. Subsections are being deleted from rule to remove authorized employment and the self-employment standard deduction.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

There is no anticipated fiscal impact to the state general fund or any other funds as a result of this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is to align with federal requirements and other Department rules.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

CONTACT INFORMATION, WEB ADDRESS, ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Callie Harrold at (208) 334-0663.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 31st Day of August, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5564; fax: (208) 334-6558
e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0305-1502
(Only Those Sections With Amendments Are Shown.)

105. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.
To be eligible for AABD cash and Medicaid, an individual must be a member of one (1) of the groups listed in Subsections 105.01 through 105.16 of this rule. An individual must also provide proof of identity as provided in Section 104 of these rules. (3-20-14)

01. U.S. Citizen. A U.S. Citizen or a "national of the United States." (3-20-14)

02. Child Born Outside the U.S. A child born outside the U.S., as defined in Public Law 106-395, is considered a citizen if all of the following conditions are met: (3-30-07)

a. At least one (1) parent is a U.S. Citizen. The parent can be a citizen by birth or naturalization. This includes an adoptive parent; (3-30-07)

b. The child is residing permanently in the U.S. in the legal and physical custody of a parent who is a U.S. Citizen; (3-30-07)

c. The child is under eighteen (18) years of age; (3-30-07)

d. The child is a lawful permanent resident; and (3-30-07)

e. If the child is an adoptive child, the child was residing in the U.S. at the time the parent was naturalized and was in the legal and physical custody of the adoptive parent. (3-30-07)

03. Full-Time Active Duty U.S. Armed Forces Member. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) currently on full-time active duty with the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard, or a spouse or unmarried dependent child of the U.S. Armed Forces member. (3-30-07)

04. Veteran of the U.S. Armed Forces. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) honorably discharged from the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard for a reason other than their citizenship status or a spouse, including a surviving spouse who has not remarried, or an unmarried dependent child of the veteran. (3-30-07)

05. Non-Citizen Entering the U.S. Before August 22, 1996. A non-citizen who entered the U.S. before August 22, 1996, and is currently a qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) and remained continuously present in the U.S. until they became a qualified alien. (3-30-07)

06. Non-Citizen Entering on or After August 22, 1996. A non-citizen who entered on or after August 22, 1996, and; (3-30-07)

a. Is a refugee admitted into the U.S. under 8 U.S.C. 1157, and can be eligible for seven (7) years from their date of entry; (3-30-07)

b. Is an asylee granted asylum into the U.S. under 8 U.S.C. 1158, and can be eligible for seven (7) years from the date their asylee status is assigned; (3-30-07)

c. Is an individual whose deportation or removal from the U.S. has been withheld under 8 U.S.C. 1253 or 1231(b)(3) as amended by Section 305(a) of Division C of Public Law 104-208, and can be eligible for seven (7) years from the date their deportation or removal was withheld; (3-30-07)

d. Is an Amerasian immigrant admitted into the U.S. under 8 U.S.C. 1612(b)(2)(A)(i)(V), and can be

eligible for seven (7) years from the date of entry; (4-7-11)

e. Is a Cuban or Haitian entrant to the U.S. under Section 501(e) of the Refugee Assistance Act, and can be eligible for seven (7) years from their date of entry; (4-7-11)

f. Is an Afghan special immigrant, as defined in Public Law 110-161, who has special immigration status after December 26, 2007; or (4-7-11)

g. Is an Iraqi special immigrant, as defined in Public Law 110-181, who has special immigration status after January 28, 2008. (4-7-11)

07. Qualified Non-Citizen Entering on or After August 22, 1996. A qualified non-citizen under 8 U.S.C. 1641(b) or (c), entering the U.S. on or after August 22, 1996, and who has held a qualified non-citizen status for at least five (5) years. (3-30-07)

08. American Indian Born in Canada. An American Indian born in Canada under 8 U.S.C. 1359. (3-30-07)

09. American Indian Born Outside the U.S. An American Indian born outside of the U.S., and is a member of a U.S. federally recognized tribe under 25 U.S.C. 450 b(e). (3-30-07)

10. Qualified Non-Citizen Child Receiving Federal Foster Care. A qualified non-citizen child as defined in 8 U.S.C. 1641(b) or (c), and receiving federal foster care assistance. (3-30-07)

11. Victim of Severe Form of Trafficking. A victim of a severe form of trafficking in persons, as defined in 22 U.S.C. 7102(13); who meets one (1) of the following: (3-20-04)

a. Is under the age of eighteen (18) years; or (3-20-04)

b. Is certified by the U.S. Department of Health and Human Services as willing to assist in the investigation and prosecution of a severe form of trafficking in persons; and (3-20-04)

i. Has made a bona fide application for a temporary visa under 8 U.S.C. 1104(a)(15)(T), which has not been denied; or (3-20-04)

ii. Is remaining in the U.S. to assist the U.S. Attorney General in the prosecution of traffickers in persons. (3-30-07)

12. Qualified Non-Citizen Receiving Supplement Security Income (SSI). A qualified non-citizen under 8 U.S.C. 1641(b) or (c), and is receiving SSI; or (3-20-04)

13. Permanent Resident Receiving AABD Cash On August 22, 1996. A permanent resident receiving AABD cash on August 22, 1996. (3-20-04)

~~***14. Employment Authorized Alien**. An alien granted an employment authorization document (EAD), as defined in 8 CFR Part 274a.12(c).*~~ ~~*(3-20-14)*~~

1~~5~~4. **Individuals Not Meeting the Citizenship or Qualified Non-Citizen Requirements**. An individual who does not meet the citizenship or qualified non-citizen requirements in Subsections 105.01 through 105.1~~4~~3 of this rule, may be eligible for emergency medical services if he meets all other conditions of eligibility. ~~*(3-20-14)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

402. SELF-EMPLOYMENT ALLOWABLE EXPENSES.

Allowable operating expenses subtracted from self-employment income are listed in Subsections 402.01 through 402.1~~7~~6 of this rule. ~~(3-29-12)~~( )

~~***01. Self-Employment Standard Deduction.*** *The Department uses a standard self-employment deduction, unless the applicant claims that his actual allowable expenses exceed the standard deduction and provides proof of the allowable expenses described in Subsection 402.02 through 402.17 of this rule. The self-employment standard deduction is determined by subtracting fifty percent (50%) of the gross monthly self-employment income as calculated in Section 401 of these rules.~~ ~~(3-29-12)~~

0~~2~~1. **Labor**. Labor paid to individuals not in the family. (7-1-99)

0~~3~~2. **Materials**. Materials such as stock, seed and fertilizer. (7-1-99)

0~~4~~3. **Rent**. Rent on business property. (7-1-99)

0~~5~~4. **Interest**. Interest paid to purchase income producing property. (7-1-99)

0~~6~~5. **Insurance**. Insurance paid for business property. (7-1-99)

0~~7~~6. **Taxes**. Taxes on income producing property. (7-1-99)

0~~8~~7. **Business Transportation**. Business transportation as defined by the IRS. (7-1-99)

0~~9~~8. **Maintenance**. Landscape and grounds maintenance. (7-1-99)

~~1~~09. **Lodging**. Lodging for business related travel. (7-1-99)

1~~1~~0. **Meals**. Meals for business related travel. (7-1-99)

1~~2~~1. **Use of Home**. Costs of partial use of home for business. (7-1-99)

1~~3~~2. **Legal**. Business related legal fees. (7-1-99)

1~~4~~3. **Shipping**. Business related shipping costs. (7-1-99)

1~~5~~4. **Uniforms**. Business related uniforms. (7-1-99)

1~~6~~5. **Utilities**. Utilities for business property. (7-1-99)

1~~7~~6. **Advertising**. Business related advertising. (7-1-99)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1501

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearings concerning this rulemaking will be held as follows:

Friday, October 23, 2015 9:00 a.m. MDT	Friday, October 23, 2015 12:00 p.m. MDT	Friday, October 23, 2015 2:00 p.m. PDT
Medicaid Central Office **3232 W. Elder Street** **Conference Room D -- West/East** **Boise, ID**	**Medicaid Region VI Office** **1070 Hiline Road** **Suite #230** **Pocatello, ID**	**Medicaid Region I Office** **1120 Ironwood Drive** **Large Conference Room** **Coeur d'Alene, ID**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

These rule changes clarify gaps that have been identified in these rules and adjust to changes in current Medicaid practice regarding school-based services and therapy services. Further, these rule changes adjust requirements currently resulting in unnecessary regulatory burdens on providers in their efforts to remain in compliance with the rules.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking has no fiscal impact to the state general fund. This rulemaking is intended to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the June 3, 2015, Idaho Administrative Bulletin, **Vol. 15-6, pages 42 and 43**.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

CONTACT INFORMATION, WEB ADDRESS, ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Frede' Trenkle-MacAllister at (208) 287-1169.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 31st Day of August, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5564; fax: (208) 334-6558
e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0309-1501
(Only Those Sections With Amendments Are Shown.)

730. THERAPY SERVICES: DEFINITIONS.
For the purposes of these rules, the following terms are used as defined below: (4-2-08)

01. Duplicate Services. Services are considered duplicate: (4-2-08)

a. When participants receive any combination of physical therapy, occupational therapy, or speech-language pathology services with treatments, evaluations, treatment plans, or goals that are not separate and unique to each service provided; or (4-2-08)

b. When more than one (1) type of therapy is provided at the same time. (4-2-08)

02. Feeding Therapy. Feeding Therapy means those therapy services necessary for the treatment of feeding disorders. Feeding disorders include problems gathering food and getting ready to suck, chew, or swallow it. ( )

02~~.~~3. Maintenance Program. A ~~*maintenance*~~ program established by a therapist that requires the skills of a therapist and consists of ~~*any combination of drills, techniques, exercises, treatments, or activities that preserve the participant's present level of functioning and prevent regression of that function. A maintenance program begins when:*~~ activities and mechanisms to assist a participant in maximizing or maintaining the progress he or she has made during therapy or to prevent or slow further deterioration due to a disease or illness. ~~*(4-2-08)*~~( )

~~***a.** The therapeutic goals of a treatment plan have been achieved and no further functional progress is expected to occur;* (4-2-08)~~

~~***b.** The client or his caregivers, or both, have been taught and can carry out the therapy procedures; or* (4-2-08)~~

~~***c.** The skills of a therapist are no longer required.* (4-2-08)~~

03~~.~~4. Occupational Therapy Services. Therapy services that: (4-2-08)

a. Are provided within the scope of practice of licensed occupational therapists; (4-2-08)

b. Are necessary for the evaluation and treatment of impairments, functional disabilities, or changes in physical function and health status; and (4-2-08)

c. Improve the individual's ability to perform those tasks required for independent functioning. (4-2-08)

04~~.~~5. Physical Therapy Services. Therapy services that: (4-2-08)

a. Are provided within the scope of practice of licensed physical therapists; (4-2-08)

b. Are necessary for the evaluation and treatment of physical impairment or injury by the use of therapeutic exercise and the application of modalities that are intended to restore optimal function or normal development; and (4-2-08)

c. Focus on the rehabilitation and prevention of neuromuscular, musculoskeletal, integumentary, and cardiopulmonary disabilities. (4-2-08)

056. **Speech-Language Pathology Services**. Therapy services that are: (4-2-08)

a. Provided within the scope of practice of licensed speech-language pathologists; and (4-2-08)

b. Necessary for the evaluation and treatment of speech and language disorders which result in communication disabilities; or (4-2-08)

c. Necessary for the evaluation and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. (4-2-08)

~~*06. Supervision.* (4-2-08)~~

~~*a. Direct supervision requires that the therapist be physically present and available to render direction in person and on the premises where the therapy is being provided.* (4-2-08)~~

~~*b. General supervision requires direct, on-premises contact between the therapist, the therapy assistant, and the participant at least every five (5) visits or once every week if seen on a daily basis. Between direct contacts, the therapist is required to maintain indirect, off-premises contact with the therapy assistant. These indirect, off-premises contacts may be by telephone, written reports, or group conferences.* (4-2-08)~~

07. Therapeutic Procedures. Therapeutic procedures are the application of clinical skills, services, or both, that attempt to improve function. (4-2-08)

08. Therapist. An individual licensed by the appropriate Idaho state licensing board as an occupational therapist, physical therapist, or speech-language pathologist. ( )

0~~8~~9. ~~*Therapist*~~ Therapy Professional. An individual licensed by the appropriate Idaho state licensing board as an occupational therapist or occupational therapist assistant, physical therapist or physical therapist assistant, or speech-language pathologist. ~~(4-2-08)~~( )

~~*09. Therapy Assistant. An individual licensed by the appropriate therapy licensure board to assist in the practice of occupational or physical therapy under the supervision of the appropriate licensed therapist. The therapy assistant is not recognized as an independent Medicaid provider.* (4-2-08)~~

10. Therapy Services. Occupational therapy, physical therapy, and speech-language pathology services are all considered to be therapy services. These services are ordered by the participant's attending physician, nurse practitioner, or physician assistant as part of a plan of care. (4-2-08)

11. Treatment Modalities. A treatment modality is any physical agent applied to produce therapeutic changes to biological tissue, including the application of thermal, acoustic, light, mechanical or electrical energy. (4-2-08)

731. THERAPY SERVICES: PARTICIPANT ELIGIBILITY.
To be eligible for therapy services, a participant must be eligible for Medicaid benefits and must have: (4-2-08)

01. Physician Order. A physician order for therapy services; and ~~(4-2-08)~~( )

~~*02. Referral. A referral from their Healthy Connections Primary Care Provider when applicable;*~~

~~(4-2-08)~~

0~~3~~2. **A Therapy Evaluation Showing Need**. A therapy evaluation of the participant showing a need for therapy due to a functional limitation, a loss or delay of skill, or both; and (4-2-08)

0~~4~~3. **A Therapy Evaluation Establishing Participant Benefit**. A therapy evaluation establishing that the participant will benefit and demonstrate progress as a result of the therapy services. (4-2-08)

732. THERAPY SERVICES: COVERAGE AND LIMITATIONS.
Therapy services are covered under these rules when delivered by a therapy professional and provided by one (1) of the following providers: outpatient hospitals, outpatient rehabilitation facilities, comprehensive outpatient rehabilitative facilities, nursing facilities, school-based services, Idaho Infant Toddler Program, independent practitioners, and home health agencies. ~~(7-1-13)~~( )

01. Service Description: **Occupational Therapy and Physical Therapy**. Modalities, therapeutic procedures, tests, and measurements as described in the Physical Medicine and Rehabilitation Subsection and the Neurology and Neuromuscular Procedures Subsection of the Physician's Current Procedural Terminology (CPT Manual) are covered with the following limitations: (4-2-08)

a. Any evaluation or re-evaluation may only be performed by the therapist. Any changes in the participant's condition not consistent with planned progress or treatment goals necessitate a documented re-evaluation by the therapist before further treatment is carried out. (4-2-08)

b. Any CPT procedure code that falls under the heading of either, “Active Wound Care Management,” or “Tests and Measurements,” requires the therapist to have direct, one-to-one, patient contact. (4-2-08)

c. The therapist may be reimbursed for the technical component of muscle testing, joint range of motion, electromyography, or nerve velocity determinations as described in the CPT Manual when ordered by a physician, nurse practitioner, or physician assistant. (4-2-08)

d. Any assessment provided under the heading “Orthotic Management and Prosthetic Management” must be completed by the therapist. (4-2-08)

e. Any modality that is defined as “unlisted” in the CPT Manual requires prior authorization by the Department. In this case, the therapist and the physician, nurse practitioner, or physician assistant must provide information in writing to the Department that documents the medical necessity of the modality requested. (4-2-08)

f. The services of occupational or physical therapy assistants used when providing covered therapy benefits are included as part of the covered service. These services are billed by the supervising therapist. Therapy assistants may not provide evaluation services, make clinical judgments or decisions, or take responsibility for the service. The therapist has full responsibility for the service provided. Therapy assistants act at the direction and under the supervision of the treating therapist and in accordance with state licensure rules. ~~(4-2-08)~~( )

02. Service Description: Speech-Language Pathology. Speech-language pathology services must be provided as defined in Section 730 of these rules. Services provided by speech-language pathology assistants are considered unskilled services, and will be denied as not medically necessary if they are billed as speech-language pathology services. (4-2-08)

03. Non-Covered Services: Occupational Therapy, Physical Therapy, and Speech-Language Pathology. (4-2-08)

a. Continuing services for participants who do not exhibit the capability to achieve measurable improvement. (4-2-08)

b. Services that address developmentally acceptable error patterns. (4-2-08)

c. Services that do not require the skills of a ~~therapist or~~ therapy ~~assistant~~ professional.

~~(4-2-08)~~( )

~~**d.** *Services provided by unlicensed aides or technicians, even if under the supervision of a therapist, except as provided under Section 854 of these rules.* (4-2-08)~~

~~**e**~~**d.** Massage, work hardening, and conditioning. (4-2-08)

~~**f**~~**e.** Services that are not medically necessary, as defined in Section 011 of these rules. (4-2-08)

~~**g.** *Maintenance programs, as defined under Section 730 of these rules.* (4-2-08)~~

~~**h**~~**f.** Duplicate services, as defined under Section 730 of these rules. (4-2-08)

~~**i**~~**g.** Group therapy in settings other than school-based services and the Idaho Infant Toddler Program. (7-1-13)

h. Acupuncture (with or without electrical stimulation). ( )

i. Biofeedback. ( )

j. Duplicate Services. ( )

k. Services that are considered to be experimental or investigational. ( )

l. Vocational Program. ( )

m. Vision Therapy. ( )

04. Service Limitations. (4-2-08)

a. Physical therapy (PT) and speech-language pathology (SLP) services are limited to a combined annual dollar amount for all PT and SLP services. The Department will set the total amount based on the annual Medicare caps. The Department may authorize additional therapy services, when the services are determined to be medically necessary and supporting documentation is provided to the Department. (3-29-12)

b. Occupational therapy services are limited to an annual dollar amount set by the Department based on the annual Medicare caps. The Department may authorize additional therapy services, when the services are determined to be medically necessary and supporting documentation is provided to the Department. (3-29-12)

c. Exceptions to service limitations. (3-29-12)

i. Therapy provided by home health agencies is subject to the limitations on home health services contained in Section 722 of these rules. (3-29-12)

ii. Therapy provided through school-based services or the Idaho Infant Toddler Program is not included in the service limitations under Subsection 732.04 of this rule. (7-1-13)

iii. Therapy provided to EPSDT participants under the age of twenty-one (21) in accordance with the EPSDT requirements contained in Sections 881 through 883 of these rules, and in Section 1905(r) of the Social Security Act, will be authorized by the Department when additional therapy services are medically necessary. (3-29-12)

d. Feeding therapy services are covered for children with a diagnosed feeding disorder that results in a clinically significant deviation from normal childhood development. The provider of feeding therapy is an occupational therapist or speech therapist with training specific to feeding therapy. ( )

e. Maintenance therapy is covered when an individualized assessment of the participant's condition

demonstrates that skilled care is required to carry out a safe and effective maintenance program. ( )

f. Telehealth modalities are covered to the extent they are allowed under the rules of the applicable board of licensing. The Department will define limitations on telehealth in the provider handbook to promote quality services and program integrity. ( )

733. THERAPY SERVICES: PROCEDURAL REQUIREMENTS.
The Department will pay for therapy services rendered by ~~*or under the supervision of a licensed therapist*~~ a therapy professional if such services are ordered by ~~*the attending*~~ a physician, nurse practitioner, or physician assistant as part of a plan of care. ~~*(4-2-08)*~~( )

01. Physician Orders. (4-2-08)

a. All therapy must be ordered by a physician, nurse practitioner, or physician assistant. Such orders must include at a minimum, the service to be provided, the frequency, and, where applicable, the expected duration of ~~*each therapeutic session*~~ time for which the therapy will be needed. If the initial physician, nurse practitioner, or physician assistant order does not specify at least the type of service and the frequency, then: ~~*(4-2-08)*~~( )

i. The therapist may perform a therapy evaluation based on the initial physician order for the evaluation. ( )

ii. The therapist must then develop a plan of care based on that evaluation and send the plan to the ordering physician, nurse practitioner, or physician assistant and begin care. ( )

iii. The physician, nurse practitioner, or physician assistant must either sign an order specifying the service to be provided, the frequency and the duration, or they must sign the therapy plan of care within thirty (30) days for therapy to continue. No claims may be billed until the complete order or the plan of care is signed by the physician, nurse practitioner, or physician assistant. ( )

b. In the event that services are required for extended periods, these services must be reordered as necessary, but at least every ninety (90) days for all participants with the following exceptions: (5-8-09)

i. Therapy provided by home health agencies must be included in the home health plan of care and be reordered at least every sixty (60) days. (4-2-08)

ii. Therapy for individuals with ~~*chronic*~~ long-term medical conditions, as documented by physician, nurse practitioner, or physician assistant, must be reordered at least every ~~*six (6) months*~~ three hundred sixty-five (365) days. ~~*(4-2-08)*~~( )

02. Level of Supervision. ~~*(4-2-08)*~~

~~***a.*** *General* ~~*s*~~Supervision of physical therapist assistants and occupational therap~~*y*~~ist assistants ~~*is required when therapy services are provided by outpatient hospitals, nursing facilities, home health agencies, outpatient rehabilitation facilities, comprehensive outpatient rehabilitation facilities, the Idaho Infant Toddler Program, and providers of school-based services*~~ by the physical therapist or occupational therapist must be done according to the rules of the applicable licensure board. ~~*(7-1-13)*~~( )

~~***b.*** *Direct supervision of therapy assistants is required when therapy services are provided by independent practitioners.* *(4-2-08)*~~

03. Plan of Care. All therapy is provided under a plan of care that is established prior to beginning treatment. The plan of care must be signed by the person who established the plan. The plan of care must be consistent with the therapy evaluation and must contain, at a minimum: ( )

a. Diagnoses; ( )

b. Treatment goals that are measurable and pertain to the identified functional impairment(s); and

~~( )~~

c. Type, frequency, and duration of therapy services. ~~( )~~

734. THERAPY SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
The following providers are qualified to provide therapy services as Medicaid providers. (4-2-08)

01. Occupational Therapist, Licensed. A person licensed by the State Board of Medicine to conduct occupational therapy assessment and therapy in accordance with the Occupational Therapy Practice Act, Title 54, Chapter 37, Idaho Code, and IDAPA ~~22.01.09~~ 24.06.01, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants." ~~(4-2-08)~~( )

02. Physical Therapist, Licensed. A person licensed by the Physical Therapy Licensure Board to conduct physical therapy assessments and therapy in accordance with the Physical Therapy Practice Act, Title 54, Chapter 22, Idaho Code, and IDAPA 24.13.01, "Rules Governing the Physical Therapy Licensure Board." (4-2-08)

03. Speech-Language Pathologist, Licensed. A person licensed by the Speech and Hearing Services Licensure Board to conduct speech-language assessments and therapy in accordance with the Speech and Hearing Services Practice Act, Title 54, Chapter 29, Idaho Code, and IDAPA 24.23.01, "Rules of the Speech and Hearing Services Licensure Board," who possesses a certificate of clinical competence in speech-language pathology from the American Speech, Language, and Hearing Association (ASHA) or who will be eligible for certification within one (1) year of employment. (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

850. SCHOOL-BASED SERVICE: DEFINITIONS.

01. Activities of Daily Living (ADL). The performance of basic self-care activities in meeting an individual's needs for sustaining him in a daily living environment, including, but not limited to, bathing, washing, dressing, toileting, grooming, eating, communication, continence, mobility, and associated tasks. (3-30-07)

02. Educational Services. Services that are provided in buildings, rooms, or areas designated or used as a school or a~~s~~n educational ~~facilities~~ setting, which are provided during the specific hours and time periods in which the educational instruction takes place in the ~~normal~~ school day and period of time for these students, ~~and~~ which are included in the individual educational plan (IEP) for the ~~participant~~ student. ~~(3-29-10)~~( )

03. School-Based Services. School-based services are health-related and rehabilitative services provided by Idaho public school districts and charter schools under the Individuals with Disabilities Education Act (IDEA). (7-1-13)

04. The Psychiatric Rehabilitation Association (PRA). An association that works to improve and promote the practice and outcomes of psychiatric rehabilitation and recovery. The PRA also maintains a certification program to promote the use of qualified staff to work for individuals with mental illness. ~~https://netforum.avectra.com/eWeb/StartPage.aspx?Site=USPRA~~.http://www.uspra.org ~~(3-20-14)~~( )

05. Practitioner of the Healing Arts. A physician's assistant, nurse practitioner, or clinical nurse specialist who is licensed and approved by the state of Idaho to make such recommendations or referrals for Medicaid services. (7-1-13)

06. Serious Mental Illness (SMI). In accordance with 42 CFR 483.102(b)(1), a person with SMI: (3-20-14)

a. Currently or at any time during the year, must have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified in the DSM-V; and (3-20-14)

b. Must have a functional impairment that substantially interferes with or limits one (1) or more major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning with an individual's basic daily living skills, instrumental living skills, and functioning in social, family, vocational or educational contexts. Instrumental living skills include maintaining a household, managing money, getting around the community, and taking prescribed medication. An adult who met the functional impairment criteria during the past year without the benefit of treatment or other support services is considered to have a serious mental illness. (3-20-14)

07. Serious and Persistent Mental Illness (SPMI). A participant must meet the criteria for SMI, have at least one (1) additional functional impairment, and have a diagnosis under DSM-V with one (1) of the following: Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a conclusive diagnosis. (3-20-14)

851. SCHOOL-BASED SERVICE: PARTICIPANT ELIGIBILITY.
To be eligible for medical assistance reimbursement for covered services, school districts and charter schools must ensure the student is: (7-1-13)

01. Medicaid Eligible. Eligible for Medicaid and the service for which the school district or charter school is seeking reimbursement; (7-1-13)

02. School Enrollment. Enrolled in an Idaho school district or charter school; (7-1-13)

03. Age. Twenty-one (21) years of age or younger and the semester in which his twenty-first birthday falls is not finished; (3-30-07)

04. Educational Disability. Identified as having an educational disability under the Department of Education standards in IDAPA 08.02.03, "Rules Governing Thoroughness." (7-1-13)

~~***05. Inpatients in Hospitals or Nursing Homes**. Payment for school-related services will not be provided to students who are inpatients in nursing homes or hospitals. Health related services for students residing in an ICF/ID are eligible for reimbursement.* (7-1-13)~~

05. Parental Consent. Providers must obtain consent from a parent or legal guardian for school-based Medicaid reimbursement. ( )

852. SCHOOL-BASED SERVICE: SERVICE-SPECIFIC PARTICIPANT ELIGIBILITY.
~~*Psychosocial Rehabilitation (PSR),*~~ Community Based Rehabilitation Services (CBRS). Behavioral Intervention, Behavioral Consultation, and Personal Care Services (PCS) have additional eligibility requirements. ~~*(3-20-14)*~~( )

01. ~~*Psychosocial Rehabilitation (PSR)*~~ Community Based Rehabilitation Services (CBRS). To be eligible for ~~*PSR*~~ CBRS, the student participant must meet one (1) of the following: ~~*(3-20-14)*~~( )

a. A student who is a child under eighteen (18) years of age must meet the Serious Emotional Disturbance (SED) eligibility criteria for children in accordance with the Children's Mental Health Services Act, Section 16-2403, Idaho Code~~*, and have documented evidence of a history and physical examination that has been completed within the last twelve (12) months prior to the initiation of mental health services*~~. A child who meets the criteria for SED must experience a substantial impairment in functioning. The child's level and type of functional impairment must be documented in the ~~*medical*~~ school record. ~~*The Child and Adolescent Functional Assessment Scale/ Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS) instrument*~~ A Department-approved assessment must be used to obtain the child's initial functional impairment score. Subsequent scores must be obtained at ~~*regular intervals*~~ least annually in order to determine the child's change in functioning that occurs as a result of mental health treatment. ~~*Items endorsed on the CAFAS/PECFAS must be supported by specific descriptions of the child's observable behavior in the comprehensive diagnostic assessment. Substantial impairment requires that the child score in the moderate range in at least two (2) subscales on the CAFAS/PECFAS. One (1) of the two (2) subscales must be from the following: Self-harmful Behavior, Moods/Emotions, or Thinking. In addition, the child*~~

~~must have obtained a comprehensive diagnostic assessment that indicates:~~ ~~(3-20-14)~~( )

~~i. The service represents the least restrictive setting and other services have failed or are not appropriate for the clinical needs of the child;~~ ~~(3-20-14)~~

~~ii. The service can reasonably be expected to improve the child's condition or prevent further regression so that the current level of care is no longer necessary or may be reduced; and~~ ~~(3-20-14)~~

~~iii. Verification that the child is not at immediate risk of self-harm or harm to others who cannot be stabilized, not in need of more restrictive care or inpatient care, and not over the age of eighteen (18).~~ ~~(3-20-14)~~

b. A student who is eighteen (18) years old or older must meet the criteria of Serious and Persistent Mental Illness (SPMI). This requires that a student participant meet the criteria for SMI, as described in 42 CFR 483.102(b)(1), have at least one (1) additional functional impairment, and have a diagnosis under DSM-V, or later edition, with one (1) of the following: Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a conclusive diagnosis. In addition, the psychiatric disorder must be of sufficient severity to affect the participant's functional skills negatively, causing a substantial disturbance in role performance or coping skills in at least two (2) of the areas listed below on either a continuous or intermittent basis, at least once per year. ~~The participant's comprehensive diagnostic assessment must clearly identify the participant's need for skill training services that target skill deficits caused by his mental health condition. The participant's record must contain documentation that collaboration has occurred with the participant's other service providers in order to prevent duplication of skill training treatment services.~~ The skill areas that are targeted must be consistent with the participant's ability to engage and benefit from treatment. The detail of the participant's level and type of functional impairment must be documented in the medical record in the following areas: ~~(3-20-14)~~( )

i. Vocational/educational; (3-20-14)

ii Financial; (3-20-14)

iii. Social relationships/support; (3-20-14)

iv. Family; (3-20-14)

v. Basic living skills; (3-20-14)

vi. Housing; (3-20-14)

vii. Community/legal; or (3-20-14)

viii. Health/medical. (3-20-14)

~~c. A student must meet the Department of Education's criteria for emotional disturbance found in the Idaho Special Education Manual available online at the Idaho Department of Education website, http://www.sde.idaho.gov/site/special_edu/.~~ ~~(3-20-14)~~

02. Behavioral Intervention and Behavioral Consultation. To be eligible for behavioral intervention and behavioral consultation services, the student must: (3-20-14)

a. Meet the criteria for developmental disabilities as identified in Section 66-402(5), Idaho Code, and have documentation to support eligibility using the standards under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 501-503; and ~~(3-20-14)~~( )

b. Exhibit maladaptive behaviors that include frequent disruptive behaviors, aggression, self-injury, criminal or dangerous behavior evidenced by a score of at least one point five (1.5) standard deviations from the mean in at least two (2) behavior domains and by ~~at least two (2)~~ a rater~~s~~ familiar with the student, or at least two (2)

standard deviations from the mean in one (1) composite score that consists of at least three (3) behavior domains by ~~at least two (2)~~ a rater~~s~~ familiar with the student, on a standardized behavioral assessment approved by the Department; and ~~(3-20-14)~~( )

c. Have maladaptive behaviors that interfere with the student's ability to access an education. (3-20-14)

03. Personal Care Services. To be eligible for personal care services (PCS), the student must have a completed children's PCS assessment and allocation tool approved by the Department. To determine eligibility for PCS, the assessment results must find the student requires PCS due to a medical condition that impairs the physical or functional abilities of the student. ~~(3-20-14)~~( )

853. SCHOOL-BASED SERVICE: COVERAGE AND LIMITATIONS.
The Department will pay school districts and charter schools for covered rehabilitative and health-related services. Services include medical or remedial services provided by school districts or other cooperative service agencies, as defined in Section 33-317, Idaho Code. (7-1-13)

01. Excluded Services. The following services are excluded from Medicaid payments to school-based programs: (3-30-07)

a. Vocational Services. (3-30-07)

b. Educational Services. Educational services (other than health related services) or education-based costs normally incurred to operate a school and provide an education. Evaluations completed for educational services only cannot be billed. (3-30-07)

c. Recreational Services. (3-30-07)

d. Payment for school-related services will not be provided to students who are inpatients in nursing homes or hospitals. ( )

02. Evaluation And Diagnostic Services. Evaluations to determine eligibility or the need for health-related services may be reimbursed even if the student is not found eligible for health-related services. Evaluations completed for educational services only cannot be billed. Evaluations completed must: (3-30-07)

a. Be recommended or referred by a physician or other practitioner of the healing arts. A school district or charter school may not seek reimbursement for services provided prior to receiving a signed and dated recommendation or referral; (7-1-13)

b. Be conducted by qualified professionals for the respective discipline as defined in Section 855 of these rules; (3-20-14)

c. Be directed toward a diagnosis; ~~and~~ ~~(7-1-13)~~( )

d. Include recommended interventions to address each need~~.~~; and ~~(7-1-13)~~( )

e. Include name, title, and signature of the person conducting the evaluation. ( )

03. Reimbursable Services. School districts and charter schools can bill for the following health-related services provided to eligible students when the services are provided under the recommendation of a physician or other practitioner of the healing arts for the Medicaid services for which the school district or charter school is seeking reimbursement. A school district or charter school may not seek reimbursement for services provided prior to receiving a signed and dated recommendation or referral. The recommendations or referrals are valid up to three hundred sixty-five (365) days. ~~(7-1-13)~~( )

a. Behavioral Intervention. Behavioral Intervention is used to promote the student's ability to

participate in educational services, as defined in Section 850 of these rules, through a consistent, assertive, and continuous intervention process to address behavior goals identified on the IEP. It includes the development of replacement behaviors by conducting a functional behavior assessment and behavior implementation plan with the purpose ~~to~~ of preventing or treating behavioral conditions ~~of~~ for students who exhibit maladaptive behaviors. Services include individual or group behavioral interventions. ~~The following staff to participant ratios apply:~~ ~~(7-1-13)~~( )

i. ~~There must be at least~~ Group services must be provided by one (1) qualified staff providing direct services for ~~every~~ a maximum of three (3) students~~, unless the student has an assessment score of at least two (2) standard deviations from the mean in one (1) composite score~~. ~~(7-1-13)~~( )

~~ii. When intervention is provided by a professional for students with an assessment score of at least two (2) standard deviations from the mean in one (1) composite score, there must be at least one (1) qualified staff for every two (2) students.~~ ~~(7-1-13)~~

~~iii. When intervention is provided by a paraprofessional for students with an assessment score of at least two (2) standard deviations from the mean in one (1) composite score, group intervention is not allowable.~~ ~~(7-1-13)~~

i~~v~~i. As the number and severity of the students with behavioral issues increases, the staff-to-~~participant~~student ratio must be adjusted accordingly. ~~(7-1-13)~~( )

~~v~~iii. Group services should only be delivered when the child's goals relate to benefiting from group interaction. (7-1-13)

b. Behavioral Consultation. Behavioral consultation assists other service professionals by consulting with the IEP team during the assessment process, performing advanced assessment, coordinating the implementation of the behavior implementation plan and providing ongoing training to the behavioral interventionist and other team members. (7-1-13)

i. Behavioral consultation cannot be provided as a direct intervention service. (7-1-13)

ii. Behavioral consultation must be limited to thirty-six (36) hours per student per year. (7-1-13)

c. Medical Equipment and Supplies. Medical equipment and supplies that are covered by Medicaid must be medically necessary, ordered by a physician, and prior authorized~~, based on medical necessity, in order to be billed~~. Authorized items must be for use~~d~~ at the school ~~at the location~~ where the service is provided. Equipment that is too large or unsanitary to transport from home to school and back may be covered, if prior authorized. The equipment and supplies must be ~~used~~ for the student's exclusive use and must be transferred with the student if the student changes schools. ~~Equipment no longer usable by the student, may be donated to the school by the student~~ All equipment purchased by Medicaid belongs to the student. ~~(7-1-13)~~( )

d. Nursing Services. Skilled nursing services must be provided by a licensed nurse, within the scope of his or her practice. Emergency, first aid, or non-routine medications not identified on the plan as a health-related service are not reimbursed. ~~(3-30-07)~~( )

e. Occupational Therapy and Evaluation. Occupational therapy and evaluation services for vocational assessment, training or vocational rehabilitation are not reimbursed. (3-30-07)

f. Personal Care Services. School based personal care services include medically oriented tasks having to do with the student's physical or functional requirements. The provider must deliver at least one (1) of the following services: (7-1-13)

i. Basic personal care and grooming to include bathing, care of the hair, assistance with clothing, and basic skin care; (7-1-13)

ii. Assistance with bladder or bowel requirements that may include helping the student to and from the

bathroom or assisting the student with ~~*bedpan*~~ bathroom routines; ~~*(7-1-13)*~~( )

iii. Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need; (7-1-13)

~~*iv. The continuation of developmental disabilities programs to address the activities of daily living needs in the school setting as identified on the child's PCS assessment, in order to increase or maintain independence for the student with developmental disabilities as determined by the nurse or qualified intellectual disabilities professional (QIDP);*~~ ~~*(7-1-13)*~~

iv. Assisting the student with physician-ordered medications that are ordinarily self-administered, in accordance with IDAPA 23.01.01, "Rules of the Idaho Board of Nursing," Subsection 490.05; (7-1-13)

v~~*i*~~. Non-nasogastric gastrostomy tube feedings, if the task is not complex and can be safely performed in the given student care situation, and the requirements are met in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 303.01. (7-1-13)

g. Physical Therapy and Evaluation. (3-30-07)

h. Psychological Evaluation. (3-30-07)

i. Psychotherapy. (3-30-07)

j. ~~*Psychosocial Rehabilitation (PSR)*~~ Community Based Rehabilitation Services (CBRS) Services and Evaluation. ~~*Psychosocial rehabilitation (PSR)*~~ Community Based Rehabilitation ~~*s*~~Services and evaluation services that are interventions to ~~*assist*~~ reduce the student's disability by assisting in gaining and utilizing skills necessary to participate in school. Training in behavior control, social skills, communication skills, appropriate interpersonal behavior, symptom management, activities of daily living, ~~*study skills,*~~ and coping skills are types of interventions that may be reimbursed. This service is to prevent placement of the student into a more restrictive educational situation. ~~*(3-20-14)*~~( )

k. Speech/Audiological Therapy and Evaluation. (3-30-07)

l. Social History and Evaluation. (3-30-07)

m. Transportation Services. School districts and charter schools can receive reimbursement for mileage for transporting a student to and from home~~,~~ and school~~*, or location of services*~~ when: ~~*(7-1-13)*~~( )

i. The student requires special transportation assistance, ~~*such as*~~ a wheelchair lift, an attendant, or both, when medically necessary for the health and safety of the student and ~~*ordered*~~ recommended by a physician or other practitioner of the healing arts; ~~*(3-30-07)*~~( )

ii. The transportation occurs in a vehicle specifically adapted to meet the needs of a student with a disability; (3-30-07)

iii. The student requires and receives another Medicaid reimbursable service billed by the school-based services provider, other than transportation, on the day that transportation is being provided; (3-30-07)

iv. Both the Medicaid-covered service and the need for the special transportation are included on the student's plan; and (3-30-07)

v. The mileage, as well as the services performed by the attendant, are documented. See Section 855 of these rules for documentation requirements. (3-20-14)

n. Interpretive Services. Interpretive services needed by a student who is deaf or does not adequately speak or understand English and requires an interpreter to communicate with the professional or paraprofessional providing the student with a health-related service may be billed with the following limitations: (7-1-13)

i. Payment for interpretive services is limited to the specific time that the student is receiving the health-related service; documentation for interpretive service must include the Medicaid reimbursable health-related service being provided while the interpretive service is provided. ~~(3-30-07)~~( )

ii. Both the Medicaid-covered service and the need for interpretive services must be included on the student's plan; and (3-30-07)

iii. Interpretive services are not covered if the professional or paraprofessional providing services is able to communicate in the student's primary language. (3-30-07)

854. SCHOOL-BASED SERVICE: PROCEDURAL REQUIREMENTS.
The following documentation must be maintained by the provider and retained for a period of six (6) years: (7-1-13)

01. Individualized Education Program (IEP) and Other Service Plans. School districts and charter schools may bill for Medicaid services covered by a current Individualized Education Program (IEP), transitional Individualized Family Service Plan (IFSP) ~~when the child turns three (3) years old~~, or Services Plan (SP) defined in the Idaho Special Education Manual on the State Department of Education website for parentally placed private school students with disabilities when designated funds are available for special education and related services. The plan must be developed within the previous three hundred sixty-five (365) days which indicates the need for one (1) or more medically-necessary health-related service, and lists all the Medicaid reimbursable services for which the school district or charter school is requesting reimbursement. The IEP and transitional IFSP must include: ~~(7-1-13)~~( )

~~i~~**a.** Type, frequency, and duration of the service(s) provided; (7-1-13)

~~ii~~**b.** Title of the provider(s), including the direct care staff delivering services under the supervision of the professional; (7-1-13)

~~iii~~**c.** Measurable goals, when goals are required for the service; and (7-1-13)

~~iv~~**d.** Specific place of service, if provided in a location other than school. ~~(7-1-13)~~( )

02. Evaluations and Assessments. Evaluations and assessments must support services billed to Medicaid, and must accurately reflect the student's current status. Evaluations and assessments must be completed at least every (3) years. (7-1-13)

03. Service Detail Reports. A service detail report that includes: (7-1-13)

a. Name of student; (7-1-13)

b. Name, ~~and~~ title, and signature of the person providing the service; ~~(7-1-13)~~( )

c. Date, time, and duration of service; (7-1-13)

d. Place of service, if provided in a location other than school; (7-1-13)

e. Category of service and brief description of the specific areas addressed; and (7-1-13)

f. Student's response to the service when required for the service. (7-1-13)

04. One Hundred Twenty Day Review. A documented review of progress toward each service plan goal completed at least every one hundred twenty (120) days from the date of the annual plan. (7-1-13)

05. Documentation of Qualifications of Providers. (7-1-13)

06. Copies of Required Referrals and Recommendations. Copies of required referrals and

recommendations. (7-1-13)

a. School-based services must be recommended or referred by a physician or other practitioner of the healing arts for all Medicaid services for which the school district or charter school is receiving reimbursement. (7-1-13)

b. A recommendation or referral must be obtained prior to the provision of services for which the school district or charter school is seeking reimbursement. Therapy requirements for the physician's order are identified in Section 733 of these rules. ~~(7-1-13)~~( )

c. A recommendation or referral must be obtained for the service at least every three hundred sixty-five (365) days. ( )

07. Parental Notification. School districts and charter schools must document that parents were notified of the health-related services and equipment for which they will bill Medicaid. Notification must comply with the requirements in Subsection 854.08 of this rule. (3-20-14)

08. Requirements for Cooperation with and Notification of Parents and Agencies. Each school district or charter school billing for Medicaid services must act in cooperation with students' parent~~s~~ or guardian, and with community and state agencies and professionals who provide like Medicaid services to the student. ~~(7-1-13)~~( )

a. Notification of Parents. For all students who are receiving Medicaid reimbursed services, school districts and charter schools must ~~*ensure*~~ document that parents are notified of the Medicaid services and equipment for which they will bill Medicaid. Notification must describe the service(s), service provider(s), and state the type, location, frequency, and duration of the service(s). The school district must document that they provide~~d~~ the student's parent or guardian with a current copy of the child's plan and any pertinent addenda; and ~~(7-1-13)~~( )

b. ~~*Notification to*~~ Primary Care Physician (PCP). School districts and charter schools must request the name of the student's primary care physician and request a written consent to release and obtain information between the PCP and the school from the parent or guardian ~~*so the school program can share health-related information with the physician with written consent from the parent or guardian*~~. ~~*The following information must be sent to the student's primary care physician:*~~ ~~(7-1-13)~~( )

~~*i. Results of evaluations within sixty (60) days of completion; (7-1-13)*~~

~~*ii. A copy of the cover sheet and services page within thirty (30) days of the plan meeting; and (7-1-13)*~~

~~*iii. A copy of progress notes, if requested by the physician, within sixty (60) days of completion. (7-1-13)*~~

c. Other Community and State Agencies. Upon receiving a request for a copy of the evaluations or the current plan, the school district or charter school must furnish the requesting agency or professional with a copy of the plan or appropriate evaluation after obtaining consent for release of information from the student's parent or guardian. (7-1-13)

855. SCHOOL-BASED SERVICE: PROVIDER QUALIFICATIONS AND DUTIES.
Medicaid will only reimburse for services provided by qualified staff. The following are the minimum qualifications for providers of covered services: (7-1-13)

01. Behavioral Intervention. Behavioral intervention must be provided by or under the supervision of a professional. (7-1-13)

a. A behavioral intervention professional must meet the following: (7-1-13)

i. An individual with an Exceptional Child Certificate who meets the qualifications defined under

IDAPA 08.02.02, "Rules Governing Uniformity," Section 028; or (7-1-13)

ii. An individual with an Early Childhood/Early Childhood Special Education Blended Certificate who meets the qualifications defined under IDAPA 08.02.02, "Rules Governing Uniformity," Section 019; or (7-1-13)

iii. A Special Education Consulting Teacher who meets the qualifications defined under IDAPA 08.02.02, "Rules Governing Uniformity," Section 029; or (7-1-13)

iv. Habilitative intervention professional who meets the requirements defined in IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits," Section 685; or (7-1-13)

v. Individuals employed by a school as certified Intensive Behavioral Intervention (IBI) professionals prior to July 1, 2013, are qualified to provide behavioral intervention; and (7-1-13)

vi. Must be able to provide documentation of one (1) year's supervised experience working with children with developmental disabilities. This can be achieved by previous work experience gained through paid employment, university practicum experience, or internship. It can also be achieved by increased on-the-job supervision experience gained during employment at a school district or charter school. (7-1-13)

b. A paraprofessional under the direction of a qualified behavioral intervention professional, must meet the following: (7-1-13)

i. Must be at least eighteen (18) years of age; (7-1-13)

ii. Demonstrate the knowledge, have the skills needed to support the program to which they are assigned~~, and meet the requirements under the "Standards for Paraprofessionals Supporting Students with Special Needs," available online at the State Department of Education website~~; and ~~(7-1-13)~~( )

iii. Must meet the paraprofessional requirements under the Elementary and Secondary Education Act of 1965, as amended, Title 1, Part A, Section 1119. (7-1-13)

c. A paraprofessional delivering behavioral intervention services must be under the supervision of a behavioral intervention professional or behavioral consultation provider. The professional must observe and review the direct services performed by the paraprofessional on a monthly basis, or more often as necessary, to ensure the paraprofessional demonstrates the necessary skills to correctly provide the behavioral intervention service. (7-1-13)

02. Behavioral Consultation. Behavioral consultation must be provided by a professional who has a Doctoral or Master's degree in psychology, education, applied behavioral analysis, or has a related discipline with one thousand five hundred (1500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, or behavior analysis (may be included as part of degree program); and who meets one (1) of the following: (7-1-13)

a. An individual with an Exceptional Child Certificate who meets the qualifications defined under IDAPA 08.02.02, "Rules Governing Uniformity," Section 028. (7-1-13)

b. An individual with an Early Childhood/Early Childhood Special Education Blended Certificate who meets the qualifications defined under IDAPA 08.02.02, "Rules Governing Uniformity," Section 019. (7-1-13)

c. A Special Education Consulting Teacher who meets the qualifications defined under IDAPA 08.02.02, "Rules Governing Uniformity" Section 029. (7-1-13)

d. An individual with a Pupil Personnel Certificate who meets the qualifications defined under IDAPA 08.02.02, "Rules Governing Uniformity," Section 027, excluding a registered nurse or audiologist. (7-1-13)

e. An occupational therapist who is qualified and registered to practice in Idaho. (7-1-13)

f. Therapeutic consultation professional who meets the requirements defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 685. (7-1-13)

03. Medical Equipment and Supplies. See Subsection 853.03 of these rules. (3-20-14)

04. Nursing Services. Nursing services must be provided by a registered nurse or licensed professional nurse (RN), or by a licensed practical nurse (LPN) licensed to practice in Idaho. (7-1-13)

05. Occupational Therapy and Evaluation. Occupation therapy and evaluation must be provided by or under the supervision of an individual qualified and registered to practice in Idaho. For therapy-specific rules, refer to Sections 730 through 739 of these rules. ~~(7-1-13)~~( )

06. Personal Care Services. Personal care services must be provided by or under the direction of a registered nurse licensed by the State of Idaho. (7-1-13)

a. Providers of PCS must have at least one (1) of the following qualifications: (7-1-13)

i. Registered Nurse or Licensed Professional Nurse (RN). A person currently licensed by the Idaho State Board of Nursing as a registered nurse or licensed professional nurse; (7-1-13)

ii. Licensed Practical Nurse (LPN). A person currently licensed by the Idaho State Board of Nursing as a licensed practical nurse; or (7-1-13)

iii. Personal Assistant. A person who meets the standards of Section 39-5603, Idaho Code, and receives training to ensure the quality of services and meets the paraprofessional requirements under the Elementary and Secondary Education Act of 1965, as amended, Title 1, Part A, Section 1119. The assistant must be at least age eighteen (18) years of age. Medically-oriented services may be delegated to an aide in accordance with IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." The professional nurse may require a certified nursing assistant (CNA) if, in their professional judgment, the student's medical condition warrants a CNA. ~~(7-1-13)~~( )

b. The registered nurse (RN) must complete the PCS assessment and develop the written plan of care annually. Oversight provided by the RN must include all of the following: (7-1-13)

i. Development of the written PCS plan of care; (7-1-13)

ii. Review of the treatment given by the personal assistant through a review of the student's PCS record as maintained by the provider; and (7-1-13)

iii. Reevaluation of the plan of care as necessary, but at least annually. (7-1-13)

~~*c. In addition to the RN oversight, the Qualified Intellectual Disabilities Professional (QIDP) as defined in 42 CFR 483.430 provides oversight for students with developmental disabilities when identified as a need on the PCS assessment. Oversight must include:* (7-1-13)~~

~~*i. Assistance in the development of the PCS plan of care for those aspects of developmental disabilities programs that address the student's activities of daily living needs provided in the school by the personal assistant;* (7-1-13)~~

~~*ii. Review of the developmental disabilities programs given by the personal assistant through a review of the student's PCS record as maintained by the provider and through on-site observation of the student; and* (7-1-13)~~

~~*iii. Reevaluation of the PCS plan of care as necessary, but at least annually.* (7-1-13)~~

~~*d*~~**c.** The RN~~*, QIDP, or a combination of both,*~~ must conduct supervisory visits on a quarterly basis, or more frequently as determined by the IEP team and defined as part of the PCS plan of care. ~~(7-1-13)~~( )

07. Physical Therapy and Evaluation. Physical therapy and evaluation must be provided by an individual qualified and licensed as a physical therapist to practice in Idaho. For therapy-specific rules, refer to Sections 730 through 739 of these rules. ~~(7-1-13)~~( )

08. Psychological Evaluation. A psychological evaluation must be provided by a: (7-1-13)

a. Licensed psychiatrist; (7-1-13)

b. Licensed physician; (7-1-13)

c. Licensed psychologist; (7-1-13)

d. Psychologist extender registered with the Bureau of Occupational Licenses; or (7-1-13)

e. Endorsed or ~~C~~certified school psychologist. ~~(7-1-13)~~( )

09. Psychotherapy. Provision of psychotherapy services must have, at a minimum, one (1) or more of the following credentials: (7-1-13)

a. Psychiatrist, M.D.; (7-1-13)

b. Physician, M.D.; (7-1-13)

c. Licensed psychologist; (7-1-13)

d. Licensed clinical social worker; (7-1-13)

e. Licensed clinical professional counselor; (7-1-13)

f. Licensed marriage and family therapist; (7-1-13)

g. Certified psychiatric nurse (R.N.), as described in Subsection 707.13 of these rules; (7-1-13)

h. Licensed professional counselor whose provision of psychotherapy is supervised in compliance with IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; (7-1-13)

i. Licensed masters social worker whose provision of psychotherapy is supervised as described in IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; (7-1-13)

j. Licensed associate marriage and family therapist whose provision of psychotherapy is supervised as described in IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; or (7-1-13)

k. Psychologist extender, registered with the Bureau of Occupational Licenses, whose provision of diagnostic services is supervised in compliance with IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (7-1-13)

10. ~~*Psychosocial Rehabilitation (PSR)*~~ Community Based Rehabilitation Services (CBRS). ~~*Psychosocial rehabilitation*~~ CBRS providers must be under the supervision of a licensed behavioral health professional staff, physician, or nurse. The supervising practitioner is required to have regular one-to-one (1:1) supervision to review treatment provided to student participants on an ongoing basis. The frequency of the 1:1 supervision must occur at least on a monthly basis. CBRS must be provided by a: ~~(7-1-13)~~( )

a. Licensed physician, licensed practitioner of the healing arts~~, or licensed psychiatrist~~; ~~(7-1-13)~~( )

b. ~~Licensed master's level psychiatric~~ Advanced practice professional nurse; ~~(7-1-13)~~( )

c. Licensed psychologist; (7-1-13)

d. Licensed clinical professional counselor or professional counselor; (7-1-13)

e. Licensed marriage and family therapist ~~or associate marriage and family therapist~~; ~~(7-1-13)~~( )

f. Licensed masters social worker, licensed clinical social worker, or licensed social worker; (7-1-13)

g. Psychologist extender registered with the Bureau of Occupational Licenses; (7-1-13)

h. Licensed professional or registered nurse (RN); (7-1-13)

i. Licensed occupational therapist; (7-1-13)

j. Endorsed or ~~C~~certified school psychologist; ~~(3-20-14)~~( )

~~**k.** Certified school social worker; or~~ ~~(3-20-14)~~

~~**l**~~**k.** ~~Psychosocial rehabilitation (PSR)~~ Community Based Rehabilitation Services specialist. A ~~PSR~~ CBRS specialist is: ~~(3-20-14)~~( )

i. An individual who has a Bachelor's degree and holds a current PRA credential; or (3-20-14)

ii. An individual who has a Bachelor's degree or higher and was hired on or after November 1, 2010, to work as a ~~PSR~~ CBRS specialist to deliver Medicaid-reimbursable mental health services. This individual may continue to do so for a period not to exceed thirty (30) months from the initial date of hire. In order to continue as a ~~PSR~~ CBRS specialist beyond a total period of thirty (30) months from the date of hire, the worker must have completed a certificate program or earned a certification in psychiatric rehabilitation based upon the primary population with whom he works in accordance with the requirements set by the PRA. ~~(3-20-14)~~( )

iii. Credential required for ~~PSR~~ CBRS specialists ~~working primarily with adults~~. ~~(3-20-14)~~( )

(1) Applicants who intend to work primarily with adults, age eighteen (18) or older, must become a Certified Psychiatric Rehabilitation Practitioner in accordance with the PRA requirements. (3-20-14)

(2) Applicants who work primarily with adults, but also intend to work with participants under the age of eighteen (18), must have training addressing children's developmental milestones, or have evidence of classroom hours in equivalent courses. The worker's supervisor must determine the scope and amount of training the worker needs in order to work competently with children assigned to the worker's caseload. (3-20-14)

~~iv. Credential required for PSR specialists working primarily with children.~~ ~~(3-20-14)~~

(~~1~~3) Applicants who intend to work primarily with children under the age of eighteen (18) must obtain a certificate in children's psychiatric rehabilitation in accordance with the PRA requirements. (3-20-14)

(~~2~~4) Applicants who primarily work with children, but who also intend to work with participants eighteen (18) years of age or older, must have training or have evidence of classroom hours addressing adult issues in psychiatric rehabilitation. The worker's supervisor must determine the scope and amount of training the worker needs in order to competently work with adults assigned to the worker's caseload. (3-20-14)

~~v. An individual who is qualified to apply for licensure to the Idaho Bureau of Occupational Licenses, in any of the professions listed above in Subsections 855.10.a. through 855.10.i., who has failed his licensing exam or has been otherwise denied licensure is not eligible to provide services under the designation of PSR Specialist unless this individual has obtained one (1) of the PRA credentials.~~ ~~(3-20-14)~~

11. Speech/Audiological Therapy and Evaluation. Speech/audiological therapy and evaluation must be provided by or under the direction of a speech pathologist or audiologist who possesses a certificate of clinical competence from the American Speech, Language and Hearing Association (ASHA); or who will be eligible for certification within one (1) year of employment. Personnel records must reflect the expected date of certification. For therapy-specific rules, refer to Sections 730 through 739 of these rules. ~~(7-1-13)~~( )

12. Social History and Evaluation. Social history and evaluation must be provided by a registered nurse or licensed professional nurse (RN), psychologist, M.D, school psychologist, certified school social worker, or by a person who is licensed and qualified to provide social work in the state of Idaho. (7-1-13)

13. Transportation. Transportation must be provided by an individual who has a current Idaho driver's license and is covered under vehicle liability insurance that covers passengers for business use. (7-1-13)

14. Therapy Paraprofessionals. The schools may use paraprofessionals to provide occupational therapy, physical therapy, and speech therapy if they are under the supervision of the appropriate professional. The services provided by paraprofessionals must be delegated and supervised by a professional therapist as defined by the appropriate licensure and certification rules. The portions of the treatment plan that can be delegated to the paraprofessional must be identified in the IEP or transitional IFSP. ~~(7-1-13)~~( )

a. Occupational Therapy. Refer to IDAPA 24.06.01, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants," for qualifications, supervision, and service requirements. (7-1-13)

b. Physical Therapy. Refer to IDAPA 24.13.01, "Rules Governing the Physical Therapy Licensure Board," for qualifications, supervision and service requirements. (7-1-13)

c. Speech-Language Pathology. Refer to IDAPA 24.23.01, "Rule of the Speech and Hearing Services Licensure Board," and the American Speech-Language-Hearing Association (ASHA) guidelines for qualifications, supervision and service requirements for speech-language pathology. The guidelines have been incorporated by reference in Section 004 of these rules. (7-1-13)

(BREAK IN CONTINUITY OF SECTIONS)

857. SCHOOL-BASED SERVICE: QUALITY ASSURANCE AND IMPROVEMENT.
The provider will grant the Department immediate access to all information required to review compliance with these rules. ~~(3-30-07)~~( )

01. Quality Assurance. Quality Assurance consists of reviews to assure compliance with the Department's rules and regulations. If problems are identified during the review, the provider must implement a corrective action plan within forty-five (45) days after the results are received. The Department will work with the school to answer questions and provide clear direction regarding the corrective action plan. ( )

02. Quality Improvement. The Department may gather and utilize information from providers to evaluate student satisfaction, outcomes monitoring, quality assurance, quality improvement activities, and health and safety. These findings may lead to quality improvement activities to improve provider processes and outcomes for the students. ( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1502

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearings concerning this rulemaking will be held as follows:

Tuesday, October 13, 2015 9:00 a.m. & 1:00 p.m. (MDT)	Wednesday, October 14, 2015 1:00 p.m. (PDT)
Medicaid Central Office **3232 W. Elder Street** **Conference Room D -- West/East** **Boise, ID**	**Medicaid Region I Office** **1120 Ironwood Drive** **Large Conference Room** **Coeur d'Alene, ID**

The hearing sites will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The Department is moving towards outcome-based health care policy initiatives with the implementation of the legislative intent language passed by the 2015 Legislature. Current rules for primary care case management and for health homes are being revised to support the new health care policy initiatives.

The changes to these rules will provide for the services and provider reimbursement changes needed to support the new model of care for participants. Outdated language will be removed from these rules and other references needed to support the new model will be added.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking has no fiscal impact to the state general fund. This rulemaking is intended to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the June 3, 2015, Idaho Administrative Bulletin, **Vol. 15-6, pages 44**.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

CONTACT INFORMATION, WEB ADDRESS, ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cindy Brock at (208) 364-1983.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 28th Day of August, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720, Boise, ID 83720-0036
phone: (208) 334-5564; fax: (208) 334-6558
e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0309-1502
(Only Those Sections With Amendments Are Shown.)

210. CONDITIONS FOR PAYMENT.

01. Participant Eligibility. The Department will reimburse providers for medical care and services, regardless of the current eligibility status of the medical assistance participant in the month of payment, provided a complete and properly submitted claim for payment has been received and each of the following conditions are met: (3-20-14)

a. The participant was found eligible for medical assistance for the month, day, and year during which the medical care and services were rendered; (3-30-07)

b. The participant received such medical care and services no earlier than the third month before the month in which application was made on such participant's behalf; and (3-30-07)

c. The provider verified the participant's eligibility on the date the service was rendered and can provide proof of the eligibility verification. (3-20-14)

d. Not more than twelve (12) months have elapsed since the month of the latest participant services for which such payment is being made. Medicare cross-over claims are excluded from the twelve (12) month submittal limitation. (3-30-07)

02. Time Limits. The time limit set forth in Subsection 210.01.d. of this rule does not apply with respect to retroactive eligibility adjustment. When participant eligibility is determined retroactively, the Department will reimburse providers for services within the period of retroactive eligibility if a claim for those services is submitted within twelve (12) months of the date of the participant's eligibility determination. (3-20-14)

03. Acceptance of State Payment. By participating in the Medical Assistance Program, providers agree to accept, as payment in full, the amounts paid by the Department for services to Medicaid participants. Providers also agree to provide all materials and services without unlawfully discriminating on the grounds of race, age, sex, creed, color, national origin, or physical or intellectual disability. (3-30-07)

04. Payment in Full. If a provider accepts Medicaid payment for a covered service, the Medicaid payment must be accepted as full payment for that service, and the participant cannot be billed for the difference between the billed amount and the Medicaid allowed amount. (3-30-07)

05. Medical Care Provided Outside the State of Idaho. Out-of-state medical care is subject to the same utilization review and other Medicaid coverage requirements and restrictions as medical care received within the state of Idaho. (3-30-07)

06. Ordering, Prescribing, and Referring Providers. Any service or supply ordered, prescribed, or referred by a physician or other professional who is not an enrolled Medicaid provider will not be reimbursed by the Department. (3-20-14)

07. Referral From Participant's Assigned Primary Care Provider. Medicaid services may require a referral from the participant's assigned primary care provider. Services requiring a referral are listed in the Idaho Medicaid Provider Handbook. Services provided without a referral, when one is required, are not covered and are subject to sanctions, recoupment, or both. The Department may change the services that require a referral after appropriate notification of Medicaid-eligible individuals and providers as specified in Section 563 of these rules. ( )

08. Follow-up Communication with Assigned Primary Care Provider. Medicaid services may require timely follow-up communication with the participant's assigned primary care provider. Services requiring post-service communication with the primary care provider and time frames for that communication are listed in the Idaho Medicaid Provider Handbook. Services provided without timely communication of care outcomes, when communication is required, are not covered and are subject to sanctions, recoupment, or both. The Department may change the services that require communication of care outcomes after appropriate notification of Medicaid eligible individuals and providers as specified in section 563 of these rules. ( )

(BREAK IN CONTINUITY OF SECTIONS)

399. COVERED SERVICES UNDER BASIC PLAN BENEFITS.
Individuals who are eligible for Medicaid Basic Plan Benefits are eligible for the following benefits, subject to the coverage limitations contained in these rules. Those individuals eligible for services under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," are also eligible for the services covered under this chapter of rules, unless specifically exempted. (5-8-09)

01. Hospital Services. The range of hospital services covered is described in Sections 400 through 449 of these rules. (5-8-09)

a. Inpatient Hospital Services are described in Sections 400 through 406. (3-30-07)

b. Outpatient Hospital Services are described in Sections 410 through 416. (3-30-07)

c. Reconstructive Surgery services are described in Sections 420 through 426. (3-30-07)

d. Surgical procedures for weight loss are described in Sections 430 through 436. (3-30-07)

e. Investigational procedures or treatments are described in Sections 440 through 446. (3-30-07)

02. Ambulatory Surgical Centers. Ambulatory Surgical Center services are described in Sections 450 through 499 of these rules. (5-8-09)

03. Physician Services and Abortion Procedures. Physician services and abortion procedures are described in Sections 500 through 519 of these rules. (5-8-09)

a. Physician services are described in Sections 500 through 506. (3-30-07)

b. Abortion procedures are described in Sections 510 through 516. (3-30-07)

04. Other Practitioner Services. Other practitioner services are described in Sections 520 through 559 of these rules. (5-8-09)

a. Midlevel practitioner services are described in Sections 520 through 526. (3-30-07)

b. Chiropractic services are described in Sections 530 through 536. (3-30-07)

c. Podiatrist services are described in Sections 540 through 545. (3-29-12)

d. Licensed midwife (LM) services are described in Sections 546 through 552. (3-29-12)

e. Optometrist services are described in Sections 553 through 556. (3-29-12)

05. Primary Care Case Management. Primary care case management services are described in Sections 560 through 579 of these rules**.** (5-8-09)

a. Healthy Connections services are described in Sections 560 through 566. (4-4-13)

~~***b.*** *Health Home services are described in Sections 570 through 576.* *(4-4-13)*~~

06. Prevention Services. The range of prevention services covered is described in Sections 580 through 649 of these rules. (4-4-13)

a. Child Wellness Services are described in Sections 580 through 586. (3-30-07)

b. Adult Physical Services are described in Sections 590 through 596. (3-30-07)

c. Screening mammography services are described in Sections 600 through 606. (3-30-07)

d. Diagnostic Screening Clinic services are described in Sections 610 through 614. (4-4-13)

e. Additional Assessment and Evaluation services are described in Section 615. (4-4-13)

f. Health Questionnaire Assessment is described in Section 618. (4-4-13)

g. Preventive Health Assistance benefits are described in Sections 620 through 626. (5-8-09)

h. Nutritional services are described in Sections 630 through 636. (3-30-07)

i. Diabetes Education and Training services are described in Sections 640 through 646. (3-30-07)

07. Laboratory and Radiology Services. Laboratory and radiology services are described in Sections 650 through 659 of these rules. (5-8-09)

08. Prescription Drugs. Prescription drug services are described in Sections 660 through 679 of these rules. (5-8-09)

09. Family Planning. Family planning services are described in Sections 680 through 689 of these rules. (5-8-09)

10. Outpatient Behavioral Health Services. Community-based outpatient services for behavioral health treatment are described in Sections 707 through 711 of these rules. (3-20-14)

11. Inpatient Psychiatric Hospital Services. Inpatient Psychiatric Hospital services are described in Sections 700 through 706. (3-20-14)

12. Home Health Services. Home health services are described in Sections 720 through 729 of these rules. (5-8-09)

13. Therapy Services. Occupational therapy, physical therapy, and speech-language pathology services are described in Sections 730 through 739 of these rules. (5-8-09)

14. Audiology Services. Audiology services are described in Sections 740 through 749 of these rules. (5-8-09)

15. Durable Medical Equipment and Supplies. The range of covered durable medical equipment and

supplies is described in Sections 750 through 779 of these rules. (5-8-09)

a. Durable Medical Equipment and supplies are described in Sections 750 through 756. (3-30-07)

b. Oxygen and related equipment and supplies are described in Sections 760 through 766. (3-30-07)

c. Prosthetic and orthotic services are described in Sections 770 through 776. (3-30-07)

16. Vision Services. Vision services are described in Sections 780 through 789 of these rules. (5-8-09)

17. Dental Services. The dental services covered under the Basic Plan are covered under a selective contract as described in Section 800 through 819 of these rules. (3-29-12)

18. Essential Providers. The range of covered essential services is described in Sections 820 through 859 of these rules. (5-8-09)

a. Rural health clinic services are described in Sections 820 through 826. (3-30-07)

b. Federally Qualified Health Center services are described in Sections 830 through 836. (3-30-07)

c. Indian Health Services Clinic services are described in Sections 840 through 846. (3-30-07)

d. School-Based services are described in Sections 850 through 857. (3-20-14)

19. Transportation. The range of covered transportation services is described in Sections 860 through 879 of these rules. (5-8-09)

a. Emergency transportation services are described in Sections 860 through 866. (3-30-07)

b. Non-emergency medical transportation services are described in Sections 870 through 876. (4-4-13)

20. EPSDT Services. EPSDT services are described in Sections 880 through 889 of these rules. (5-8-09)

21. Specific Pregnancy-Related Services. Specific pregnancy-related services are described in Sections 890 through 899 of these rules. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

413. OUTPATIENT HOSPITAL SERVICES: PROCEDURAL REQUIREMENTS.

01. Review Prior to Delivery of Outpatient Services. Failure to obtain a timely review from the Department or its quality improvement organization (QIO) prior to delivery of outpatient services, listed on the select procedure and diagnosis list in the QIO Idaho Medicaid Providers Manual and the Hospital Provider Handbook, as amended, for participants who are eligible at the time of service, will result in a retrospective review. The Department will assess a late review penalty, as outlined in Subsection 405.05 of these rules, when a review is conducted due to an untimely request. (4-4-13)

02. Follow-Up for Emergency Room Patients ~~***with Chronic Conditions***~~. Hospitals must establish procedures to refer Medicaid participants ~~*with targeted chronic diseases defined in Section 560 of these rules*~~ who are not enrolled in Healthy Connections to an Idaho Medicaid Healthy ~~*Home*~~ Connections provider, if one is available within a reasonable distance of the participant's residence. Hospitals must coordinate care of patients who already have a Healthy ~~*Home*~~ Connections provider with that PCP. ~~*(4-4-13)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

500. PHYSICIAN SERVICES: DEFINITIONS.

01. Physician Services. Physician services include the treatment of medical and surgical conditions by doctors of medicine or osteopathy subject to the limitations of practice imposed by state law, and to the restrictions and exclusions of coverage contained in Section 390 and Subsection 502.01 of these rules. Physician services as defined in Subsection 500.01 of this rule will be reimbursed by the Department. (5-8-09)

02. ~~*Psychiatric*~~ Telehealth. ~~*Psychiatric*~~ Telehealth ~~*is an electronic real time synchronous audio-visual contact between a physician and participant related to the treatment of the participant. The participant is in one (1) location, called the hub site, with specialized equipment including a video camera and monitor, and with the hosting provider. The physician is at another location, called the spoke site, with specialized equipment. The physician and participant interact as if they were having a face-to-face service. This rule does not apply to outpatient behavioral health services provided through the Idaho Behavioral Health Plan (IBHP) that are delivered via telehealth methods*~~ as defined in Title 54, Chapter 57, Idaho Code. ~~*(3-20-14)*~~( )

501. (RESERVED)

502. PHYSICIAN SERVICES: COVERAGE AND LIMITATIONS.

01. Outpatient Psychiatric Mental Health Services. Physician services not provided through the IBHP as outpatient psychiatric mental health services are limited to twelve (12) hours of psychiatric evaluations per eligible participant in any twelve (12) month period; and any combination of individual or group psychotherapy services provided by a physician up to a maximum of forty-five (45) hours of service in the consecutive twelve (12) months period beginning with the first such service. (3-20-14)

02. Sterilization Procedures. Particular restrictions pertaining to payment for sterilization procedures are contained in Sections 680 through 686 of these rules. (3-30-07)

03. Abortions. Restrictions governing payment for abortions are contained in Sections 511 through 514 of these rules. (3-30-07)

04. Tonometry. Payment for tonometry is limited to one (1) examination for individuals over the age of forty (40) years during any twelve (12) month period (in addition to tonometry as a component of examination to determine visual acuity). In the event examination to determine visual acuity is not done, two (2) tonometry examinations per twelve (12) month period are allowed participants over the age of forty (40). This limitation does not apply to participants receiving continuing treatment for glaucoma. (3-30-07)

05. Physical Therapy Services. Payment for physical therapy services performed in the physician's office is limited to those services which are described and supported by the diagnosis. (3-30-07)

06. Injectable Vitamins. Payment for allowable injectable vitamins will be allowed when supported by the diagnosis. Injectable vitamin therapy is limited to Vitamin B12 (and analogues), Vitamin K (and analogues), folic acid, and mixtures consisting of Vitamin B12, folic acid, and iron salts in any combination. (3-30-07)

07. Corneal Transplants and Kidney Transplants. Corneal transplants and kidney transplants are covered by the Medical Assistance Program. (3-30-07)

08. ~~*Psychiatric*~~ Telehealth. ~~*Payment for psychiatric*~~ Synchronous interaction telehealth ~~*services not provided through the IBHP is limited to psychiatric services for diagnostic assessments, pharmacological management, and psychotherapy with evaluation and management services twenty (20) to thirty (30) minutes in duration. Reimbursement is not available for a telephone conversation, electronic mail message (e-mail), or facsimile transmission (fax) between a physician and a participant. Service will not be reimbursed when provided via a videophone or webcam.*~~ encounters, delivered as defined in Title 54, Chapter 57, Idaho Code, are reimbursable as follows: ~~*(3-20-14)*~~( )

a. Physician services delivered via telehealth are subject to primary care provider communication requirements in Section 210 of these rules. The Department will define limitations for telehealth in the Idaho Medicaid Provider Handbook to promote quality services and program integrity. ( )

b. Fee for service reimbursement is not available for a telephone conversation, electronic mail message (e-mail), or facsimile transmission (fax) between a physician and a participant. ( )

(BREAK IN CONTINUITY OF SECTIONS)

560. HEALTHY CONNECTIONS ~~*AND IDAHO MEDICAID HEALTH HOME*~~: DEFINITIONS.
Healthy Connections is a primary care case management program in which a primary care provider or team provides comprehensive medical care for participants with the goal of improving health outcomes. For purposes of this Sub Area that includes Sections 560 through 5~~79~~66 of these rules, the following terms and definitions apply:
~~*(4-4-13)*~~( )

~~***01. Best Practices Protocol**. A regimen of proven, effective and evidence-based practices. (4-2-08)*~~

~~***02. Care Plan**. A patient specific document that identifies health care orders for the patient and serves as a guide to care. It can either be written for an individual patient or be retrieved from a computer and individualized. (4-4-13)*~~

~~***03. Chronic Disease Management**. The process of applying best practices protocol to manage a chronic disease in order to produce the best health outcomes for a participant with the targeted chronic disease. (4-2-08)*~~

01. Capitated Payments. Payments to a primary care provider made on a per assigned participant per month basis for patient services. Capitated payments will vary to reflect the level of responsibility for services the provider elects to provide as described in Section 564 of these rules. Capitated payments may include payment for all provider services at a set rate per participant per month when that type of full-risk reimbursement is agreed to by the provider and the Department. ( )

0~~4~~2. Clinic. Two (2) or more qualified medical professionals who provide services jointly through an organization for which an individual is given authority to act on its behalf. It also includes Federally Qualified Health Centers (FQHCs), Certified Rural Health Clinics, and Indian Health Clinics. (3-30-07)

~~***05. Covered Services**. Those medical services and supplies for which reimbursement is available under the State Plan. (3-30-07)*~~

0~~6~~3. Grievance. The formal process by which problems and complaints related to Healthy Connections are addressed and resolved. Grievance decisions may be appealed as provided herein. (3-30-07)

~~***07. Health Home**. A primary care provider organization contracted with Medicaid to lead a team approach for chronic disease management. The Health Home provides comprehensive patient centered care management and health promotion services to patients with chronic conditions in accordance with the requirements described in section 560 through 579 of these rules and Section 1945 of the Social Security Act. (4-4-13)*~~

~~***08. Health Information Technology**. Electronic tools utilized to securely exchange or manage health information between two or more entities. (4-4-13)*~~

~~***09. Healthy Connections**. The provision of health care services through a single point of entry for the purposes of managing participant care with an emphasis on preventative and primary care and reducing inappropriate utilization of services and resulting costs. This is sometimes referred to as managed care. Healthy Connections is a primary care case management model. (4-2-08)*~~

~~***10. Individual or Family Supports**. Community based social supports or recovery services available to*~~

~~assist individuals or families in need.~~ ~~(4-4-13)~~

~~**11. National Committee for Quality Assurance (NCQA).** Accrediting organization which develops health care performance measurements and provides certifications of quality to health care providers.~~ ~~(4-4-13)~~

04. Patient-Centered Medical Home. A model of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. This results in primary care being delivered at the right place, at the right time, and in the manner that best suits a patient's needs. ( )

~~12~~**05. Preventive Care**. Medical care that focuses on disease prevention and health maintenance. (4-4-13)

~~13~~**06. Primary Care Case Management**. ~~The process~~ A model of care in which ~~a~~ primary care providers ~~is~~ and their primary care team are responsible for direct care of a participant, and for coordinating ~~and controlling~~ access to ~~or initiating and/or supervising other health care~~ services ~~needed by the participant~~ that improve the health of the participant. ~~(4-2-08)~~( )

~~14~~**07. Primary Care Provider (PCP)**. A ~~qualified medical professional~~ physician, physician assistant, or advanced practice nurse practitioner who contracts with Medicaid to coordinate and manage the care of ~~certain~~ participants enrolled in the Healthy Connections program. ~~(4-4-13)~~( )

08. Primary Care Team. A multidisciplinary team of health care providers who work together to meet the physical, emotional, and psychological needs of their patients using a patient-centered and coordinated approach. ( )

~~**15. Qualified Medical Professional.** A duly licensed physician in the following specialties: Pediatrics, Internal Medicine, Family Practice, General Practice, General Surgery, Obstetrics/Gynecology, or a physician in any other specialty who chooses to assume the function of primary care case management. It also includes nurse practitioners, and physician assistants. Licenses must be held in the state(s) where services are being rendered.~~ ~~(3-30-07)~~

~~**16. Quality Improvement Program**. A program of organized, ongoing, and systematic efforts to improve and assess the quality of care within a primary care provider practice or organization.~~ ~~(4-4-13)~~

~~**17. Quality Measures**. A measure of health care performance based on specified dimensions of care and service.~~ ~~(4-4-13)~~

~~18~~**09. Referral**. A documented communication from a participant's primary care provider (PCP) to another Medicaid provider authorizing specific covered services subject to primary care case management that are not provided by the participant's PCP. (4-4-13)

~~**19. Risk Factor.** A characteristic, condition, or behavior that increases the possibility of disease or injury.~~ ~~(4-4-13)~~

~~**20. Targeted Chronic Disease**. A disease identified by the Department for management under the Idaho Medicaid Health Home program. Specific conditions are identified in the Medicaid Provider Handbook available at www.idmedicaid.com.~~ ~~(4-4-13)~~

~~2~~**10. Transitional Care**. ~~The care or services provided by a health care provider~~ A set of actions designed to ensure the coordination and continuity of health care ~~of the~~ as patients ~~as they move~~ transfer between ~~health~~ different locations or different levels of care ~~settings or between healthcare providers~~ within the same location. ~~(4-4-13)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

562. HEALTHY CONNECTIONS: ~~COVERAGE AND LIMITATIONS~~ PRIMARY CARE SERVICES.

01. ~~Exempted~~ Eligible Services. ~~All services are subject to primary care case management unless specifically exempted. The following services are exempt~~ Participants enrolled with a primary care provider (PCP) are eligible to receive: ~~(3-30-07)~~( )

a. ~~Family planning services~~ Basic care management and care coordination; ~~(3-30-07)~~( )

b. ~~Treatment for emergency medical conditions defined in Subsection 010.23 of these rules~~ Timely access to routine primary care; ~~and~~ ~~(4-4-13)~~( )

c. ~~Hospital admissions subsequent to an emergency room visit provided that the patient's discharge is coordinated with a PCP~~ A patient-centered health care decision making process; ~~(4-4-13)~~( )

d. ~~Dental care~~ Twenty-four (24) hour, seven (7) days per week access to an on-call medical professional; and ~~(4-2-08)~~( )

e. ~~Podiatry (performed in the office);~~ Referral to other medically necessary services as specified in Section 210 of these rules, based on the clinical judgement of their primary care provider. ~~(3-30-07)~~( )

~~**f.** Audiology (hearing tests or screening, does not include ear/nose/throat services); (3-30-07)~~

~~**g.** Optical/Ophthalmology/Optometrist services (performed in the office); (3-30-07)~~

~~**h.** Chiropractic (performed in the office); (3-30-07)~~

~~**i.** Pharmacy (prescription drugs only); (3-30-07)~~

~~**j.** Nursing home; (3-30-07)~~

~~**k.** ICF/ID services; (3-30-07)~~

~~**l.** Immunizations (not requiring an office visit); (4-2-08)~~

~~**m.** Flu shots and/or pneumococcal vaccine (not requiring an office visit); (3-30-07)~~

~~**n.** Diagnosis and/or treatment for sexually transmitted diseases; (3-30-07)~~

~~**o.** One screening mammography per calendar year for women age forty (40) or older; (3-30-07)~~

~~**p.** Indian Health Clinic/638 Clinic services provided to individuals eligible for Indian Health Services; (4-2-08)~~

~~**q.** In home services, known as Personal Care Services and Personal Care Services Case Management; (4-2-08)~~

~~**r.** Laboratory services, including pathology; (4-2-08)~~

~~**s.** Anesthesiology services; (3-29-12)~~

~~**t.** Radiology services; (4-4-13)~~

~~**u.** Services rendered at an Urgent Care Clinic when the participant's PCP's office is closed; (4-4-13)~~

~~**v.** School-based services; (4-4-13)~~

~~**w.** Services managed directly by the Department, as defined in the provider handbook for those~~

~~*services at www.idmedicaid.com; and*~~ ~~*(4-4-13)*~~

~~***x.*** *Pregnancy related services provided by an obstetrician or gynecologist not enrolled as a Healthy Connections provider.*~~ ~~*(4-4-13)*~~

02. Change in ~~*Services That Require a Referral*~~ Primary Care Provider. ~~*The Department may change the services that require a referral after appropriate notification of Medicaid eligible individuals and providers.*~~ Participants may change their primary care provider at any time by contacting Healthy Connections staff. ~~*(3-30-07)*~~( )

563. HEALTHY CONNECTIONS: PROCEDURAL REQUIREMENTS.

01. ~~*Primary Care Case Management*~~. ~~*Under the Healthy Connections model of managed care, each participant obtains medical services through a PCP. This provider either provides the needed service, or makes a referral for needed services. This management function neither reduces nor expands the scope of covered services.*~~ **Changes to Requirements**. The Department will provide sixty (60) day notice of any substantive and significant changes to requirements for referrals, primary care provider reimbursement, as specified in Section 565 of these rules, or provider duties on its website and provider portal. The Department will provide a method to allow providers to provide input and comment on proposed changes. ~~*(4-2-08)*~~( )

~~***a.*** *Referrals. The primary care provider is responsible for making all reasonable efforts to monitor and manage the participant's care, providing primary care services, and making referrals for services when medically necessary. All services not specifically exempted in Section 562 of these rules require receipt of a referral prior to delivery of services. Services that require a referral, but are provided without a referral are not covered. All referrals must be documented in the participant's patient record.*~~ ~~*(4-4-13)*~~

~~***b.*** *Changing PCP. If a participant is dissatisfied with his PCP, he may change providers by contacting his designated Healthy Connections Representative at least ten (10) days prior to the end of the month. The change is effective the first day of the following month. This advance notice requirement may be waived by the Department.*~~ ~~*(4-4-13)*~~

~~***c.*** *Changing Service Areas. A participant who moves from the area where he is enrolled must contact his designated Healthy Connections Representative to disenroll from his current PCP and enroll with a new PCP in the area where moving. Enrollment with the new PCP is effective the first day of the month following the request.*~~ ~~*(4-4-13)*~~

02. Problem Resolution. (3-30-07)

a. To help assure the success of Healthy Connections, the Department provides a mechanism for timely and personal attention to problems and complaints related to the program. (4-4-13)

b. To facilitate problem resolution, the Department will have a designated representative who will receive and attempt to resolve all complaints and problems related to the program and function as a liaison between participants and providers. It is anticipated that most problems and complaints will be resolved informally at this level. (4-4-13)

c. A participant or a provider may register a complaint or notify the Department of a problem related to Healthy Connections either in writing, electronically, or by telephone to the designated representative. The designated representative will attempt to resolve conflicts and disputes whenever possible and refer the complainant to alternative forums where appropriate. (4-4-13)

d. If a participant or provider is not satisfied with the resolution of a problem or complaint addressed by the designated representative, he may file a formal grievance in writing to the representative. The manager of the managed care program may, where appropriate, refer the matter to a review committee designated by the Department to address issues such as quality of care or medical necessity. However, such decisions are not binding on the Department. The Department will respond in writing to grievances within thirty (30) days of receipt. (4-4-13)

e. Decisions in response to grievances may be appealed. Appeals are governed by the requirements of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings," and must be filed according to the provisions of that chapter. (4-4-13)

564. HEALTHY CONNECTIONS: PROVIDER QUALIFICATIONS AND DUTIES.

01. ~~Provider Participation Qualifications~~. ~~Primary care case management services may be provided by qualified medical professionals, licensed to practice in the state where services are being rendered.~~ **Primary Care Providers**. Primary care services may be provided by enrolled physicians, physician assistants, advanced practice nurse practitioners, and by care teams under those providers' direction. ~~(3-30-07)~~( )

02. Provider Duties. All Healthy Connections providers are responsible for delivering the services listed in Section 562 of these rules. ( )

03. Additional Services. Healthy Connections providers may also elect to provide specific additional sets of patient-centered medical home services in exchange for increased reimbursement as described in Section 565 of these rules. The definition and provision of additional patient-centered medical home services are subject to specific requirements as defined by the Department and described in the Idaho Medicaid Provider Handbook and individual provider agreements with the Department. Additional services may include: ( )

a. Connection to the Idaho Health Data Exchange; ( )

b. Maintaining third-party patient-centered medical home recognition or certification; ( )

c. Expanded patient access to services; ( )

d. Provision of an evidence-based primary care service model that enables improved patient health outcomes; ( )

e. Reporting clinical data to the Department to allow for assessment of provider abilities and impact of their services on patient health outcomes; ( )

f. Coordination of transitions of care between health care settings; ( )

g. Integration of behavioral health services; and ( )

h. Other indicators of improved patient health outcomes associated with primary care provider abilities. ( )

0~~2~~4. Provider Participation Conditions and Restrictions. (3-30-07)

~~**a.** Quality of Services. Each provider must:~~ ~~(4-4-13)~~

~~i. Maintain and provide services in accordance with community standards of care;~~ ~~(4-4-13)~~

~~ii. Exercise his best efforts to effectively control utilization of services; and~~ ~~(4-4-13)~~

~~iii. Provide twenty-four (24) hour coverage by telephone to assure participant access to services.~~ ~~(4-4-13)~~

~~**b**~~**a.** Provider Agreements. Each independent provider or provider organization participating in primary care case management must: (4-4-13)

i. Sign an agreement; (4-4-13)

ii. Enroll with the Department all primary care providers and all clinic locations participating in the Healthy Connections program; and (4-4-13)

iii. ~~*Sign an addendum to the primary care case management provider agreement when participating in the Idaho Medicaid Health Home program*~~ Complete pre-enrollment requirements for participation in the Healthy Connections program as defined by the Department in the Idaho Medicaid Provider Handbook. ~~*(4-4-13)*~~( )

~~*e*~~**b.** Patient Limits. A provider may limit the number of participants he manages. Subject to this limit, the provider must accept all participants who either elect or are assigned to the provider, unless disenrolled in accordance with Subsection 564.02.d. of this rule. A provider may change the participant limit effective the first day of any month. The provider must make the request in writing to the Department thirty (30) days prior to the effective date of the change. ~~*This advance notice requirement maybe waived by the Department.*~~ ~~*(4-4-13)*~~( )

~~*d*~~**c.** Disenrollment. When the provider-patient relationship breaks down due to failure of the participant to follow the care plan or for other reasons, a provider may choose to withdraw as the participant's primary care provider effective the first day of any month. The PCP must notify in writing, both the participant and the Department thirty (30) days prior to the date of withdrawal. This advance notice requirement may be waived by the Department. (4-4-13)

~~*e*~~**d.** Record Retention. Each provider must: (4-4-13)

i. Retain patient and financial records and provide the Department access to those records for a minimum of six (6) years from the date of service; (4-4-13)

ii. Upon the reassignment of a participant to another PCP, the provider must transfer (if a request is made) a copy of the patient's medical record to the new PCP; and (4-4-13)

iii. Disclose information required by Subsection 205.01 of these rules, when applicable. (4-4-13)

~~*f*~~**e.** Termination or Amendment of Provider Agreements. The Department may terminate a provider's agreement as provided in Subsection 205.03 of these rules. An agreement may be amended for the same reasons. (3-30-07)

565. HEALTHY CONNECTIONS: PROVIDER REIMBURSEMENT.

~~***01. Case Management Fee.*** *Reimbursement is as follows:* ***(4-2-08)***~~

~~***a.*** *A PCP is paid a case management fee for primary care case management services based on the level of each participant's health care needs.* ***(4-4-13)***~~

~~***b.*** *A PCP enrolled in the Idaho Medicaid Health Home program is paid a chronic disease case management fee.* ***(4-4-13)***~~

~~***c.*** *The amount of the fee is determined by the Department.* ***(4-4-13)***~~

~~***d.*** *The amount of the fee is fixed and the same for all participating PCPs.* ***(4-2-08)***~~

01. Capitated Payments. Healthy Connections providers are compensated for their patient care services on a per participant per month basis. ( )

~~***02. Primary Care Case Management Reimbursement is based on:*** ***(3-29-12)***~~

~~***a.*** *The number of participants enrolled with the provider on the first day of each month multiplied by the amount of the case management fee established for participants enrolled in the Basic Plan Benefit package;* ***(4-4-13)***~~

~~***b.*** *The number of participants enrolled with the provider on the first day of each month, multiplied by the amount of the case management fee established for participants enrolled in the Enhanced Plan Benefit package; and* ***(4-4-13)***~~

~~c. An incentive payment is added per participant to the primary care case management fee in Subsection 565.01.a. of this rule when the PCP offers extended hours of service in one (1) of the following ways:~~ ~~(4-4-13)~~

~~i. The number of hours the PCP's office is available for delivery of service to participants equals or exceeds forty-six (46) hours per week. The extended hours must be verified by and on file with the Department prior to an increase to the monthly case management fee; or~~ ~~(4-4-13)~~

~~ii. The PCP has electronic health records available and accessible for delivery of services at a nearby service location that is within the same Healthy Connections provider organization and makes services available to the participant at least forty-six (46) hours per week. The alternate location and extended hours must be verified by and on file with the Department prior to an increase to the monthly case management fee.~~ ~~(4-4-13)~~

~~d. The number of participants enrolled with an Idaho Medicaid Health Home provider on the first day of the month for services described in Section 572 these rules, multiplied by the case management fee established per participant enrolled in that program.~~ ~~(4-4-13)~~

02. Capitated Payment Amounts. Capitated payment amounts are determined by the Department and reflect the complexity of the patient's health combined with the provider's ability to impact patient health outcomes. This monthly payment to a provider is based on the number of participants assigned to the provider on the first day of each month. ( )

(BREAK IN CONTINUITY OF SECTIONS)

~~**567. -- 569. (RESERVED)**~~

~~**SUB AREA: PREVENTION SERVICES**~~
~~**(Sections 570 -- 649)**~~

~~**570. IDAHO MEDICAID HEALTH HOME: DEFINITIONS.**~~
~~For purposes of the Idaho Medicaid Health Home program, the terms and definitions in Section 560 of these rules apply.~~ ~~(4-4-13)~~

~~**571. IDAHO MEDICAID HEALTH HOME: PARTICIPANT ELIGIBILITY.**~~

~~**01. Eligibility**. A Medicaid participant diagnosed with two (2) targeted chronic diseases, or one (1) targeted chronic disease and one (1) or more risk factors is eligible for enrollment in the Idaho Medicaid Health Home program.~~ ~~(4-4-13)~~

~~**02. Eligibility Determination**. A participant who meets the diagnostic criteria for health home eligibility is identified by the PCP to the Department. The Department will utilize claims data and other documentation as needed to verify the participant is eligible for Idaho Medicaid Health Home services.~~ ~~(4-4-13)~~

~~**572. IDAHO MEDICAID HEALTH HOME: COVERAGE AND LIMITATIONS.**~~
~~The following services are covered for an eligible participant assigned to a Health Home provider:~~ ~~(4-4-13)~~

~~**01. Comprehensive Care Management**. A Health Home provider must develop and implement a patient-centered care plan based on an individual's health risk assessment. The care plan must describe how the Health Home provider will coordinate clinical care with other providers as well as non-clinical health care related needs and services.~~ ~~(4-4-13)~~

~~**02. Care Coordination and Health Promotion**. A Health Home provider must:~~ ~~(4-4-13)~~

~~a. Coordinate the participant's care by sharing clinical information relevant to patient care with other~~

providers; (4-4-13)

b. Provide educational information and information about health care resources to the participant; (4-4-13)

c. Have ongoing communication with the participant to encourage compliance with prescribed treatment; and (4-4-13)

d. Provide other activities necessary to facilitate improved health outcomes for the participant. (4-4-13)

03. **Comprehensive Transitional Care**. A Health Home provider must: (4-4-13)

a. Receive relevant medical information from and share relevant medical information with emergency rooms and inpatient facilities to foster a coordinated approach to preventing avoidable readmissions; and (4-4-13)

b. Review and update care plans after unplanned admissions to adjust care coordination and management activities to address identifiable causes for the admission. (4-4-13)

04. **Individual, Family, Community, and Social Support Services**. A Health Home provider must: (4-4-13)

a. Coordinate care in a manner that effectively utilizes available individual and family supports to improve and maintain the health of the participant; and (4-4-13)

b. Provide information on available community and social support services that aid in promoting healthy behaviors and reducing physical and mental health risk factors. (4-4-13)

573. IDAHO MEDICAID HEALTH HOME: PROCEDURAL REQUIREMENTS.

01. **Provider Agreement**. A Health Home provider must sign an addendum to the primary care case management provider agreement which identifies the location of the Health Home and other requirements necessary to meet the Health Home service requirements in these rules. (4-4-13)

02. **Data Reporting**. Health Home providers must report data to the Department on a periodic basis in keeping with schedules outlined in the provider handbook and the terms of the Health Homes provider agreement. (4-4-13)

03. **Quality Improvement Program**. A provider must establish a continuous quality improvement program directed towards improving care for patients with chronic conditions. (4-4-13)

574. IDAHO MEDICAID HEALTH HOME: PROVIDER QUALIFICATIONS AND DUTIES.

01. **Provider Infrastructure and Health Home Assessment**. A prospective Health Home provider must complete a Health Home practice assessment in cooperation with the Department to determine the ability of the provider to provide the required services in keeping with a patient-centered medical home model. This assessment must demonstrate that the provider; (4-4-13)

a. Has identified the qualified medical and mental health professionals and other resources available to provide Health Home services; (4-4-13)

b. Has the ability to utilize health information technology to coordinate and facilitate communication of health information and to link to services; (4-4-13)

c. Is able to submit clinical and practice transformation data within six (6) months of the date the provider agreement is signed; and (4-4-13)

~~d. Has a chronic disease patient registry in place within three (3) months of the date the provider agreement is signed. (4-4-13)~~

~~02. Qualifications. An Idaho Medicaid Health Home provider must: (4-4-13)~~

~~a. Possess a current NCQA patient-centered medical home level one (1) recognition, or demonstrate that the provider is actively pursuing that recognition. A provider that does not achieve this NCQA recognition within two (2) years of the initiation date of their Idaho Medicaid Health Home provider agreement will be terminated as a Health Home provider for non-compliance with the provider agreement; (4-4-13)~~

~~b. Be enrolled as a Healthy Connections primary care provider (PCP); (4-4-13)~~

~~c. Sign an addendum to their primary care provider agreement which identifies the location of the enrolled site and indicates reporting schedule and quality measurement requirements;. (4-4-13)~~

~~d. Have qualified medical professionals, licensed to practice in the state where services are being rendered; and (4-4-13)~~

~~e. Maintain office hours that allow enhanced access to care as described in Section 565.02 of these rules. (4-4-13)~~

~~03. Provider Duties. A Health Home provider must provide or coordinate the following elements of Health Home services: (4-4-13)~~

~~a. Care Plan. Develop a patient-centered care plan for each participant that coordinates and integrates both clinical and non-clinical health care related needs and services; (4-4-13)~~

~~b. Chronic Disease Management. Provide access to chronic disease management, including self-management support to the participant and the participant's family; (4-4-13)~~

~~c. Individual, Family, and Community Supports. Facilitate access to individual, family, and community supports outlined in the provider's agreement. (4-4-13)~~

~~d. Mental Health & Substance Abuse Services. Facilitate access to mental health and substance abuse services. (4-4-13)~~

~~e. Preventive Care. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance abuse disorders. (4-4-13)~~

~~f. Quality Improvement Program. Establish a continuous quality improvement program and report on quality improvement measures outlined in the provider agreement and the provider handbook. (4-4-13)~~

~~g. Quality of Services. Maintain and provide quality services for each Home Health participant. (4-4-13)~~

~~h. Transitional Care. Coordinate and provide access to comprehensive care management and transitional care from and to inpatient settings and from a pediatric to an adult system of health care. (4-4-13)~~

~~575. (RESERVED)~~

~~576. IDAHO MEDICAID HEALTH HOME: QUALITY ASSURANCE.~~
~~The Department will establish performance measurements to evaluate the effectiveness of the Idaho Medicaid Health Home program through the collection and reporting of quality measures as specified in Section 1945 of the Social Security Act. (4-4-13)~~

5~~7~~6. -- 579. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1501

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearings concerning this rulemaking will be held as follows:

Monday, October 19, 2015 10:00 a.m. (MDT)	Monday, October 19, 2015 2:00 p.m. (MDT)	Tuesday, October 20, 2015 1:30 p.m. (PDT)
Medicaid Central Office **3232 W. Elder Street** **Conference Room D -- West/East** **Boise, ID**	**Medicaid Region VII Office** **150 Shoup Ave., Suite 20** **Large Conference Room** **Idaho Falls, ID**	**Medicaid Region II Office** **1118 "F" Street** **2nd Floor Conference Room** **Coeur d'Alene, ID**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

These rule changes are needed to align with and implement new requirements in federal regulations that went into effect March 17, 2014, for Idaho's Home and Community Based Services (HCBS) offered through the State Plan, and under the authority of the HCBS 1915(c) waiver and the 1915(i) State Plan Option. The purpose of the regulations is to enhance participants' opportunity to receive services in the most integrated settings appropriate, and to increase their opportunities for choice and access to the benefits of community living.

New rules pertaining to Home and Community Based Services are being added to this chapter to ensure that participants receiving HCBS live in and receive services in settings that comply with required qualities of settings, service delivery methods, and person-centered planning processes.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking has no fiscal impact to the state general fund. This rulemaking is intended to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the June 3, 2015, Idaho Administrative Bulletin, **Vol. 15-6, pages 45-46**.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

CONTACT INFORMATION, WEB ADDRESS, ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Stephanie Perry at (208) 364-1878.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 31st Day of August, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5564; fax: (208) 334-6558
e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0310-1501
(Only Those Sections With Amendments Are Shown.)

011. DEFINITIONS: E THROUGH K.
For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. Educational Services. Services which are provided in buildings, rooms or areas designated or used as a school or as educational facilities; which are provided during the specific hours and time periods in which the educational instruction takes place in the normal school day and period of time for these students; and which are included in the individual educational plan for the participant or required by federal and state educational statutes or regulations; are not related services**;** and such services are provided to school age individuals as defined in Section 33-201, Idaho Code. (3-19-07)

02. Eligibility Rules. IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." (3-19-07)

03. Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (3-19-07)

a. Placing the health of the individual, or, with respect to a pregnant woman, the health of the woman or unborn child, in serious jeopardy. (3-19-07)

b. Serious impairment to bodily functions. (3-19-07)

c. Serious dysfunction of any bodily organ or part. (3-19-07)

04. Enhanced Plan. The medical assistance benefits included under this chapter of rules. (3-19-07)

05. EPSDT. Early and Periodic Screening Diagnosis and Treatment. (3-19-07)

06. Equity. The net book value of all tangible and intangible assets less the recorded value of all liabilities, as recognized and measured in conformity with generally accepted accounting principles. (3-19-07)

07. Facility. Facility refers to a hospital, nursing facility, or an intermediate care facility for persons with intellectual disabilities. (3-19-07)

a. "Free-standing and Urban Hospital-based Behavioral Care Unit" means the same as Subsection 011.07.b. or 011.07.h. of this rule, and qualifies as a behavioral care unit nursing facility provider described in

Section 266 of these rules. (4-4-13)

b. "Free-standing Nursing Facility" means a nursing facility that is not owned, managed, or operated by, nor is otherwise a part of a licensed hospital. (3-19-07)

c. "Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID)" means an entity as defined in Subsection 011.30 in this rule. (4-4-13)

d. "Nursing Facility (NF)" means a facility licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare patients. (3-19-07)

e. "Rural Hospital-based Provider" means a hospital-based nursing facility not located within a metropolitan statistical area (MSA) as defined by the United States Bureau of the Census. (4-4-13)

f. "Rural Hospital-based Behavioral Care Unit" means the same as Subsection 011.07.e., and qualifies as a behavioral care unit nursing facility provider described in Section 266 of these rules. (4-4-13)

g. Skilled Nursing Facility" means a nursing facility licensed by the Department to provide twenty-four (24) hour skilled nursing services and federally certified as a "Nursing Facility" under Title XVIII. (3-19-07)

h. "Urban Hospital-based Nursing Facility" means a hospital-based nursing facility located within a metropolitan statistical area (MSA) as defined by the United States Bureau of the Census. (4-4-13)

08. Fiscal Intermediary Agency. An entity that provides services that allow the participant receiving personal assistance services, or his designee or legal representative, to choose the level of control he will assume in recruiting, selecting, managing, training, and dismissing his personal assistant regardless of who the employer of record is, and allows the participant control over the manner in which services are delivered. (5-8-09)

09. Fiscal Year. An accounting period that consists of twelve (12) consecutive months. (3-19-07)

10. Forced Sale. A forced sale is a sale required by a bankruptcy, foreclosure, the provisions of a will or estate settlement pursuant to the death of an owner, physical or mental incapacity of an owner which requires ownership transfer to existing partner or partners, or a sale required by the ruling of a federal agency or by a court order. (3-19-07)

11. Funded Depreciation. Amounts deposited or held which represent recognized depreciation. (3-19-07)

12. Generally Accepted Accounting Principles (GAAP). A widely accepted set of rules, conventions, standards, and procedures for reporting financial information as established by the Financial Standards Accounting Board. (3-19-07)

13. Goodwill. The amount paid by the purchaser that exceeds the value of the net tangible assets. The value of goodwill is derived from the economic benefits that a going concern may enjoy, as compared with a new one, from established relations in the related markets, with government departments and other noncommercial bodies and with personal relationships. These intangible assets cannot be separated from the business and sold as can plant and equipment. Under the theory that the excess payment would be made only if expected future earnings justified it, goodwill is often described as the price paid for excess future earnings. The amortization of goodwill is a nonallowable, nonreimbursable expense. (3-19-07)

14. Healthy Connections. The primary care case management model of managed care under Idaho Medicaid. (3-19-07)

15. Historical Cost. The actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architects' fees, and engineering studies. (3-19-07)

16. Home and Community Based Services (HCBS). HCBS are those long-term services and supports

that assist eligible participants to remain in their home and community. ( )

16~~7~~. ICF/ID Living Unit. The physical structure that an ICF/ID uses to house patients. (3-19-07)

17~~8~~. Improvements. Improvements to assets which increase their utility or alter their use. (3-19-07)

18~~9~~. Indirect Care Costs. The following costs either directly coded to the nursing facility or allocated to the nursing facility through the Medicare step-down process described in the PRM: (3-19-07)

a. Activities; (3-19-07)

b. Administrative and general care costs; (3-19-07)

c. Central service and supplies; (3-19-07)

d. Dietary (non-"raw food" costs); (3-19-07)

e. Employee benefits associated with the indirect salaries; (3-19-07)

f. Housekeeping; (3-19-07)

g. Laundry and linen; (3-19-07)

h. Medical records; (3-19-07)

i. Other costs not included in direct care costs, or costs exempt from cost limits; and (3-19-07)

j. Plant operations and maintenance (excluding utilities). (3-19-07)

~~19~~20. Inflation Adjustment. The cost used in establishing a nursing facility's prospective reimbursement rate is indexed forward from the midpoint of the cost report period to the midpoint of the rate year using the inflation factor plus one percent (+1%) per annum. (3-19-07)

20~~1~~. Inflation Factor. For use in establishing nursing facility prospective rates, the inflation factor is the Skilled Nursing Facility Market Basket as established by Data Resources, Inc. (DRI), or its successor. If subsequent to the effective date of these rules, Data Resources, Inc., or its successor develops an Idaho-specific nursing facility index, it will be used. The Department is under no obligation to enter into an agreement with DRI or its successor to have an Idaho-specific index established. The national index is used when there is no state or regional index. (3-19-07)

21~~2~~. In-State Care. Medical services provided within the Idaho border or in counties bordering Idaho are considered to be in-state, excluding long term care. (3-19-07)

22~~3~~. Inspection of Care Team (IOCT). An interdisciplinary team which provides inspection of care in intermediate care facilities for persons with intellectual disabilities approved by the Department as providers of care for eligible medical assistance participants. Such a team is composed of: (3-19-07)

a. At least one (1) registered nurse; and (3-19-07)

b. One (1) Qualified Intellectual Disabilities Professional (QIDP); and when required, one (1) of the following: (3-19-07)

i. A consultant physician; or (3-19-07)

ii. A consultant social worker; or (3-19-07)

iii. When appropriate, other health and human services personnel responsible to the Department as

employees or consultants. (3-19-07)

23~~3~~4. Instrumental Activities of Daily Living (IADL). Those activities performed in supporting the activities of daily living, including, but not limited, to managing money, preparing meals, shopping, light housekeeping, using the telephone, or getting around in the community. (3-19-07)

24~~4~~5. Interest. The cost incurred for the use of borrowed funds. (3-19-07)

25~~5~~6. Interest on Capital Indebtedness. The cost incurred for borrowing funds used for acquisitions of capital assets, improvements, etc. These costs are reported under property costs. (3-19-07)

26~~6~~7. Interest on Working Capital. The costs incurred for borrowing funds which will be used for "working capital" purposes. These costs are reported under administrative costs. (3-19-07)

27~~7~~8. Interest Rate Limitation. The interest rate allowed for working capital loans and for loans for major movable equipment for ICF/ID facilities is the prime rate as published in the western edition of the Wall Street Journal or successor publication, plus one percent (+1%) at the date the loan is made. (3-19-07)

28~~8~~9. Interim Reimbursement Rate (IRR). A rate paid for each Medicaid patient day which is intended to result in total Medicaid payments approximating the amount paid at audit settlement. The interim reimbursement rate is intended to include any payments allowed in excess of the percentile cap. (3-19-07)

~~29~~30. Intermediary. Any organization that administers the Title XIX and Title XXI program; in this case the Department of Health and Welfare. (3-19-07)

30~~0~~1. Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID). An entity licensed as an ICF/ID and federally certified to provide care to Medicaid and Medicare participants with developmental disabilities. (3-19-07)

31~~1~~2. Keyman Insurance. Insurance on owners or employees with extraordinary talents in which the direct or indirect beneficiary is the facility or its owners. Premiums related to keyman insurance are not allowable. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

013. DEFINITIONS: P THROUGH Z.
For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. Patient Day. (3-21-12)

a. For ICF/ID, a calendar day of care includes the day of admission and excludes the day of discharge, unless discharge occurs after 3:00 p.m. or it is the date of death. When admission and discharge occur on the same day, one (1) day of care is deemed to exist. (3-21-12)

b. For a nursing facility, a calendar day of care includes the day of admission and excludes the day of discharge, unless it is the date of death. When admission and discharge occur on the same day, one (1) day of care is deemed to exist. (3-21-12)

02. Participant. A person eligible for and enrolled in the Idaho Medical Assistance Program. (3-19-07)

03. Patient. The person undergoing treatment or receiving services from a provider. (3-19-07)

04. Personal Assistance Agency. An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for services provided, provides payroll and benefits for personal

assistants working for them, and is the employer of record as well as the actual employer. (5-8-09)

05. Personal Assistance Services (PAS). Services that include both attendant care for participants under an HCBS waiver and personal care services for participants under the Medicaid State Plan. PAS means services that involve 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 instrumental activities of daily living (IADLs). These services may include personal assistance and medical tasks that can be done by unlicensed persons or delegated to unlicensed persons by a health care professional or participant. Services are based on the participant's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. (5-8-09)

06. Person-Centered Planning. The process whereby a service plan for home and community based services is developed, with a focus on the needs and preferences of the participant. ( )

0~~6~~7. Physician. A person possessing a Doctorate of Medicine degree or a Doctor of Osteopathy degree and licensed to practice medicine by a state or United States territory. (3-19-07)

0~~7~~8. Physician's Assistant. A person who meets all the applicable requirements to practice as licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants." (3-19-07)

0~~8~~9. Picture Date. A point in time when case mix indexes are calculated for every nursing facility based on the residents in the nursing facility on that day. The picture date to be used for rate setting will be the first day of the first month of a quarter. The picture date from that quarter will be used to establish the nursing facility's rate for the next quarter. (3-19-07)

10~~9~~. Plan of Care. A written description of medical, remedial, or rehabilitative services to be provided to a participant, developed by or under the direction and written approval of a physician. Medications, services and treatments are identified specifically as to amount, type and duration of service. (3-19-07)

1~~0~~1. Private Rate. Rate most frequently charged to private patients for a service or item. (3-19-07)

1~~1~~2. PRM. The Provider Reimbursement Manual. (3-19-07)

1~~2~~3. Property. The homestead and all personal and real property in which the participant has a legal interest. (3-19-07)

1~~3~~4. Property Costs. Property costs are the total of allowable interest expense, plus depreciation, property insurance, real estate taxes, amortization, and allowable lease/rental expense. The Department may require and utilize an appraisal to establish which components are an integral part of property costs. (3-19-07)

1~~4~~5. Property Rental Rate. A rate paid per Medicaid patient day to free-standing nursing facilities and ICF/IDs in lieu of reimbursement for property costs other than property taxes, property insurance, and the property costs of major movable equipment at ICF/ID facilities. (3-19-07)

1~~5~~6. Provider. Any individual, partnership, association, corporation or organization, public or private, that furnishes medical goods or services in compliance with these rules and who has applied for and received a Medicaid provider number and has entered into a written provider agreement with the Department in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205. (3-19-07)

1~~6~~7. Provider Agreement. An written agreement between the provider and the Department, in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205. (3-19-07)

1~~7~~8. Provider Reimbursement Manual (PRM). The Providers Reimbursement Manual, a federal publication which specifies accounting treatments and standards for the Medicare program, CMS Publications 15-1 and 15-2, which are incorporated by reference in Section 004 of these rules. (3-19-07)

18~~8~~9. Psychologist, Licensed. A person licensed to practice psychology in Idaho under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (3-19-07)

~~19~~20. Psychologist Extender. A person who practices psychology under the supervision of a licensed psychologist as required under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners," and who is registered with the Bureau of Occupational Licenses. (3-19-07)

20~~0~~1. Public Provider. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (3-19-07)

21~~1~~2. Raw Food. Food used to meet the nutritional needs of the residents of a facility, including liquid dietary supplements, liquid thickeners, and tube feeding solutions. (3-19-07)

22~~2~~3. Reasonable Property Insurance. Reasonable property insurance means that the consideration given is an amount that would ordinarily be paid by a cost-conscious buyer for comparable insurance in an arm's length transaction. Property insurance per licensed bed in excess of two (2) standard deviations above the mean of the most recently reported property insurance costs per licensed bed of all facilities in the reimbursement class as of the end of a facility's fiscal year cannot be considered reasonable. (3-19-07)

23~~3~~4. Recreational Therapy (Services). Those activities or services that are generally perceived as recreation such as, but not limited to, fishing, hunting, camping, attendance or participation in sporting events or practices, attendance at concerts, fairs or rodeos, skiing, sightseeing, boating, bowling, swimming, and special day parties (birthday, Christmas, etc.). (7-1-11)

24~~4~~5. Regional Nurse Reviewer (RNR). A registered nurse who reviews and makes determinations on applications for entitlement to and continued participation in Title XIX and Title XXI long term care for the Department. (3-19-07)

25~~5~~6. Registered Nurse - R.N. Which in the state of Idaho is known as a Licensed Professional Nurse and who meets all the applicable requirements to practice as a licensed professional nurse under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01 "Rules of the Idaho Board of Nursing." (3-19-07)

26~~6~~7. Related Entity. An organization with which the provider is associated or affiliated to a significant extent, or has control of, or is controlled by, that furnishes services, facilities, or supplies for the provider. (3-19-07)

27~~7~~8. Related to Provider. The provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies. (3-19-07)

28~~8~~9. Residential Care or Assisted Living Facility. A facility or residence, however named, operated on either a profit or nonprofit basis for the purpose of providing necessary supervision, personal assistance, meals, and lodging to three (3) or more adults not related to the owner. In this chapter, Residential Care or Assisted Living Facilities are referred to as "facility." Distinct segments of a facility may be licensed separately, provided each segment functions independently and meets all applicable rules. (3-19-07)

~~29~~30. Resource Utilization Groups (RUG). A process of grouping residents according to the clinical and functional status identified by the responses to key elements of the MDS. The RUG Grouper is used for the purposes of rate setting and determining nursing facility level of care. (4-2-08)

30~~0~~1. Skilled Nursing Care. The level of care for patients requiring twenty-four (24) hour skilled nursing services. (3-19-07)

31~~1~~2. Social Security Act. 42 USC 101 et seq., authorizing, in part, federal grants to the states for medical assistance to low-income persons meeting certain criteria. (3-19-07)

32~~2~~3. State Plan. The contract between the state and federal government under 42 U.S.C. section

1396a(a). (3-19-07)

3~~3~~4. **Supervision**. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (3-19-07)

3~~4~~5. **Title XVIII**. Title XVIII of the Social Security Act, known as Medicare, for the aged, blind, and disabled administered by the federal government. (3-19-07)

3~~5~~6. **Title XIX**. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources. (3-19-07)

3~~6~~7. **Title XXI**. Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children. (3-19-07)

3~~7~~8. **Third Party**. Includes a person, institution, corporation, public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a participant of medical assistance. (3-19-07)

3~~8~~9. **Transportation**. The physical movement of a participant to and from a medical appointment or service by the participant, another person, taxi or common carrier. (3-19-07)

~~39~~40. **Uniform Assessment**. A set of standardized criteria to assess functional and cognitive abilities. (3-19-07)

4~~0~~1. **Uniform Assessment Instrument (UAI)**. A set of standardized criteria adopted by the Department of Health and Welfare to assess functional and cognitive abilities as described in IDAPA 16.03.23 "Rules Governing Uniform Assessments of State-Funded Clients." (3-19-07)

4~~1~~2. **Updated Assessments**. Assessments are considered updated and current when a qualified professional with the same credential or the same qualifications of that professional who completed the assessment has reviewed such assessment and verified by way of their signature and date in the participant's file that the assessment continues to reflect the participant's current status and assessed needs. (3-29-12)

4~~2~~3. **Utilities**. All expenses for heat, electricity, water and sewer. (3-19-07)

4~~3~~4. **Utilization Control (UC)**. A program of prepayment screening and annual review by at least one (1) Regional Nurse Reviewer to determine the appropriateness of medical entitlement and the need for continued medical entitlement of applicants or participants to Title XIX and Title XXI benefits in a nursing facility. (3-19-07)

4~~4~~5. **Utilization Control Team (UCT)**. A team of Regional Nurse Reviewers which conducts on-site reviews of the care and services in the nursing facilities approved by the Department as providers of care for eligible medical assistance participants. (3-19-07)

4~~5~~6. **Vocational Services**. Services or programs which are directly related to the preparation of individuals for paid or unpaid employment. The test of the vocational nature of the service is whether the services are provided with the expectation that the participant would be able to participate in a sheltered workshop or in the general work force within one (1) year. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

075. ENHANCED PLAN BENEFITS: COVERED SERVICES.
Individuals who are eligible for the Medicaid Enhanced Plan Benefits are eligible for all benefits covered under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." In addition to those benefits, individuals in the enhanced plan are eligible for the following enhanced benefits as provided for in this chapter of rules. (4-11-15)

01. Dental Services. Dental Services are provided as described under Sections 080 through 089 of these rules. (3-29-12)

02. Enhanced Hospital Benefits. Organ transplants are provided under the Enhanced Hospital services as described in Sections 090 through 099 of these rules. (3-19-07)

03. Enhanced Outpatient Behavioral Health Benefits. Enhanced Outpatient Behavioral Health services are described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." (3-20-14)

04. Enhanced Home Health Benefits. Private Duty Nursing services are provided under the Enhanced Home Health as described in Sections 200-219 of these rules. (3-19-07)

05. Therapies. Physical, Speech, and Occupational Therapy Providers as described in Section 215 of these rules. (3-19-07)

06. Long Term Care Services. The following services are provided under the Long Term Care Services. (3-30-07)

a. Nursing Facility Services as described in Sections 220 through 299 of these rules. (3-19-07)

b. Personal Care Services as described in Sections 300 through 308 of these rules. (3-30-07)

c. A & D Wavier Services as described in Sections 320 through 330 of these rules. (3-30-07)

07. Hospice. Hospice services as described in Sections 450 through 459 of these rules. (3-19-07)

08. Developmental Disabilities Services. (3-19-07)

~~*a. Developmental Disability Standards as described in Sections 500 through 506 of these rules. (3-19-07)*~~

~~*b.*~~**a.** Children's Developmental Disability Services as described in Sections 520 through 528, 660 through 666, and 680 through 686 of these rules. (7-1-13)

~~*c.*~~**b.** Adult Developmental Disabilities Services as described in Sections 507 through 520, and 649 through 657 of these rules. (7-1-13)

~~*d.*~~**c.** ICF/ID as described in Sections 580 through 649 of these rules. (3-19-07)

~~*e. Developmental Disabilities Agencies as described in Sections 700 through 719 of these rules. (3-19-07)*~~

09. Service Coordination Services. Service coordination as described in 720 through 779 of these rules. (3-19-07)

10. Breast and Cervical Cancer Program. Breast and Cervical Cancer Program is described in Sections 780 through 800 of these rules. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

302. PERSONAL CARE SERVICES: ELIGIBILITY.

01. Financial Eligibility. The participant must be financially eligible for medical assistance under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," or 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." (3-19-07)

02. Other Eligibility Requirements. Regional Medicaid Services (RMS) will prior authorize payment for the amount and duration of all services when all of the following conditions are met: (3-19-07)

a. The RMS finds that the participant is capable of being maintained safely and effectively in his own home or personal residence using PCS. (3-19-07)

b. The participant is an adult for whom a Uniform Assessment Instrument (UAI) has been completed, or a child for whom a children's PCS assessment has been completed; (3-29-10)

c. The RMS reviews the documentation for medical necessity; and (4-2-08)

d. The participant has a plan of care that meets the person-centered planning requirements described in Sections 315 and 316 of these rules. ~~(4-2-08)~~( )

03. State Plan Option. A participant who receives medical assistance is eligible for PCS under the State Medicaid Plan option if the Department finds he requires PCS due to a medical condition that impairs his physical or mental function or independence. (3-19-07)

04. Annual Eligibility Redetermination. The participant's eligibility for PCS must be redetermined at least annually under Subsections 302.01. through 302.03 of these rules. (3-19-07)

a. The annual financial eligibility redetermination must be conducted under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," or 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." RMS must make the medical eligibility redetermination. The redetermination can be completed more often than once each year at the request of the participant, the Self-Reliance Specialist, the Personal Assistance Agency, the personal assistant, the supervising RN, the QIDP, or the physician. (4-2-08)

b. The medical redetermination must assess the following factors: (3-19-07)

i. The participant's continued need for PCS; (3-19-07)

ii. Discharge from PCS; and (3-19-07)

iii. Referral of the participant from PCS to a nursing facility. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

304. PERSONAL CARE SERVICES: PROCEDURAL REQUIREMENTS.

01. Service Delivery Based on Plan of Care or NSA. All PCS services are provided based on a written plan of care or a negotiated service agreement (NSA). The requirements for the NSA for participants in Residential Care or Assisted Living Facilities are described in IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." The requirements for the NSA for participants in Certified Family Homes are described in IDAPA 16.03.19, "Rules Governing Certified Family Homes." The Personal Assistance Agency and the participant who lives in his own home are responsible to prepare the plan of care. (3-19-07)

a. The plan of care for participants who live in their own homes or in a PCS Family Alternate Care Home is based on: (3-29-10)

i. The physician's or authorized provider's information if applicable; (4-2-08)

ii. The results of the UAI for adults, the children's PCS assessment and, if applicable, the QIDP's assessment and observations of the participant; and (3-29-10)

iii. Information obtained from the participant. (3-19-07)

b. The plan of care 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. (3-19-07)

c. The plan of care must be revised and updated based upon treatment results or a change(s) in the participant's needs, or both, but at least annually. (3-19-07)

d. The plan of care or NSA must meet the person-centered planning requirements described in Sections 315 and 316 of these rules. ( )

02. Service Supervision. The delivery of PCS may be overseen by a licensed professional nurse (RN) or Qualified Intellectual Disabilities Professional (QIDP). The RMS must identify the need for supervision.(3-19-07)

a. Oversight must include all of the following: (3-19-07)

i. Assistance in the development of the written plan of care; (3-19-07)

ii. Review of the treatment given by the personal assistant through a review of the participant's PCS record as maintained by the provider; (3-19-07)

iii. Reevaluation of the plan of care as necessary; and (3-19-07)

iv. Immediate notification of the guardian, emergency contact, or family members of any significant changes in the participant's physical condition or response to the services delivered. (3-19-07)

b. All participants who are developmentally disabled, other than those with only a physical disability as determined by the RMS, may receive oversight by a QIDP as defined in 42 CFR 483.430. Oversight must include: (3-19-07)

i. Assistance in the development of the plan of care for those aspects of active treatment which are provided in the participant's personal residence by the personal assistant; (3-19-07)

ii. Review of the care or training programs given by the personal assistant through a review of the participant's PCS record as maintained by the provider and through on-site interviews with the participant; (3-19-07)

iii. Reevaluation of the plan of care as necessary, but at least annually; and (3-19-07)

iv. An on-site visit to the participant to evaluate any change of condition when requested by the personal assistant, the Personal Assistance Agency, the nurse supervisor, the service coordinator or the participant. (3-19-07)

03. Prior Authorization Requirements. All PCS services must be prior authorized by the Department. Authorizations will be based on the information from: (3-29-10)

a. The children's PCS assessment or Uniform Assessment Instrument (UAI) for adults; (3-29-10)

b. The individual service plan developed by the Personal Assistance Agency; and (3-29-10)

c. Any other medical information that supports the medical need. (3-29-10)

04. PCS Record Requirements for a Participant in His Own Home. The PCS records must be maintained on all participants who receive PCS in their own homes or in a PCS Family Alternate Care Home. (3-29-10)

a. Written Requirements. The PCS provider must maintain written documentation of every visit made

to the participant's home and must record the following minimum information: (3-19-07)

i. Date and time of visit; (3-19-07)

ii. Length of visit; (3-19-07)

iii. Services provided during the visit; and (3-19-07)

iv. Documentation of any changes noted in the participant's condition or any deviations from the plan of care. (3-19-07)

b. Participant's Signature. The participant must sign the record of service delivery verifying that the services were delivered. The RMS may waive this requirement if it determines the participant is not able to verify the service delivery. (3-19-07)

c. A copy of the information required in Subsection 304.04 of these rules must be maintained in the participant's home unless the RMS authorizes the information to be kept elsewhere. Failure to maintain this information may result in recovery of funds paid for undocumented services. (3-19-07)

d. Telephone Tracking System. Agencies may employ a software system that allows personal assistants to register their start and stop times and a list of services by placing a telephone call to the agency system from the participant's home. This system will not take the place of documentation requirements of Subsection 304.04 of these rules. (3-19-07)

e. Participant in a Residential or Assisted Living Facility. The PCS record requirements for participants in Residential Care or Assisted Living Facilities are described in IDAPA 16.03.22. "Residential Care or Assisted Living Facilities in Idaho." (3-19-07)

f. Participant in a Certified Family Home. The PCs record requirements for participants in Certified Family Homes are described in IDAPA 16.03.19, "Rules Governing Certified Family Homes." (3-19-07)

05. Provider Responsibility for Notification. The Personal Assistance Agency is responsible to notify the RMS and physician or authorized provider when any significant changes in the participant's condition are noted during service delivery. This notification must be documented in the Personal Assistance Agency record. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

308. PERSONAL CARE SERVICES (PCS): QUALITY ASSURANCE.

01. Responsibility for Quality. Personal Assistance Agencies are responsible for assuring that they provide quality services in compliance with applicable rules. (3-19-07)

02. Review Results. Results of quality assurance reviews conducted by the Department must be transmitted to the provider within forty-five (45) days after the review is completed. (3-19-07)

03. Quality Improvement Plan. The provider must respond within forty-five (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. (3-19-07)

04. HCBS Compliance. Personal Assistance Agencies, Residential Care or Assisted Living Facilities, and Certified Family Homes are responsible for ensuring that they meet the person-centered planning and setting quality requirements described in Sections 311 through 317 of these rules and must comply with associated Department quality assurance activities. The Department may take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with any term or provision of

the provider agreement, or any applicable state or federal regulation. ( )

309. (RESERVED)

**SUB AREA: HOME AND COMMUNITY BASED SERVICES
(Sections 310 - 317)**

310. HOME AND COMMUNITY BASED SERVICES.
Home and Community Based Services (HCBS) are those long-term services and supports that assist eligible participants to remain in their home and community. The federal authorities under 42 CFR 441.301, 42 CFR 441.710, and 42 CFR 441.725 require the state to deliver HCBS in accordance with the rules described in Sections 310 through 317 of these rules. HCBS include the following: ( )

01. Children's Developmental Disability Services. Children's developmental disability services as defined in Sections 665 and 685 of these rules. ( )

02. Adult Developmental Disability Services. Adult developmental disability services as defined in Sections 645 through 659, 703, and 705 of these rules. ( )

03. Consumer-Directed Services. Consumer-directed services as defined in IDAPA 16.03.13, "Consumer-Directed Services." ( )

04. Aged and Disabled Waiver Services. Aged and disabled waiver services as defined in Section 326 of these rules. ( )

05. Personal Care Services. Personal care services as defined in Section 303 of these rules. ( )

311. HOME AND COMMUNITY BASED SETTINGS.
Home and community based settings include all locations where participants who receive HCBS live or receive their services. ( )

01. Home and Community Based Settings Not Included. Home and community based settings do not include the following: ( )

a. A nursing facility; ( )

b. An institution for mental diseases; ( )

c. An intermediate care facility for persons with intellectual disabilities (ICF/ID); ( )

d. A hospital; or ( )

e. Any other location that has the qualities of an institutional setting. These institutional qualities include: ( )

i. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment; or ( )

ii. A building on the grounds of, or immediately adjacent to, a state or federally operated inpatient treatment facility; or ( )

iii. Any setting that has the effect of isolating participants receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS. ( )

312. HOME AND COMMUNITY BASED SETTINGS REQUIREMENTS.
Home and community based settings must support eligible 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. Through the person-centered planning process, goals will be identified which teach the participant those strategies that support them to be successful in HCBS settings. These supportive strategies must be documented in the service plan. Providers must develop and implement policies and procedures to address HCBS setting requirements. ( )

01. Home and Community Based Settings. Home and community based settings are required to have the following qualities: ( )

a. Integration and Access. The setting is integrated in and supports full access of participants receiving HCBS to the greater community. 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. ( )

b. Selection of Setting. Home and community based settings are selected by the participant or legal guardian from among setting options, including non-disability specific settings, and are based on the participant needs and preferences as well as consideration of the participant's safety and the safety of those around the participant. ( )

c. Participant Rights. The setting ensures a participant's rights of privacy, dignity, and respect, and freedom from coercion and unauthorized restraint. ( )

d. Autonomy and Independence. The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including daily activities, physical environment, and with whom to interact. ( )

e. Choice. The setting facilitates opportunities for participant choice regarding the services and supports provided in the setting. ( )

02. HCBS Requirements and Decision-making Authority. HCBS requirements, contained in this rule and in Sections 313 through Sections 316 of these rules, do not supersede decision-making authority legally assigned to another individual or entity on the participant's behalf. This includes: ( )

a. A representative payee appointed by the Social Security Administration; ( )

b. Court-imposed restrictions related to probation or parole; and ( )

c. Legal guardians who retain all decision-making authority for the participant unless otherwise indicated in the individual guardianship documents. It is presumed that the parent or parents of participants birth through seventeen (17) are the legal guardians with full decision-making capabilities, unless the minor child has a designated legal guardian. ( )

03. Services Delivered in the Participant's Own Home. 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 described in this rule. Providers may not impose restrictions on HCBS setting qualities in a participant's own home without a supportive strategy that has been agreed to through the person-centered planning process. ( )

313. RESIDENTIAL PROVIDER-OWNED OR CONTROLLED SETTING QUALITIES.
In addition to the requirements for the setting described in Section 312 of these rules, provider-owned or controlled settings, including Residential Care or Assisted Living Facilities and Certified Family Homes that provide services to HCBS participants, must also meet the following conditions: ( )

01. Written Agreement. A lease, residency agreement, admission agreement, or other form of written agreement will be in place for each HCBS participant at the time of occupancy. The lease or residency agreement must provide protections that address eviction processes and appeals comparable to those provided under Idaho landlord tenant law. ( )

02. Privacy. Participants have the right to privacy within their residence. Each participant must have privacy in their sleeping or living unit to include the following: ( )

a. The right to entrance doors which are lockable by the individual, with only appropriate staff having keys to doors. ( )

b. Participants sharing units have a choice of roommates in that setting. ( )

03. Décor. Participants have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement. ( )

04. Schedules and Activities. Participants have the freedom and support to control their own schedules and activities. ( )

05. Access To Food. Participants have access to food at any time. ( )

06. Visitors. Participants are able to have visitors of their choosing at any time. ( )

07. Accessibility. The setting is physically accessible to the participant. ( )

314. EXCEPTIONS TO RESIDENTIAL PROVIDER-OWNED OR CONTROLLED SETTING QUALITIES.
Exceptions to residential setting requirements outlined in Section 313 of these rules must be made based on the needs of the participant that are identified through person-centered planning. Service plans with exceptions to residential setting 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: ( )

01. Assessed Needs. Specific and individualized assessed needs that are related to the exception. ( )

02. Interventions and Supports. Positive interventions and supports used prior to any exceptions to the person-centered service plan. ( )

03. Prior Methods. List less intrusive methods previously implemented that were unsuccessful in addressing the needs of the participant. ( )

04. Description of Intervention. A clear description of the intervention for the exception that is directly proportionate to the specific assessed needs. ( )

05. Data Collection. Regular collection and review of data to measure the ongoing effectiveness of the exception. ( )

06. 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. ( )

07. Informed Consent. Informed consent of the participant or legal guardian for the exception. ( )

08. Assurance of No Harm. An assurance that interventions and supports will cause no harm to the participant. ( )

315. HOME AND COMMUNITY BASED PERSON-CENTERED PLANNING REQUIREMENTS.
All participants who receive HCBS must direct the development of their service plan through a person-centered planning process. Information and support must be given to the HCBS participant to maximize their ability to make informed choices and decisions. With the aid of a facilitator, the participant receiving HCBS will direct the person-centered planning process. Individuals invited to participate in the person-centered planning process should be identified by the participant or his legal guardian. Unless all decision-making authority has been conferred to the

legal guardian, the legal guardian will have a participatory role as needed and defined by the participant. The person-centered planning process must: ( )

01. Timely and Convenient. Be timely and occur at times and locations of convenience to the participant. ( )

02. Cultural Considerations. Reflect cultural considerations of the participant. ( )

03. In Plain Language and Accessible. 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 as defined in 42 CFR 435.905(b). ( )

04. Conflict Resolution. Utilize strategies for solving conflict or disagreement within the process, and follow clear conflict-of-interest guidelines for all planning participants. ( )

05. Facilitators Cannot Be Service Providers. Individuals responsible for facilitating the person-centered planning meeting and developing the plan of service cannot be providers of direct services to the participant. ( )

316. HOME AND COMMUNITY BASED PERSON-CENTERED SERVICE PLAN REQUIREMENTS. All person-centered service plans must reflect the following components: ( )

01. Services And Supports. Clinical services and supports that are important for the participant's behavioral, functional, and medical needs as identified through an assessment. ( )

02. Service Delivery Preferences. Indication of what is important to the participant with regard to the service provider and preferences for the delivery of such services and supports. ( )

03. Setting Selection. HCBS settings selected by the participant are chosen from among a variety of setting options, including non-disability-specific settings. The person-centered service plan must identify and document the alternative home and community setting options that were considered by the participant. ( )

04. Participant Strengths and Preferences. ( )

05. Individually Identified Goals and Desired Outcomes. ( )

06. Paid and Unpaid Services and Supports. Paid and unpaid services and supports that will assist the participant to achieve identified goals, and the providers of those services and supports, including natural supports. ( )

07. 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. ( )

08. Understandable Language. Be understandable to the participant receiving services and supports, and the individuals important in supporting him or her. At a minimum, the written plan must be understandable, and written in plain language in a manner that is accessible to participants with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b). ( )

09. Plan Monitor. Identify the name of the individual or entity responsible for monitoring the plan. ( )

10. Plan Signatures. Be finalized and agreed to, with the informed consent of the participant in writing, and signed by all individuals and providers responsible for its implementation. ( )

a. Children's DD service providers responsible for implementation of the plan include those identified in Sections 665 and 685 of these rules. ( )

b. Adult DD service providers responsible for implementation of the plan include those required to develop a provider implementation plan as defined in Sections 513 and 654 of these rules. ( )

c. Consumer-directed service providers responsible for implementation of the plan include the participant, Support Broker, and Fiscal Employment Agency as identified in IDAPA 16.03.13, "Consumer-Directed Services." ( )

d. Personal Care and Aged and Disabled Waiver service providers responsible for the implementation of the plan include the providers of those services defined in Sections 305, 306, and 328 of these rules. ( )

11. Plan Distribution. Be distributed to the participant and other people involved in the implementation of the plan. At a minimum, the following providers will receive a copy of the plan: ( )

a. Children's DD service providers defined in Sections 665 and 685 of these rules as identified on the plan of service developed by the family-centered planning team. Additionally, the participant and parent or legal guardian will determine during the person-centered planning process whether the service plan, in whole or in part, will be distributed to any other developmental disability service provider. ( )

b. Adult DD service providers required to develop a provider implementation plan as defined in Sections 513 and 654 of these rules. 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 developmental disability service provider. ( )

c. Consumer-Directed service providers as defined in IDAPA 16.03.13, "Consumer-Directed Services," Section 110. In addition, the participant will determine during the person-centered planning process whether the service plan, in whole or in part, is to be distributed to any other community support worker or vendors. ( )

d. Personal Care and Aged and Disabled Waiver service providers defined in Sections 305, 306, and 329 of these rules. ( )

12. Residential Requirements. For participants living in residential provider owned or controlled settings as described in Section 313 of these rules, the following additional requirements apply: ( )

a. Options described in Subsection 316.03 of this rule 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. ( )

b. Any exception to residential provider owned or controlled setting qualities as described in Section 313 of these rules must be documented in the person-centered plan as described in Section 314 of these rules. ( )

317. HCBS TRANSITION PLAN.

As required by the Department, all current providers of HCBS must complete and return a Department-approved self assessment form related to the setting requirements and qualities described in Sections 311 through 313 of these rules no later than January 1, 2017. ( )

01. Provider Transition Plan. Providers not in compliance with any portion of the new requirements and qualities, as identified through the self assessment process, must submit a transition plan detailing their proposal for coming into compliance. All transition plans must be reviewed and approved by the Department. ( )

02. New HCBS Providers or Service Settings. New HCBS providers or service settings are expected to fully comply with the HCBS requirements and qualities as a condition of becoming a Medicaid provider. ( )

03. Quality Assurance. The Department will begin enforcement of quality assurance compliance with Sections 311 through 313 of these rules on January 1, 2017. ( )

3~~09~~18. -- 319. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

328. AGED AND DISABLED WAIVER SERVICES: PROCEDURAL REQUIREMENTS.

01. Role of the Department. The Department or its contractor will provide for the administration of the UAI, and the development of the initial individual service plan. This will be done either by Department staff or a contractor. The Department or its contractor will review and approve all individual service plans, and will authorize Medicaid payment by type, scope, and amount. (4-4-13)

a. Services that are not in the individual service plan approved by the Department or its contractor are not eligible for Medicaid payment. (4-4-13)

b. Services in excess of those in the approved individual service plan are not eligible for Medicaid payment. (3-19-07)

c. The earliest date that services may be approved by the Department or its contractor for Medicaid payment is the date that the participant's individual service plan is signed by the participant or his designee. (4-4-13)

02. Pre-Authorization Requirements. All waiver services must be pre-authorized by the Department. Authorization will be based on the information from: (3-19-07)

a. The UAI; (3-19-07)

b. The individual service plan developed by the Department or its contractor; and (3-19-07)

c. Any other medical information which verifies the need for nursing facility services in the absence of the waiver services. (3-19-07)

03. UAI Administration. The UAI will be administered, and the initial individual service plan developed, by the Department or its contractor. (4-4-13)

04. Individual Service Plan. All waiver services must be authorized by the Department or its contractor in the Region where the participant will be residing and services provided based on a written individual service plan. (4-4-13)

a. The initial individual service plan is developed by the Department or its contractor, based on the UAI, in conjunction with: (4-4-13)

i. The waiver participant (with efforts made by the Department or its contractor to maximize the participant's involvement in the planning process by providing him with information and education regarding his rights); (4-4-13)

ii. The guardian, when appropriate; (3-30-07)

iii. The supervising nurse or case manager, when appropriate; and (3-19-07)

iv. Others identified by the waiver participant. (3-19-07)

b. The individual service plan must include the following: (3-19-07)

i. The specific type, amount, frequency, and duration of Medicaid reimbursed waiver services to be provided; (3-30-07)

ii. Supports and service needs that are to be met by the participant's family, friends, neighbors, volunteers, church, and other community services; (3-30-07)

iii. The providers of waiver services when known; (3-30-07)

iv. Documentation that the participant has been given a choice between waiver services and institutional placement; and (3-19-07)

v. The signature of the participant or his legal representative, agreeing to the plan. (3-19-07)

c. The individual service plan must be revised and updated at least annually, based upon treatment results or a change in the participant's needs. (3-19-07)

d. All services reimbursed under the Aged and Disabled Waiver must be authorized by the Department or its contractor prior to the payment of services. (4-4-13)

e. The individual service plan, which includes all waiver services, is monitored by the Personal Assistance Agency, participant, family, and the Department or its contractor. (4-4-13)

05. Service Delivered Following a Written Plan of Care. All services that are provided must be based on a written plan of care. (3-30-07)

a. The plan of care is developed by the plan of care team which includes: (3-30-07)

i. The waiver participant with efforts made to maximize his participation on the team by providing him with information and education regarding his rights; (3-30-07)

~~*ii. The Department's administrative case manager;* (3-30-07)~~

~~i~~ii. The guardian when appropriate; (3-30-07)

i~~v~~ii. Service provider identified by the participant or guardian; and (3-30-07)

iv. May include others identified by the waiver participant. (3-30-07)

b. The plan of care must be based on an assessment process approved by the Department. (3-30-07)

c. The plan of care must include the following: (3-30-07)

i. The specific types, amounts, frequency and duration of Medicaid reimbursed waiver services to be provided; (3-30-07)

ii. Supports and service needs that are to be met by the participant's family, friends and other community services; (3-30-07)

iii. The providers of waiver services; (3-30-07)

iv. Goals to be addressed within the plan year; (3-30-07)

v. Activities to promote progress, maintain functional skills, or delay or prevent regression; and (3-30-07)

vi. The signature of the participant or his legal representative and the provider or providers responsible for implementation of the plan of care. Providers of adult day health, adult residential care services, attendant care, chore services, companion services, homemaker services, skilled nursing, residential habilitation, day habilitation, and supported employment are responsible for implementation of the plan of care. ~~(3-30-07)~~( )

d. The plan must be revised and updated by the plan of care team based upon treatment results or a change in the participant's needs. A new plan must be developed and approved annually. (3-30-07)

e. The Department's case manager monitors the plan of care and all waiver services. (3-30-07)

f. The plan of care may be adjusted during the year with an addendum to the plan. These adjustments must be based on changes in a participant's need or demonstrated outcomes. Additional assessments or information may be clinically necessary. Adjustment of the plan of care is subject to prior authorization by the Department. (3-30-07)

06. Individual Service Plan and Written Plan of Care. The development and documentation of the individual service plan and written plan of care must meet the person-centered planning requirements described in Sections 315 and 316 of these rules. ( )

06~~7~~. Provider Records. Records will be maintained on each waiver participant. (3-19-07)

a. Each service provider must document each visit made or service provided to the participant, and will record at a minimum the following information: (3-19-07)

i. Date and time of visit; (3-19-07)

ii. Services provided during the visit; (3-19-07)

iii. Provider observation of the participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and (3-19-07)

iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the Department or its contractor determines that the participant is unable to do so, the service delivery will be verified by the participant as evidenced by their signature on the service record. (4-4-13)

b. The provider is required to keep the original service delivery record. A copy of the service delivery record will be maintained in the participant's living arrangement unless authorized to be kept elsewhere by the Department. Failure to maintain documentation according to these rules will result in the recoupment of funds paid for undocumented services. (4-4-13)

c. The individual service plan initiated by the Department or its contractor must specify which waiver services are required by the participant. The plan will contain all elements required by Subsection 328.04.a. of these rules and a copy of the most current individual service plan will be maintained in the participant's home and will be available to all service providers and the Department. A copy of the current individual service plan and UAI will be available from the Department or its contractor to each individual service provider with a release of information signed by the participant or legal representative. (4-4-13)

d. Record requirements for participants in residential care or assisted living facilities are described in IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." (4-4-13)

e. Record requirements for participants in certified family homes are described in IDAPA 16.03.19, "Rules Governing Certified Family Homes." (4-4-13)

07~~8~~. Provider Responsibility for Notification. The service provider is responsible to notify the Department or its contractor, physician or authorized provider, or case manager, and family if applicable, when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. (4-4-13)

08~~9~~. Records Retention. Personal Assistance Agencies, and other providers are responsible to retain their records for five (5) years following the date of service. (3-19-07)

10~~9~~. Requirements for an Fiscal Intermediary (FI). Participants of PCS will have one (1) year from

the date which services begin in their geographic region to obtain the services of an FI and become an employee in fact or to use the services of an agency. Provider qualifications are in accordance with Section 329 of these rules. (3-19-07)

329. AGED AND DISABLED WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES. Each provider must have a signed provider agreement with the Department for each of the services it provides. (3-19-07)

01. Employment Status. Unless otherwise specified by the Department, each individual service provider must be an employee of record or fact of an agency. The Department may enter into provider agreements with individuals in situations in which no agency exists, or no fiscal intermediary agency is willing to provide services. Such agreements will be reviewed annually to verify whether coverage by a personal assistance agency or fiscal intermediary agency is still not available. (5-8-09)

02. Fiscal Intermediary Services. An agency that has responsibility for the following: (5-8-09)

a. To directly assure compliance with legal requirements related to employment of waiver service providers; (3-19-07)

b. To offer supportive services to enable participants or families consumers to perform the required employer tasks themselves; (3-19-07)

c. To bill the Medicaid program for services approved and authorized by the Department; (3-19-07)

d. To collect any participant participation due; (3-19-07)

e. To pay personal assistants and other waiver service providers for service; (3-19-07)

f. To perform all necessary withholding as required by state and federal labor and tax laws, rules and regulations; (3-19-07)

g. To assure that personal assistants providing services meet the standards and qualifications under in this rule; (5-8-09)

h. To maintain liability insurance coverage; (5-8-09)

i. To conduct, at least annually, participant satisfaction or quality control reviews that are available to the Department and the general public; (5-8-09)

j. To obtain such criminal background checks and health screens on new and existing employees of record and fact as required. (5-8-09)

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 waiver as approved by CMS. (4-4-13)

a. A waiver provider cannot be a relative of any participant to whom the provider is supplying services. (3-19-07)

b. For the purposes of Section 329 of these rules, a relative is defined as a spouse or parent of a minor child. (3-19-07)

c. Individuals who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, “Criminal History and Background Checks.” (4-4-13)

04. **Quality Assurance**. Providers of Aged and Disabled waiver services are responsible for ensuring that they provide quality services in compliance with applicable rules. ( )

a. The results of a quality assurance review conducted by the Department must be transmitted to the provider within forty-five (45) days after the review is completed. ( )

b. The provider must respond to the quality assurance review within forty-five (45) days after the results are received from the Department. If problems are identified, the provider must implement a quality improvement plan and report the results to the Department upon request. ( )

05. **HCBS Compliance**. Providers of Aged and Disabled waiver services are responsible for ensuring that they meet the person-centered planning and setting quality requirements described in Sections 311 through 316 of these rules, as applicable, and must comply with associated Department quality assurance activities. The Department may take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with any term or provision of the provider agreement, or any applicable state or federal regulation. ( )

a. Providers of adult day health, day habilitation, residential habilitation, and supported employment must ensure that service delivery settings meet the HCBS setting qualities described in Section 312 of these rules. ( )

b. Providers of adult residential care must ensure that service delivery settings meet the HCBS setting qualities described in Section 312 of these rules in addition to the residential setting qualities described in Section 313 of these rules. ( )

0~~4~~6. **Specialized Medical Equipment and Supplies**. Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. Providers must ensure all items meet applicable standards of manufacture, design and installation. Preference will be given to equipment and supplies that are the most cost-effective option to meet the participant's needs. (4-4-13)

0~~5~~7. **Skilled Nursing Service**. Skilled nursing service providers must be licensed in Idaho as a registered nurse or licensed practical nurse in good standing, or must be practicing on a federal reservation and be licensed in another state. Skilled nursing providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

0~~6~~8. **Consultation Services**. Consultation services must be provided through a Personal Assistance Agency by a person who has demonstrated skills in training participants/family members in hiring, firing, training, and supervising their own care providers. (4-4-13)

0~~7~~9. **Adult Residential Care**. Adult residential care providers will meet all applicable state laws and regulations. In addition, the provider must ensure that adequate staff are provided to meet the needs of the participants accepted for admission. Adult residential care providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.03.19, "Rules Governing Certified Family Homes," or IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." (4-4-13)

1~~0~~8. **Home Delivered Meals**. Providers of home delivered meals must be a public agency or private business, and must exercise supervision to ensure that: (4-4-13)

a. Each meal meets one-third (1/3) of the Recommended Daily Allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences; (4-4-13)

b. Meals are delivered in accordance with the service plan, in a sanitary manner, and at the correct temperature for the specific type of food; (4-4-13)

c. Documentation is maintained demonstrating that the meals served are made from the highest USDA grade for each specific food served; (4-4-13)

d. The agency or business is inspected and licensed as a food establishment under IDAPA 16.02.19, "Food Safety and Sanitation Standards for Food Establishments"; (4-4-13)

e. A Registered Dietitian documents the review and approval of menus, menu cycles, and any changes or substitutions; and (4-4-13)

f. Either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule have been met. (4-4-13)

*09*11. **Personal Emergency Response Systems**. Personal emergency response system providers must demonstrate that the devices installed in a waiver participant's home meet Federal Communications Standards, or Underwriter's Laboratory Standards, or equivalent standards. (4-4-13)

1*0*2. **Adult Day Health**. Providers of adult day health must meet the following requirements: (4-4-13)

a. Services provided in a facility must be provided in a facility that meets the building and health standards identified in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." (4-4-13)

b. Services provided in a home must be provided in a home that meets the standards of home certification identified in IDAPA 16.03.19, "Rules Governing Certified Family Homes." (4-4-13)

c. Services provided in a residential adult living facility must be provided in a residential adult living facility that meets the standards identified in IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." (4-4-13)

d. Adult day health providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

e. Providers of adult day health must notify the Department on behalf of the participant, if the adult day health is provided in a certified family home other than the participant's primary residence. The adult day health provider must provide care and supervision appropriate to the participant's needs as identified on the plan. (4-4-13)

f. Adult day health providers who provide direct care or services must be free from communicable disease. (4-4-13)

g. All providers of adult day health services must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)

1*1*3. **Non-Medical Transportation Services**. Providers of non-medical transportation services must: (4-4-13)

a. Possess a valid driver's license; (4-4-13)

b. Possess valid vehicle insurance; and (4-4-13)

c. Meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)

1*2*4. **Attendant Care**. Attendant care providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." All providers of attendant care must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)

135. Homemaker Services. The homemaker must be an employee of record or fact of an agency. Homemaker service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." All providers of homemaker services must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)

146. Environmental Accessibility Adaptations. All services must be provided in accordance with applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. (4-4-13)

157. Residential Habilitation Supported Living. When residential habilitation services are provided by an agency, the agency must be certified by the Department as a residential habilitation agency under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies," and supervise the direct services provided. Individuals who provide residential habilitation services in the home of the participant (supported living) must be employed by a residential habilitation agency. Providers of residential habilitation services must meet the following requirements: (4-4-13)

a. Direct service staff must meet the following minimum qualifications: (3-30-07)

i. Be at least eighteen (18) years of age; (3-30-07)

ii. Be a high school graduate, or have a GED, or demonstrate the ability to provide services according to a plan of service; (4-4-13)

iii. Have current CPR and First Aid certifications; (3-30-07)

iv. Be free from communicable disease; (4-4-13)

v. 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 other Department-approved training. (3-30-07)

vi. Residential habilitation service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks;" (4-4-13)

vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure. Direct service staff must also have taken a traumatic brain injury training course approved by the Department. (3-30-07)

b. The provider agency is responsible for providing direct service staff with a traumatic brain injury training course approved by the Department, and training specific to the needs of the participant. (4-4-13)

c. Prior to delivering services to a participant, agency direct service staff must complete an orientation program. The orientation program must include the following subjects: (4-4-13)

i. Purpose and philosophy of services; (3-30-07)

ii. Service rules; (3-30-07)

iii. Policies and procedures; (3-30-07)

iv. Proper conduct in relating to waiver participants; (3-30-07)

v. Handling of confidential and emergency situations that involve the waiver participant; (3-30-07)

vi. Participant rights; (3-30-07)

vii. Methods of supervising participants; (3-30-07)

viii. Working with individuals with traumatic brain injuries; and (3-30-07)

ix. Training specific to the needs of the participant. (3-30-07)

d. Additional training requirements must be completed within six (6) months of employment with the residential habilitation agency and include at a minimum: (3-29-12)

i. Instructional techniques: Methodologies for training in a systematic and effective manner; (3-30-07)

ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; (3-30-07)

iii. Feeding; (3-30-07)

iv. Communication; (3-30-07)

v. Mobility; (3-30-07)

vi. Activities of daily living; (3-30-07)

vii. Body mechanics and lifting techniques; (3-30-07)

viii. Housekeeping techniques; and (3-30-07)

ix. Maintenance of a clean, safe, and healthy environment. (3-30-07)

e. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed. (4-4-13)

1~~6~~8. **Day Habilitation**. Providers of day habilitation services must have a minimum of two (2) 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. Day habilitation providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

1~~7~~9. **Respite Care**. Providers of respite care services must meet the following minimum qualifications: (4-4-13)

a. Have received care giving instructions in the needs of the person who will be provided the service; (4-4-13)

b. Demonstrate the ability to provide services according to a plan of service; (4-4-13)

c. Be free of communicable disease; and (4-4-13)

d. Respite care service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

~~18~~20. **Supported Employment**. Supported employment services must be provided by an agency that supervises the direct service and is accredited by the Commission on Accreditation of Rehabilitation Facilities or

other comparable standards, or meet State requirements to be a State-approved provider. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." Providers must also take a traumatic brain injury training course approved by the Department. (4-4-13)

21~~9~~. **Chore Services**. Providers of chore services must meet the following minimum qualifications: (4-4-13)

a. Be skilled in the type of service to be provided; and (4-4-13)

b. Demonstrate the ability to provide services according to a plan of service. (4-4-13)

c. Chore service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

d. Meet, either by formal training or demonstrated competency, the training requirements in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)

(BREAK IN CONTINUITY OF SECTIONS)

513. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PLAN OF SERVICE.
In collaboration with the participant, the Department must assure that the participant has one (1) plan of service. This plan of service is based on the individualized participant budget referred to in Section 514 of these rules and must identify all services and supports. Participants may develop their own plan or designate a paid or non-paid plan developer. In developing the plan of service, the plan developer and the participant must identify services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. Authorized services must be delivered by providers who are selected by the participant. (3-29-12)

01. Qualifications of a Paid Plan Developer. Neither a provider of direct service to the participant nor the assessor may be chosen to be the paid plan developer. Family members and all others who wish to be paid for plan development must be employed as a service coordinator as defined in Sections 729 through 732 of these rules. (3-19-07)

02. Plan Development. With the aid of a facilitator, ~~T~~the plan must be developed ~~*with*~~ by the participant. ~~*With the participant's consent, the person-centered planning team*~~ Individuals invited to participate in the person-centered planning process will be identified by the participant and may include family members, guardian, or individuals who are significant to the participant. In developing the plan of service, the plan developer and participant must identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals and outcomes. ( )

a. The plan of service must be submitted within forty-five (45) days prior to the expiration of the existing plan of service unless delayed because of participant unavailability due to extenuating circumstances. If the plan is not submitted within this time period, authorization for provider payments may be terminated. ~~*(3-19-07)*~~( )

b. The plan development process must meet the person-centered planning requirements described in Section 315 of these rules. ( )

03. Prior Authorization Outside of These Rules. The plan developer must ensure that all services that require prior authorization outside of these rules are submitted to the appropriate unit of the Department. These services include: (3-19-07)

a. Durable Medical Equipment (DME); (3-19-07)

b. Transportation; and (3-19-07)

c. Physical therapy, occupational therapy, and speech-language pathology services. (7-1-13)

04. No Duplication of Services. The plan developer will ensure that there is no duplication of services. Duplicate services will not be authorized. (3-29-12)

05. Plan Monitoring. The participant, service coordinator or plan monitor must monitor the plan. The plan developer is the plan monitor unless there is a service coordinator, in which case the service coordinator assumes the roles of both service coordinator and plan monitor. The planning team must identify the frequency of monitoring, which must be at least every ninety (90) days. Plan monitoring must include the following: (3-19-07)

a. Review of the plan of service in a face-to-face contact with the participant to identify the current status of programs and changes if needed; (3-19-07)

b. Contact with service providers to identify barriers to service provision; (3-19-07)

c. Discuss with participant satisfaction regarding quality and quantity of services; and (3-19-07)

d. Review of provider status reviews. (3-29-12)

e. The provider will immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as well as injuries of unknown origin to the agency administrator, the Department, the adult protection authority, and any other entity identified under Section 39-5303, Idaho Code, or federal law. (3-29-12)

06. Provider Status Reviews. Service providers, with exceptions identified in Subsection 513.~~11~~09 of these rules, must report the participant's progress toward goals to the plan monitor on the provider status review when the plan has been in effect for six (6) months and at the annual person-centered planning meeting. The semi-annual and annual reviews must include: ~~(3-19-07)~~( )

a. The status of supports and services to identify progress; (3-19-07)

b. Maintenance; or (3-19-07)

c. Delay or prevention of regression. (3-19-07)

07. Content of the Plan of Service. The plan of service 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. The plan of service must include activities to promote progress, maintain functional skills, or delay or prevent regression. (3-19-07)

a. The written plan of service must meet the person-centered planning requirements described in Section 316 of these rules. ( )

b. The written plan of service must be finalized and agreed to according to procedural requirements described in Section 704 of these rules. ( )

c. The Department will distribute a copy of the plan of service to adult DD service providers defined in Sections 513 and 649 of these rules. Additionally, the plan developer will be responsible to distribute a copy of the plan of service, in whole or part, to any other developmental disability service provider identified by the participant during the person-centered planning process. ( )

08. Informed Consent. Unless the participant has a guardian with ~~appropriate~~ full decision-making authority, the participant must make decisions regarding the type and amount of services required. Information and support must be given to the participant to maximize their ability to make informed choices regarding the services

and supports they receive and from whom. During plan development and amendment, planning team members must each indicate whether they believe the plan meets the needs of the participant, and represents the participant's choice. If not, the plan or amendment must be referred to the Bureau of Care Management's Medicaid Consumer Relations Specialist to negotiate a resolution with members of the planning team. ~~(3-19-07)~~( )

09. Provider Implementation Plan. Each provider of Medicaid services~~, subject to prior authorization,~~ must develop an implementation plan that complies with home and community based setting requirements and identifies specific objectives that relate to goals finalized and agreed to in the participant's authorized plan of service. These objectives must demonstrate how the provider will assist the participant to meet the participant's goals, desired outcomes, and needs identified in the plan of service. ~~(3-19-07)~~( )

a. Exceptions. An implementation plan is not required for waiver providers of: (3-19-07)

i. Specialized medical equipment; (3-19-07)

ii. Home delivered meals; (3-19-07)

iii. Environmental ~~modifications~~ accessibility adaptations; ~~(3-19-07)~~( )

iv. Non-medical transportation; (3-19-07)

v. Personal emergency response systems (PERS); (3-19-07)

vi. Respite care; and (3-19-07)

vii. Chore services. (3-19-07)

b. Time for Completion. ~~The i~~Implementation plans must be completed within fourteen (14) days ~~after the initial provision of service, and revised whenever participant needs change~~ of receipt of the authorized plan of service or the service start date, whichever is later. ~~(3-19-07)~~( )

i. If the authorized plan of service is received after the service start date, service providers must support billing by documenting service provision as agreed to by the participant and consistent with Section 704 of these rules. ( )

ii. Implementation plan revision must be based on changes to the needs of the participant. ( )

c. Documentation of Changes. Documentation of Implementation Plan changes will be included in the participant's record. This documentation must include, at a minimum, the reason for the change, documentation of coordination with other service providers (where applicable), the date the change was made, the signature of the person making the change complete with the date and title. (3-19-07)

10. Home and Community Based Services Plan of Service Signature. Upon receipt of the authorized plan of service, HCBS providers responsible for the implementation of the plan as identified in Section 316 of these rules must sign the plan indicating they will deliver services according to the finalized and authorized plan of service, and consistent with home and community based setting requirements. Each HCBS provider responsible for the implementation of the plan must maintain their signed plan in the participant's record. Provider signature will be completed each time an initial or annual plan of service is implemented. ( )

1~~0~~1. Addendum to the Plan of Service. A plan of service 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, or a change of provider. Additional assessments or information may be clinically necessary. Adjustment of the plan of service is subject to prior authorization by the Department. (3-29-12)

~~**11. Community Crisis Supports**. Community crisis supports are interventions for participants who have been determined eligible for developmental disability services and who are at risk of losing housing, employment or income, or are at risk of incarceration, physical harm, family altercation, or other emergencies.~~

~~*Community crisis support may be authorized the following business day after the intervention if there is a documented need for immediate intervention, no other means of support are available, and the services are appropriate to rectify the crisis. Community crisis support is limited to a maximum of twenty (20) hours during any consecutive five (5) day period.* (3-19-07)~~

~~**a.** *Emergency Room. Crisis services may be provided in an emergency room during the ER evaluation process if the goal is to prevent hospitalization and return the participant to the community.* (3-19-07)~~

~~**b.** *Before Plan Development. Community crisis support may be provided before or after the completion of the assessment and plan of service. If community crisis support is provided before the completion of the assessment and plan of service, the plan of service must include an identification of the factors contributing to the crisis and a strategy for addressing those factors in the future.* (3-19-07)~~

~~**c.** *Crisis Resolution Plan. 'After community crisis support has been provided, the provider of the community crisis support service must complete a crisis resolution plan and submit it to the Department for approval within three (3) business days.* (3-19-07)~~

12. Annual Reauthorization of Services. A participant's plan of service must be reauthorized annually. The Department must review and authorize the new plan of service prior to the expiration of the current plan. (3-19-07)

a. Plan Developer Responsibilities for Annual Reauthorization. A new plan of service must be provided to the Department by the plan developer at least forty-five (45) days prior to the expiration date of the current plan. Prior to this, the plan developer must: (3-19-07)

i. Notify the providers who appear on the plan of service of the annual review date. (3-19-07)

ii. Obtain a copy of the current annual provider status review from each provider for use by the person-centered planning team. Each provider status review must meet the requirements in Subsection 513.~~14.d.~~06 of these rules. ~~(3-19-07)~~( )

iii. Convene the person-centered planning team to develop a new plan of service; inviting individuals to participate that have been identified by the participant. ~~(3-19-07)~~( )

b. Evaluation and Prior Authorization of the Plan of Service. The plan of service must be evaluated and prior authorized in accordance with the requirements in Sections 507 and 513 of these rules. (3-19-07)

c. Adjustments to the Annual Budget and Services. The annual budget and services may be adjusted by the Department based on demonstrated outcomes, progress toward goals and objectives, and benefit of services. (3-29-12)

d. Annual Status Reviews Requirement. If the provider's annual status reviews are not submitted with the annual plan, services will not be authorized at the time of the annual reauthorization. These services may be added to the plan of service only by means of an addendum to the plan in accordance with Subsection 513.1~~2~~0 of these rules. ~~(3-19-07)~~( )

e. Reapplication After a Lapse in Service. For participants who are re-applying for service after a lapse in service, the assessor must evaluate whether assessments are current and accurately describe the status of the participant. (3-19-07)

f. Annual Assessment Results. An annual assessment must be completed in accordance with Section 512 of these rules. (3-19-07)

13. Complaints and Administrative Appeals. (3-29-12)

a. Participant complaints about the assessment process, eligibility determination, plan development, quality of service, and other relevant concerns may be referred to the Division of Medicaid. (3-29-12)

b. A participant who disagrees with a Department decision regarding program eligibility and authorization of services under these rules may file an appeal. Administrative appeals are governed by provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (3-29-12)

(BREAK IN CONTINUITY OF SECTIONS)

515. ADULT DEVELOPMENTAL DISABILITY SERVICES: QUALITY ASSURANCE AND IMPROVEMENT.

01. Quality Assurance. Quality Assurance consists of audits and reviews to assure compliance with the Department's rules and regulations. If problems are identified during the review or audit, the provider must implement a corrective action plan within forty-five (45) days after the results are received. The Department may ~~*terminate authorization of service for providers who do not comply with the corrective action plan*~~ take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with the corrective action plan, any term or provision of the provider agreement, or any applicable state or federal regulation. ~~*(3-19-07)*~~( )

02. Quality Improvement. The Department may gather and utilize information from providers to evaluate customer satisfaction, 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. ~~*(3-19-07)*~~( )

03. Exception Review. The Department will complete an exception review of plans or addendums requesting services that exceed the assigned budget authorized by the assessor. Requests for these services will be authorized when one (1) of the following conditions are met: (4-11-15)

a. Services are needed to assure the health and safety of participants who require residential high or intense supported living, and the services requested on the plan or addendum are required based on medical necessity as defined in Subsection 012.14 of these rules. (4-11-15)

b. Supported employment services as defined in Section 703 of these rules are needed for the participant to obtain or maintain employment. The request must be submitted on the Department-approved Exception Review Form and is reviewed and approved based on the following: (4-11-15)

i. A supported employment service recommendation must be submitted that includes: recommended amount of service, level of support needed, employment goals, and a transition plan. When the participant is transitioned from the Idaho Division of Vocational Rehabilitation (IDVR) services, the recommendation must be completed by IDVR. When a participant is in an established job, the recommendation must be completed by the supported employment agency identified on the plan of service or addendum; (4-11-15)

ii. The participant's plan of service was developed by the participant and his person-centered planning team and includes a goal for supported employment services. Prior to the submission of an exception review with an addendum, a comprehensive review of all services on the participant's plan must occur. The participant's combination of services must support the increase or addition of supported employment services; and (4-11-15)

iii. An acknowledgement signed by the participant and his legal guardian, if one exists, that additional budget dollars approved to purchase supported employment services must not be reallocated to purchase any other Medicaid service. (4-11-15)

04. Concurrent Review. The Department will obtain the necessary information to determine that participants continue to meet eligibility criteria, services continue to be clinically necessary, services continue to be the choice of the participant, services support participant integration, autonomy, and participant rights are maintained, and services constitute appropriate care to warrant continued authorization or need for the service. ~~*(3-19-07)*~~( )

05. Abuse, Fraud, or Substandard Care. 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. (3-19-07)

516. -- 519. (RESERVED)

SUB-PART: CHILDREN'S DEVELOPMENTAL DISABILITIES PRIOR AUTHORIZATION (Sections 520 - 528)

520. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA).
The purpose of the children's DD Prior Authorization is to ensure the provision of the right care, in the right place, at the right price, and with the right outcomes in order to enhance health and safety, and to promote participants' rights, self-determination, and independence. Prior authorization involves the assessment of the need for services, development of a budget, development of a plan of service, prior approval of services, and a quality improvement program. Prior authorization is intended to prevent the provision of unnecessary or inappropriate services and supports. Services are reimbursable if they are identified on the authorized plan of service and are consistent with the purpose and rule for prior authorization as well as rules for HCBS as described in Section 310 through 316 of these rules, and for the specific services included on the plan. ~~(7-1-11)~~( )

521. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA): DEFINITIONS.
For the purposes of Sections 520 through 528 of these rules, the following terms are used as defined below. (7-1-11)

01. Assessment. A process that is described in Section 522 of these rules for program eligibility and in Section 526 of these rules for plan of service. (7-1-11)

02. Baseline. A participant's skill level prior to intervention written in measurable, behaviorally-stated terms. (7-1-11)

03. Child. A person who is under the age of eighteen (18) years. (7-1-11)

04. Family. The participant and his parent(s) or legal guardian. (7-1-11)

05. Family-Centered Planning Process. A participant-focused planning process directed by the participant or legal guardian and facilitated by the plan developer~~, by which t~~The family-centered planning team ~~collaborates with the participant to develop~~ discusses the participant's strengths and needs and helps the participant make informed choices of the services and supports included on the plan of service. ~~(7-1-11)~~( )

06. Family-Centered Planning Team. The planning group who helps inform the participant about available support services in order to develop~~s~~ the plan of service. This group includes, at a minimum, the child participant ~~(unless otherwise determined by the family-centered planning team)~~, the participant's parent or legal guardian, and the plan developer. The family-centered planning team ~~may~~ must include ~~others identified by~~ people chosen by the participant and the family, or agreed upon by the participant and the family ~~and the Department~~ as important to the process. ~~(7-1-11)~~( )

07. ICF/ID. Intermediate care facility for persons with intellectual disabilities. (7-1-11)

08. Individualized Family Service Plan (IFSP). An initial or annual plan of service~~,~~ for providing early intervention services to children from birth to three (3) years of age (thirty-six (36) months old). The plan is developed by the family-centered planning team that includes the parent or legal guardian and eligible child participant, other planning team members chosen by the parent or legal guardian, and the Department or its designee~~, for providing early intervention services to children from birth up to three (3) years of age (36 months)~~. Th~~is~~e ~~plan~~ IFSP must meet the provisions of the Individuals with Disabilities Education Act (IDEA), Part C, and must be developed in accordance with Sections 315 through 316 of these rules. The IFSP may serve as the plan of service if it meets all of the components of the plan of service. The IFSP may also serve as a program implementation plan.

~~(7-1-13)~~( )

09. Level of Support. The amount of services and supports necessary to allow the individual to live independently and safely in the community. (7-1-11)

10. Medical, Social, and Developmental Assessment Summary. A form used by the Department to gather a participant's medical, social and developmental history and other summary information. It is required for all participants receiving home and community-based services under a plan of service. The information is used in the assessment and authorization of a participant's services. (7-1-11)

11. Plan Developer. A paid or non-paid person identified by the participant who is responsible for developing one (1) plan of service and subsequent addenda that cover all services and supports based on a family-centered planning process and meets the HCBS person-centered plan requirements as described in Section 316 of these rules. ~~(7-1-11)~~( )

12. Plan Monitor. A person who oversees the provision of services on a paid or non-paid basis and is identified on the participant's person-centered plan of service. ~~(7-1-11)~~( )

13. Plan of Service. An initial or annual plan of service, developed by the participant, parent or legal guardian, and the family-centered planning team, that identifies all services and supports based on a family-centered planning process, and which is developed for providing DD services to children birth ~~through seventeen~~ up to eighteen (1~~7~~8) years of age. This plan must be developed in accordance with Section 316 of these rules. ~~(7-1-11)~~( )

14. Practitioner of the Healing Arts, Licensed. A licensed physician, physician assistant, or nurse practitioner. (7-1-11)

15. Prior Authorization (PA). A process for determining a participant's eligibility for services and medical necessity prior to the delivery or payment of services as provided by Sections 520 and 528 these rules. (7-1-11)

16. Provider Status Review. The written documentation that identifies the participant's progress toward goals defined in the plan of service, and demonstrates the continued need for the service. (7-1-11)

17. Right Care. Accepted treatment for defined diagnosis, functional needs and abilities to achieve the desired outcome. The right care is consistent with best practice and continuous quality improvement. (7-1-11)

18. Right Place. Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. (7-1-11)

19. Right Price. The most integrated and least expensive services that are sufficiently intensive to address the participant's needs. The amount is based on the individual's needs for services and supports as identified in the assessment. (7-1-11)

20. Right Outcomes. 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. (7-1-11)

21. Services. Evaluation, diagnostic, therapy, training, assistance, and support services that are provided to persons with developmental disabilities. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

524. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA): COVERAGE AND LIMITATIONS.
The scope of these rules defines prior authorization for the following Medicaid developmental disabilities services for

children included in Section 310 of these rules: ~~(7-1-11)~~( )

01. Children's Home and Community Based State Plan Option Services. Children's home and community based state plan option services as described in Sections 660 through 666 of these rules; and (7-1-11)

02. Children's DD Waiver Services. Children's DD waiver services as described in Sections 680 through 686 of these rules. (7-1-11)

525. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA): PROCEDURAL REQUIREMENTS.
Prior to the development of the plan of service, the plan developer will gather and make referrals for the following information to ~~guide~~ facilitate the family-centered planning process: ~~(7-1-11)~~( )

01. Eligibility Determination Documentation. Eligibility determination documentation completed by the Department or its contractor as defined in Subsection 522.03 of these rules. (7-1-11)

02. History and Physical. A current history and physical completed by a practitioner of the healing arts is required at least annually or more frequently as determined by the practitioner. For participants in Healthy Connections, the Healthy Connections physician must conduct the history and physical, and may refer the participant for other evaluations. (7-1-11)

03. Discipline-Specific Assessments. Participants must be referred for an occupational therapy, physical therapy, or speech-language pathology assessment when the participant has a targeted need in one of these disciplines. The assessment is used to guide the provision of services identified on the plan of service. (7-1-11)

04. Additional Information. Gather assessments and information related to the participant's medical conditions, risk of deterioration, living conditions, individual goals, and behavioral or psychiatric needs. (7-1-11)

526. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA): PLAN OF SERVICE PROCESS.
In collaboration with the participant, the Department must ensure that the participant has one (1) plan of service. This plan of service is developed within the individualized participant budget referred to in Section 527 of these rules and must identify all services and supports. The participant and his parent or legal guardian may develop their own plan or use a paid or non-paid plan developer to assist with plan development. The plan of service must identify services and supports if available outside of Medicaid-funded services that can help the participant meet desired goals. (7-1-11)

01. Plan Development and Monitoring. Paid plan development and monitoring must be provided by the Department or its contractor in accordance with Section 315 of these rules. Non-paid plan development and monitoring may be provided by the family, or a person of their choosing, in accordance with the Home and Community Based Services (HCBS) regulations in Section 315 of these rules, when this person is not a paid provider of services identified on the child's plan of service. ~~(7-1-11)~~( )

02. Plan of Service Development. The plan of service must meet the requirements described in Section 316 of these rules. The service plan must be developed with the parent or legal guardian~~,~~ and the child participant. ~~(unless otherwise determined by the family-centered planning team)~~ and facilitated by the Department or its designee. With the parent or legal guardian's consent, the family-centered planning team may include other family members or individuals who are significant to the participant. ~~(7-1-11)~~( )

a. In developing the plan of service, the family-centered planning team must identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. (7-1-11)

b. The plan of service must identify, at a minimum, the type of service to be delivered, goals and desired outcomes to be addressed within the plan year, strengths and preferences of the participant, target dates, and methods for collaboration. ~~(7-1-11)~~( )

03. No Duplication of Services. The plan developer must ensure that there is no duplication of

services. (7-1-11)

04. Plan Monitoring. The family-centered planning team must identify the frequency of monitoring, which must be at least every six (6) months. The plan developer must meet face-to-face with the participant and his parent or legal guardian at least annually. Plan monitoring must include the following: ~~(7-1-11)~~( )

a. Review of the plan of service with the participant and his parent or legal guardian to identify the current status of programs and changes if needed; ~~(7-1-11)~~( )

b. Contact with service providers to identify barriers to service provision; (7-1-11)

c. Discuss with participant and his parent or legal guardian their satisfaction regarding quality and quantity of services; and ~~(7-1-11)~~( )

d. Review of provider status reviews. (7-1-11)

05. Provider Status Reviews. The service providers in Sections 664 and 684 of these rules must report to the plan monitor the participant's progress toward goals. The provider must complete a six (6) month and annual provider status review. The provider status review must be submitted to the plan monitor within forty-five (45) calendar days prior to the expiration of the existing plan of service. (7-1-11)

06. Informed Consent. The participant and his parent or legal guardian must make decisions regarding the type and amount of services required. During plan development and amendments, planning team members must ~~each~~ indicate whether they believe the plan is in accordance with the participant's choices of the services and supports identified in the meeting and indicate whether they believe the plan meets the needs of the participant~~, and represents the participant's choice.~~ ~~(7-1-11)~~( )

07. Program Implementation Plan. Providers of children's waiver services listed under Section 684 of these rules must develop an implementation plan that identifies specific objectives that demonstrate how the provider will assist the participant to meet the participant's goals and needs identified in the plan of service. (7-1-13)

a. The implementation plan must be completed within fourteen (14) calendar days after the initial provision of service, and revised whenever participant needs change. (7-1-11)

b. Documentation of implementation plan changes will be included in the participant's record. This documentation must include, at a minimum, the reason for the change, documentation of coordination with other service providers (where applicable), the date the change was made, and the signature of the person making the change complete with his title and the date signed. (7-1-11)

08. Addendum to the Plan of Service. A plan of service may be adjusted during the year with an addendum to the plan. These adjustments must be based on changes in a participant's need or demonstrated outcomes. Additional assessments or information may be clinically necessary. Adjustment of the plan of service requires a parent's or legal guardian's signature and may be subject to prior authorization by the Department. (7-1-11)

09. Annual Reauthorization of Services. A participant's plan of service must be reauthorized annually. The Department must review and authorize the new plan of service prior to the expiration of the current plan. (7-1-11)

a. Annual Eligibility Determination Results. An annual determination must be completed in accordance with Section 522 of these rules. (7-1-11)

b. Plan Developer Responsibilities for Annual Reauthorization. A new plan of service must be provided to the Department by the plan developer at least ten (10) calendar days prior to the expiration date of the current plan. Prior to this, the plan developer must: (7-1-13)

i. Notify the providers who appear on the plan of service of the annual review date. (7-1-11)

ii. Obtain a copy of the current annual provider status review from each provider for use by the family-centered planning team. Each provider status review must meet the requirements in Subsection 526.06 of these rules. (7-1-11)

iii. Convene the family-centered planning team to develop a new plan of service. (7-1-11)

c. Evaluation and Prior Authorization of the Plan of Service. The plan of service must be evaluated and prior authorized in accordance with the requirements in Sections 520 and 526 of these rules. (7-1-11)

d. Adjustments to the Annual Budget and Services. The annual budget may be adjusted when there are documented changes that may support placement in a different budget category as identified in Section 527 of these rules. Services may be adjusted at any time during the plan year. (7-1-13)

e. Reapplication After a Lapse in Service. For participants who are re-applying for service after at least a thirty (30) calendar day lapse in service, the assessor must evaluate whether assessments are current and accurately describe the status of the participant. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

528. CHILDREN'S DEVELOPMENTAL DISABILITIES PRIOR AUTHORIZATION (PA): DEPARTMENT'S QUALITY ASSURANCE AND IMPROVEMENT PROCESSES.

01. Quality Assurance. Quality Assurance consists of audits and reviews to ensure compliance with the Department's rules and regulations. If problems are identified during the review or audit, the provider must implement a corrective action plan within forty-five (45) calendar days after the results are received. The Department may terminate authorization of service or the provider agreement for providers who do not comply with the corrective action plan. If the Department finds a provider's deficiency or deficiencies immediately jeopardize the health or safety of its participants, the Department may immediately terminate the provider agreement. (7-1-11)

02. Quality Improvement. The Department may gather and utilize information from participants and providers to evaluate customer satisfaction, participant satisfaction, outcomes monitoring, care management, quality assurance, quality improvement activities, and health and safety. These findings lead to quality improvement activities to improve provider processes and outcomes for participants. (7-1-11)

03. Plan of Service Review. The Department will obtain the necessary information to determine that participants continue to meet eligibility criteria, services continue to be clinically necessary, services continue to be the choice of the participant, and services constitute appropriate care to warrant continued authorization or need for the service. (7-1-11)

04. HCBS Compliance. Providers of children's developmental disability services are responsible for ensuring that they meet the person-centered planning and setting quality requirements described in Sections 312 through 317 of these rules, as applicable, and must comply with associated Department quality assurance activities. The Department may take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with any term or provision of the provider agreement, or any applicable state or federal regulation. ( )

(BREAK IN CONTINUITY OF SECTIONS)

634. -- 648 4. (RESERVED)

**ADULT DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY BASED SERVICES (HCBS) STATE PLAN OPTION
(Sections 645 - 659)**

645. HOME AND COMMUNITY BASED SERVICES (HCBS) STATE PLAN OPTION.
Home and community based services are provided through the HCBS State Plan option as allowed in Section 1915(i) of the Social Security Act for adults with developmental disabilities who do not meet the ICF/ID level of care. The HCBS state plan option services must comply with Sections 310 through 317, and Sections 647 through 659 of these rules. ( )

646. COMMUNITY CRISIS SUPPORTS.
Community crisis supports are interventions for participants who have been determined eligible for developmental disability services and who are at risk of losing housing, employment, or income, or are at risk of incarceration, physical harm, family altercation, or other emergencies. ( )

647. COMMUNITY CRISIS SUPPORTS: ELIGIBILITY.
Prior to receiving community crisis supports, an individual must be determined by the Department or its contractor to have a developmental disability under Sections 500 through 506 of these rules and Section 66-402, Idaho Code, be eighteen (18) years of age or older, and live in the community. ( )

648. COMMUNITY CRISIS SUPPORTS COVERAGE AND LIMITATIONS.
Community crisis support may be authorized the following business day after the intervention if there is a documented need for immediate intervention, no other means of support are available, and the services are appropriate to rectify the crisis. Community crisis support is limited to a maximum of twenty (20) hours during any consecutive five (5) day period. ( )

01. Emergency Room. Crisis services may be provided in an emergency room during the ER evaluation process if the goal is to prevent hospitalization and return the participant to the community. ( )

02. Before Plan Development. Community crisis support may be provided before or after the completion of the assessment and plan of service. If community crisis support is provided before the completion of the assessment and plan of service, the plan of service must include an identification of the factors contributing to the crisis and a strategy for addressing those factors in the future. ( )

03. Crisis Resolution Plan. After community crisis support has been provided, the provider of the community crisis support service must complete a crisis resolution plan and submit it to the Department for approval within three (3) business days. ( )

(BREAK IN CONTINUITY OF SECTIONS)

651. DEVELOPMENTAL THERAPY: COVERAGE REQUIREMENTS AND LIMITATIONS.
Developmental therapy must be recommended by a physician or other practitioner of the healing arts. (7-1-13)

01. Requirements to Deliver Developmental Therapy. Developmental therapy may be delivered in a developmental disabilities agency center-based program, the community, or the home of the participant. Participants living in a certified family home must not receive home-based developmental therapy in a certified family home. Developmental therapy includes individual developmental therapy and group developmental therapy. Developmental therapy must be delivered by Developmental Specialists or paraprofessionals qualified in accordance with these rules, based on an assessment completed prior to the delivery of developmental therapy. (7-1-13)

a. Areas of Service. These services must be directed toward the rehabilitation or habilitation of physical or developmental disabilities in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. (7-1-13)

b. Age-Appropriate. Developmental therapy includes instruction in daily living skills the participant has not gained at the normal developmental stages in his life, or is not likely to develop without training or therapy. Developmental therapy must be age-appropriate. (7-1-11)

c. Tutorial Activities and Educational Tasks are Excluded. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the participant's disability. (7-1-11)

d. Settings for Developmental Therapy. Developmental Therapy may be provided in home and community based settings as described in Section 311 of these rules. Developmental therapy, in both individual and group formats, must be available in both community-based and home-based settings, and be based on participant needs, interests, or choices. ~~(7-1-11)~~( )

e. Staff-to-Participant Ratio. When group developmental therapy is center-based, there must be a minimum of one (1) qualified staff, who may be a paraprofessional or a Developmental Specialist, providing direct services for every twelve (12) participants. The community-based services must occur in integrated, inclusive settings and with no more than three (3) participants per qualified staff at each session. Additional staff must be added, as necessary, to meet the needs of each individual served. (7-1-13)

02. Excluded Services. The following services are excluded for Medicaid payments: (7-1-11)

a. Vocational services; (7-1-11)

b. Educational services; and (7-1-11)

c. Recreational services. (7-1-11)

03. Limitations on Developmental Therapy. Developmental therapy may not exceed the limitations as specified below. (7-1-13)

a. Developmental therapy must not exceed twenty-two (22) hours per week. (7-1-13)

b. Developmental therapy provided in combination with Community Supported Employment services under Subsection 703.04 of these rules, must not exceed forty (40) hours per week. (7-1-13)

c. When a participant receives adult day health as provided in Subsection 703.12 of these rules, the combination of adult day, health and developmental therapy must not exceed thirty (30) hours per week. (7-1-13)

d. Only one (1) type of therapy will be reimbursed during a single time period by the Medicaid program. Developmental therapy will not be reimbursed during periods when the participant is being transported to and from the agency. (7-1-13)

(BREAK IN CONTINUITY OF SECTIONS)

653. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS FOR INDIVIDUALS WITH AN IPP.

01. Eligibility Determination. Prior to the delivery of developmental therapy, the person must be determined by the Department or its contractor to be eligible as defined under Section 66-402, Idaho Code, be eighteen (18) years of age or older, and live in the community. (7-1-13)

02. Intake. Individuals using the Home and Community-Based Services (HCBS) waiver for the Aged and Disabled (A&D) or State Plan Personal Care Services and only requesting DDA services, have the option to access services through an Individual Program Plan. Individuals who select this option are not required to have a developmental disability plan developer ~~*or an Individual Service Plan*~~. Services delivered through an Individual Program Plan must be authorized by the Department or its contractor and be based on the Aged and Disabled written Individual Service Plan as defined in Section 328 of these rules. Prior to the delivery of developmental therapy, a DDA must complete an Individual Program Plan (IPP) that meets the standards described below. ~~(7-1-13)~~( )

03. Individual Program Plan (IPP) Definitions. The delivery of developmental therapy on a ~~plan~~ written plan of care must be defined in terms of the type, amount, frequency, and duration of the service. ~~(7-1-13)~~( )

a. Type of service refers to the kind of service described in terms of: (7-1-11)

i. Group, individual, or family; and (7-1-11)

ii. Whether the service is home, community, or center-based. (7-1-11)

b. Amount of service is the total number of service hours during a specified period of time. This is typically indicated in hours per week. (7-1-11)

c. Frequency of service is the number of times service is offered during a week or month. (7-1-11)

d. Duration of service is the length of time. This is typically the length of the plan year. For ongoing services, the duration is one (1) year; services that end prior to the end of the plan year must have a specified end date. (7-1-11)

04. Individual Program Plan (IPP). (7-1-13)

a. The IPP must be developed following obtainment or completion of all applicable assessments consistent with the requirements of this chapter. (7-1-11)

b. The planning process must include the participant, his legal guardian if one exists, and others the participant or his legal guardian chooses. The participant and his legal guardian if one exists must sign the IPP indicating ~~participation in its development~~ they directed the person-centered planning process. The participant and his legal guardian if one exists must be provided a copy of the completed IPP by the DDA. ~~If the participant or his legal guardian is unable to participate, the reason must be documented in the participant's record.~~ A physician or other practitioner of the healing arts, the participant, and his legal guardian if one exists, must sign the IPP prior to initiation of any services identified within the plan. ~~(7-1-13)~~( )

c. The planning process must occur at least annually, or more often if necessary, to review and update the plan to reflect any changes in the needs or status of the participant. Revisions to the IPP requiring a change in type, amount, or duration of the service provided must be recommended by the physician or other practitioner of the healing arts prior to implementation of the change. Such recommendations require written authorization by the participant, his legal guardian if one exists, and must be maintained in the participant's file. (7-1-13)

d. The IPP must be supported by the documentation required in the participant's record in accordance with IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)" record requirements. (7-1-11)

e. The IPP must promote self-sufficiency, the participant's choice in program objectives and activities, encourage the participant's participation and inclusion in the community, and contain objectives that are age-appropriate. The IPP must include: (7-1-11)

i. The participant's name and medical diagnosis; (7-1-11)

ii. The name of the assigned Developmental Specialist, the date of the planning meeting, and the names and titles of those present at the meeting; (7-1-11)

iii. The dated signature of the physician or other practitioner of the healing arts indicating his recommendation of the services on the plan; (7-1-11)

iv. The type, amount, frequency, and duration of therapy to be provided. For developmental therapy, the total hours of services provided cannot exceed the amount recommended on the plan. The amount and frequency of the type of therapy must not deviate from the IPP more than twenty percent (20%) over a period of a four (4) weeks, unless there is documentation of a participant-based reason; (7-1-11)

v. A list of the participant's current personal goals and desired outcomes, interests, and choices; ~~(7-1-11)~~( )

vi. An accurate, current, and relevant list of the participant's specific developmental and behavioral strengths and needs. The list will identify which needs are priority based on the participant's choices and preferences. An IPP objective must be developed for each priority need; (7-1-11)

vii. A list of measurable behaviorally stated objectives, which correspond to the list of priority needs. A Program Implementation Plan must be developed for each objective; (7-1-11)

viii. The Developmental Specialist responsible for each objective; (7-1-13)

ix. The target date for completion of each objective; (7-1-11)

x. The review date; and (7-1-11)

xi. A transition plan. The transition plan is designed to facilitate the participant's independence, personal goals, and interests. The transition plan must specify criteria for participant transition into less restrictive, more integrated settings. These settings may include community-based organizations and activities, vocational training, supported or independent employment, volunteer opportunities, or other less restrictive settings. The implementation of some components of the plan may necessitate decreased hours of service or discontinuation of services from a DDA. (7-1-13)

05. Documentation of Plan Changes. Documentation of required Program Implementation Plan changes must be included in the participant's record. This documentation must include, at a minimum: (7-1-13)

a. The reason for the change; (7-1-11)

b. Documentation of coordination with other services providers, where applicable; (7-1-11)

c. The date the change was made; and (7-1-11)

d. The signature of the professional making the change complete with date, credential, and title. Changes to the IPP require documented notification of the participant and his legal guardian if one exists. Changes in type, amount, or duration of services must be recommended by a physician or other practitioner of the healing arts. Such recommendations require written authorization by the participant and his legal guardian if one exists prior to the change. If the signatures of the participant or his legal guardian cannot be obtained, then the agency must document in the participant's record the reason the signatures were not obtained. (7-1-13)

06. Home and Community Based Person-Centered Planning. Individual Program Plans completed by a DDA must meet the person-centered planning requirements described in Sections 315 and 316 of these rules and must be included in the participant's individual service plan as described in Section 328 of these rules. ( )

654. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS.

01. Assessment and Diagnostic Services. DDAs must obtain assessments required under Sections 507 through 515 of these rules. Four (4) hours is the maximum Medicaid reimbursable time allowed for the combination of all assessment, evaluation, or diagnostic services provided in any calendar year. The following assessment and diagnostic services are reimbursable when provided in accordance with these rules: (7-1-13)

a. Comprehensive Developmental Assessment; and (7-1-13)

b. Specific Skill Assessment. (7-1-13)

02. Comprehensive Developmental Assessments. Assessments must be conducted by qualified professionals defined under Section 655 of these rules. (7-1-13)

a. Comprehensive Assessments. A comprehensive assessment must: (7-1-11)

i. Determine the necessity of the service; (7-1-11)

ii. Determine the participant's needs; (7-1-11)

iii. Guide treatment; (7-1-11)

iv. Identify the participant's current and relevant strengths, needs, and interests when these are applicable to the respective discipline; and (7-1-11)

b. Date, Signature, and Credential Requirements. Assessments must be signed and dated by the professional completing the assessment and include the appropriate professional credential or qualification of that person. (7-1-11)

c. Requirements for Current Assessments. Assessments must accurately reflect the current status of the participant. To be considered current, assessments must be completed or updated at least every two (2) years for service areas in which the participant is receiving services on an ongoing basis. (7-1-13)

d. Comprehensive Developmental Assessment. A comprehensive developmental assessment must reflect a person's developmental status in the following areas: (7-1-13)

i. Self-care; (7-1-11)

ii. Receptive and expressive language; (7-1-11)

iii. Learning; (7-1-11)

iv. Gross and fine motor development; (7-1-11)

v. Self-direction; (7-1-11)

vi. Capacity for independent living; and (7-1-11)

vii. Economic self-sufficiency. (7-1-11)

03. Specific Skill Assessments. Specific skill assessments must: (7-1-13)

a. Further assess an area of limitation or deficit identified on a comprehensive assessment. (7-1-13)

b. Be related to a goal on the IPP or ISP. (7-1-13)

c. Be conducted by qualified professionals. (7-1-13)

d. Be conducted for the purposes of determining a participant’s skill level within a specific domain. (7-1-13)

e. Be used to determine baselines and develop the program implementation plan. (7-1-13)

04. DDA Program Documentation Requirements. Each DDA must maintain records for each participant the agency serves. Each participant's record must include documentation of the participant's involvement in and response to the services provided. (7-1-11)

a. General Requirements for Program Documentation. For each participant the following program documentation is required: (7-1-11)

i. Daily entry of all activities conducted toward meeting participant objectives. (7-1-11)

ii. Sufficient progress data to accurately assess the participant's progress toward each objective; and (7-1-11)

iii. A review of the data, and, when indicated, changes in the daily activities or specific implementation procedures by the qualified professional. The review must include the qualified professional's dated initials. (7-1-11)

iv. Documentation of six (6) month and annual reviews by the Developmental Specialist that includes a written description of the participant's progress toward the achievement of therapeutic goals, and the reason(s) why he continues to need services. (7-1-13)

v. Signed, authorized plan as described in Section 513 of these rules. ( )

b. DDAs must also submit provider status reviews to the plan monitor in accordance with Sections 507 through 515 of these rules. (7-1-13)

05. DDA Program Implementation Plan Requirements. For each participant, the DDA must develop a Program Implementation Plan for each DDA objective included on the participant's required plan of service. All Program Implementation Plans must be related to a goal or objective on the participant's plan of service. The Program Implementation Plan must be ~~*written and implemented*~~ developed within fourteen (14) days ~~*after the first day of ongoing programming*~~ from the plan of service start date or receipt of the authorized plan of service and be revised whenever participant needs change. ~~*If the Program Implementation Plan is not completed within this time frame, the participant's records must contain participant-based documentation justifying the delay*~~ If consistent with the timeframes above, a participant's annual Program Implementation Plan is completed after the start date of the annual plan of service, the provider will address goals and objectives as agreed to by the participant until the annual Program Implementation Plan is complete and must document service provision related to these interim goals and objectives consistent with Section 654 of these rules. The Program Implementation Plan must include the following requirements: ~~*(7-1-11)*~~( )

a. Name. The participant's name. (7-1-11)

b. Baseline Statement. A baseline statement addressing the participant's skill level and abilities related to the specific skill to be learned. (7-1-11)

c. Objectives. Measurable, behaviorally-stated objectives that correspond to those goals or objectives ~~*previously identified on*~~ finalized and agreed to in the required plan of service. ~~*(7-1-11)*~~( )

d. Written Instructions to Staff. These instructions may 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 individualized and revised as necessary to promote participant progress toward the stated objective. (7-1-11)

e. Service Environments. Identification of the type of environment(s) where services will be provided. (7-1-11)

f. Target Date. Target date for completion. (7-1-11)

g. Results of the Psychological or Psychiatric Assessment. When a participant has had a psychological or psychiatric assessment, the results of the psychological or psychiatric assessment must be used when developing objectives to ensure therapies provided in the DDA accommodate the participant's mental health needs and to ensure that none of the therapeutic methods are contra-indicated or delivered in a manner that presents a risk to the participant's mental health status. (7-1-11)

h. Home and Community Based Services Requirements. All program implementation plans must meet home and community based setting qualities defined in Section 312 of these rules. ( )

(BREAK IN CONTINUITY OF SECTIONS)

663. CHILDREN'S HCBS STATE PLAN OPTION: COVERAGE AND LIMITATIONS.
All children's home and community based services must be identified on a plan of service ~~*developed by the family-centered planning team, including*~~ directed by the participant or legal guardian and facilitated by the plan developer, and must be recommended by a physician or other practitioner of the healing arts. The following services are reimbursable when provided in accordance with these rules: ~~*(7-1-11)*~~( )

01. Respite. Respite provides supervision to the participant on an intermittent or short-term basis because of the need for relief of the primary unpaid caregiver. Respite is available in response to a family emergency or crisis, or may be used on a regular basis to provide relief to the caregiver. Respite may be provided in the participant's home, the private home of the respite provider, a DDA, or in the community. Payment for respite services are not made for room and board. (7-1-11)

a. Respite must only be offered to participants living with an unpaid caregiver who requires relief. (7-1-11)

b. Respite cannot exceed fourteen (14) consecutive days. (7-1-11)

c. Respite must not be provided at the same time other Medicaid services are being provided.(7-1-11)

d. Respite must not be provided on a continuous, long-term basis as a daily service that would enable an unpaid caregiver to work. (7-1-11)

e. The respite provider must not use restraints on participants, other than physical restraints in the case of an emergency. Physical restraints may be used in an emergency to prevent injury to the participant or others, and must be documented in the participant's record. (7-1-11)

f. When respite is provided as group respite, the following applies: (7-1-11)

i. When group respite is center-based, there must be a minimum of one (1) qualified staff providing direct services to every six (6) 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. (7-1-11)

ii. When group respite is community-based, there must be a minimum of one (1) qualified staff providing direct services to every three (3) 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. (7-1-11)

g. Respite cannot be provided as group- or center-based respite when delivered by an independent respite provider. (7-1-11)

h. For Act Early waiver participants, the cost of respite services cannot exceed ten (10) percent of the child's individualized budget amount to ensure the child receives the recommended amount of intervention based on evidence-based research. (7-1-11)

02. Habilitative Supports. Habilitative Supports provides assistance to a participant with a disability by facilitating the participant's independence and integration into the community. This service provides an opportunity 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. Habilitative Supports must: (7-1-11)

a. Not supplant services provided in school or therapy, or supplant the role of the primary caregiver; (7-1-11)

b. Ensure the participant is involved in age-appropriate activities and is engaging with typical peers according to the ability of the participant; and (7-1-11)

c. Have a minimum of one (1) qualified staff providing direct services to every three (3) participants when provided as group habilitative supports. As the number and severity of the participants with functional impairments increases, the staff participant ratio shall be adjusted accordingly. (7-1-11)

03. Family Education. Family education is professional assistance to families to help them better meet the needs of the participant. It offers education to the parent or legal guardian that is specific to the individual needs of the family and child as identified on the plan of service. Family education is delivered to families to provide an orientation to developmental disabilities and to educate families on generalized strategies for behavioral modification and intervention techniques specific to their child's diagnoses. (7-1-11)

a. Family education may also provide assistance to the parent or legal guardian in educating other unpaid caregivers regarding the needs of the participant. (7-1-11)

b. The family education providers must maintain documentation of the training in the participant's record documenting the provision of activities outlined in the plan of service. (7-1-11)

c. Family education may be provided in a group setting not to exceed five (5) participants' families. (7-1-11)

04. Family-Directed Community Supports. Families of participants eligible for the children's home and community based state plan option may choose to direct their individualized budget rather than receive the traditional services described in Subsections 663.01 through 663.03 of this rule when the participant lives at home with his parent or legal guardian. The requirements for this option are outlined in IDAPA 16.03.13 "Consumer-Directed Services." (7-1-11)

05. Limitations. (7-1-11)

a. HCBS state plan option services are limited by the participant's individualized budget amount. (7-1-11)

b. For the children's HCBS state plan option services listed in Subsections 663.01, 663.02, and 663.04 of this rule, the following are excluded for Medicaid payment: (7-1-11)

i. Vocational services; and (7-1-11)

ii. Educational services. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

680. CHILDREN'S WAIVER SERVICES.

01. Purpose of and Eligibility for Waiver Services. Under 42 CFR Section 440.180, it is the intention of the Department to provide waiver services to eligible children to prevent unnecessary institutional placement, provide for the greatest degree autonomy and of independence possible, enhance the quality of life, encourage individual choice, and achieve and maintain community integration. For a participant to be eligible, the Department must find that the participant requires services due to a developmental disability that impairs his mental or physical function or independence, is capable of being maintained safely and effectively in a non-institutional setting, and would, in the absence of such services, need to reside in an ICF/ID. ~~(7-1-13)~~( )

02. Waiver Services Provided by a DDA or the Infant Toddler Program. Services provided by a developmental disabilities agency or the Infant Toddler Program to children birth to three (3) years of age must meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C; the Family

Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. These requirements include adherence to procedural safeguards and time lines, multi-disciplinary assessments, evaluations, individualized family service plans, provision of early intervention services in the natural environment, transition planning, and enrollment and reporting requirements. (7-1-13)

683. CHILDREN'S WAIVER SERVICES: COVERAGE AND LIMITATIONS.
All children's DD waiver services must be identified on a plan of service ~~*developed by the family centered planning team, including*~~ directed by the participant or legal guardian and facilitated by the plan developer, and must be recommended by a physician or other practitioner of the healing arts. In addition to the children's home and community based state plan option services described in Section 663 of these rules, the following services are available for waiver eligible participants and are reimbursable services when provided in accordance with these rules: ~~*(7-1-11)*~~( )

01. Family Training. Family training is professional one-on-one (1 on 1) instruction to families to help them better meet the needs of the waiver participant receiving intervention services. (7-1-11)

a. Family training is limited to training in the implementation of intervention techniques as outlined in the plan of service. (7-1-11)

b. Family training must be provided to the participant's parent or legal guardian when the participant is present. (7-1-11)

c. The family training provider must maintain documentation of the training in the participant's record documenting the provision of activities outlined in the plan of service. (7-1-11)

d. The parent or legal guardian of the waiver participant is required to participate in family training when the participant is receiving habilitative interventions. The following applies for each waiver program: (7-1-11)

i. For participants enrolled in the Children's DD Waiver, the amount, duration, and frequency of the training must be determined by the family-centered planning team and the parent or legal guardian, and must be listed as a service on the plan of service. (7-1-11)

ii. For participants enrolled in the Act Early Waiver, the parent or legal guardian will be required to be present and actively participate during the intervention service session for at least twenty percent (20%) of the intervention time provided to the child. (7-1-11)

02. Interdisciplinary Training. Interdisciplinary training is professional instruction to the direct service provider. Interdisciplinary training must only be provided during the provision of a support or intervention service. Interdisciplinary training is provided to assist the direct provider to meet the needs of the waiver participant. (7-1-11)

a. Interdisciplinary training includes: (7-1-11)

i. Health and medication monitoring; (7-1-11)

ii. Positioning and transfer; (7-1-11)

iii. Intervention techniques; (7-1-11)

iv. Positive Behavior Support; (7-1-11)

v. Use of equipment; (7-1-11)

b. Interdisciplinary training must only be provided to the direct service provider when the participant is present. (7-1-11)

c. The interdisciplinary training provider must maintain documentation of the training in the participant's record documenting the provision of activities outlined in the plan of service. (7-1-11)

d. Interdisciplinary training between a habilitative interventionist and a therapeutic consultant is not a reimbursable service. (7-1-11)

e. Interdisciplinary training between employees of the same discipline is not a reimbursable service. (7-1-11)

03. Habilitative Intervention Evaluation. The purpose of the habilitative intervention evaluation is to guide the formation of developmentally-appropriate objectives and intervention strategies related to goals identified through the family-centered planning process. The habilitative interventionist must complete an evaluation prior to the initial provision of habilitative intervention services. The evaluation must include: (7-1-11)

a. Specific skills assessments for deficit areas identified through the eligibility assessment; (7-1-11)

b. Functional behavioral analysis; (7-1-11)

c. Review of all assessments and relevant histories provided by the plan developer; and (7-1-11)

d. Clinical Opinion. Professional summary that interprets and integrates the results of the testing. This summary includes functional, developmentally appropriate recommendations to guide treatment. (7-1-11)

04. Habilitative Intervention. Habilitative intervention services must be consistent, aggressive, and continuous and are provided to improve a child's functional skills and minimize problem behavior. Services include individual or group behavioral interventions and skill development activity. Habilitative intervention must be based upon the well-known and widely regarded principles of evidence-based treatment. Evidence-based treatment (EBT) refers to the use of mental and behavioral health interventions for which systematic empirical research has provided evidence of statistically significant effectiveness as treatments for specific problems. As "promising practices" meet statistically significant effectiveness, they could be included as approved approaches. (7-1-11)

a. Habilitative intervention must be provided to meet the intervention needs of the participant by developing adaptive skills for all participants, and addressing maladaptive behaviors for participants who exhibit them. (7-1-11)

i. When goals to address maladaptive behavior are identified on the plan of service, the intervention must include the development of replacement behavior rather than merely the elimination or suppression of maladaptive behavior that interferes with the child's overall general development, community, and social participation. (7-1-11)

ii. When goals to address skill development are identified on the plan of service, the intervention must provide for the acquisition of skills that are functional. (7-1-11)

b. Habilitative intervention must be provided in the participant's home or community setting, and in addition may be provided in a center-based setting. (7-1-11)

c. Group intervention may be provided in the community and center. When habilitative intervention is provided as group intervention, the following applies: (7-1-11)

i. There must be a minimum of one (1) qualified staff providing direct services for every three (3) participants. As the number and severity of the participants with functional impairments or behavioral issues increases, the staff participant ratio must be adjusted accordingly. (7-1-11)

ii. When group intervention is community-based, the child must be integrated in the community in a natural setting with typically developing peers. (7-1-11)

iii. Group intervention must be directly related to meeting the needs of the child, and be identified as

an objective in accordance with a plan of service goal. (7-1-11)

05. Therapeutic Consultation. Therapeutic consultation provides a higher level of expertise and experience to support participants who exhibit severe aggression, self-injury, and other dangerous behaviors. Therapeutic consultation is provided when a participant receiving habilitative intervention has been assessed as requiring a more advanced level of training and assistance based on the participant's complex needs. A participant requires therapeutic consultation when interventions are not demonstrating outcomes and it is anticipated that a crisis event may occur without the consultation service. (7-1-11)

a. The therapeutic consultant assists the habilitative interventionist by: (7-1-11)

i. Performing advanced assessments as necessary; (7-1-11)

ii. Developing and overseeing the implementation of a positive behavior support plan; (7-1-11)

iii. Monitoring the progress and coordinating the implementation of the positive behavioral support plan across environments; and (7-1-11)

iv. Providing consultation to other service providers and families. (7-1-11)

b. Telehealth resources may be used by a therapeutic consultant to provide consultation as appropriate and necessary. (7-1-11)

c. Therapeutic consultation providers are subject to the following limitations: (7-1-11)

i. Therapeutic consultation cannot be provided as a direct intervention service. (7-1-11)

ii. Participants must be receiving habilitative intervention services prior to accessing therapeutic consultation, with the exception of crisis situations. (7-1-11)

iii. Therapeutic consultation is limited to eighteen (18) hours per year per participant. (7-1-11)

iv. Therapeutic consultation must be prior authorized by the Department. (7-1-11)

06. Crisis Intervention. Crisis intervention services provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience a psychological, behavioral, or emotional crisis. The need for crisis intervention must meet the definition of crisis in Section 681 of these rules. This service may provide training and staff development related to the needs of a participant, and also provides emergency back-up involving the direct support of the participant in crisis. Children's crisis intervention services: (7-1-11)

a. Are provided in the home and community. (7-1-11)

b. Are provided on a short-term basis typically not to exceed thirty (30) days. (7-1-11)

c. Cannot exceed fourteen (14) days of out-of-home placement. (7-1-11)

d. Must be prior authorized by the Department. (7-1-11)

i. Authorization for crisis intervention may be requested retroactively as a result of a crisis, defined in Section 681 of these rules, when no other means of support is available to the participant. In retroactive authorizations, the crisis intervention provider must submit a request for crisis intervention to the Department within seventy-two (72) hours of providing the service. (7-1-11)

ii. If staying in the home endangers the health and safety of the participant, the family, or both, the provider may request short-term out of home placement for the participant. Out of home placement must be prior authorized by the Department. (7-1-11)

e. Must use positive behavior interventions prior to and in conjunction with the implementation of any restrictive intervention. (7-1-11)

f. Telehealth resources may be used by a crisis interventionist to provide consultation in a crisis situation. (7-1-11)

07. Family-Directed Community Supports. Families of participants eligible for the children's DD waiver may choose to direct their individualized budget rather than receive the traditional services described in Subsections 683.01 through 683.06 of this rule when the participant lives at home with the parent or legal guardian. The requirements for selecting and participating in this option are outlined in IDAPA 16.03.13 "Consumer Directed Services." Act Early Waiver participants do not have the option to choose the family-directed services path. The Act Early Waiver is intended to be a more structured program that requires increased involvement from families, and ensures children receive an intense amount of services based on evidence-based research. (7-1-11)

08. Service limitations. Children's waiver services are subject to the following limitations: (7-1-11)

a. Place of Service Delivery. Waiver services may be provided in the participant's personal residence, community, or DDA. The following living situations are specifically excluded as a place of service for waiver services: (7-1-11)

i. Licensed skilled or intermediate care facilities, certified nursing facility (NF) or hospital; and (7-1-11)

ii. Licensed Intermediate Care Facility for persons with Intellectual Disabilities (ICF/ID); and (7-1-11)

iii. Residential Care or Assisted Living Facility; (7-1-11)

iv. Additional limitations to specific services are listed under that service definition. (7-1-11)

b. According to 42 CFR 440.180, Medicaid Waiver services cannot be used to pay for special education and related services that are included in a child's Individual Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA), that are otherwise available through a local educational agency. (7-1-11)

c. Children's waiver services are limited by the participant's individualized budget amount, excluding crisis intervention. (7-1-11)

d. For the children's waiver services listed in Subsections 683.01 through 683.07 of these rules, the following are excluded for Medicaid payment: (7-1-11)

i. Vocational services; (7-1-11)

ii. Educational services; and (7-1-11)

iii. Recreational services. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

703. ADULT DD WAIVER SERVICES: COVERAGE AND LIMITATIONS.

01. Residential Habilitation. Residential habilitation services consist of an integrated array of individually tailored services and supports furnished to eligible participants. These services and supports are designed to assist the participants to reside successfully in their own homes, with their families, or in certified family homes. The services and supports that may be furnished consist of the following: (4-4-13)

a. Habilitation services aimed at assisting the individual to acquire, retain, or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (3-19-07)

i. Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (3-19-07)

ii. Money management including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (3-19-07)

iii. Daily living skills including 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, home safety, first aid, and emergency procedures; (3-19-07)

iv. Socialization including 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 non-therapeutic activities which are merely diversional or recreational in nature); (3-19-07)

v. Mobility, including 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; (3-19-07)

vi. Behavior shaping and management includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services, which consist of reinforcing physical, occupational, speech and other therapeutic programs. (3-19-07)

b. Personal Assistance Services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on his own behalf. (3-19-07)

c. Skills training to teach waiver participants, family members, alternative family caregiver(s), or 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. (3-19-07)

02. Chore Services. 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. (4-4-13)

a. Intermittent Assistance may include the following: (4-4-13)

i. Yard maintenance; (4-4-13)

ii. Minor home repair; (4-4-13)

iii. Heavy housework; (4-4-13)

iv. Sidewalk maintenance; and (4-4-13)

v. Trash removal to assist the participant to remain in the home. (4-4-13)

b. Chore activities may include the following: (4-4-13)

i. Washing windows; (4-4-13)

ii. Moving heavy furniture; (4-4-13)

iii. Shoveling snow to provide safe access inside and outside the home; (4-4-13)

iv. Chopping wood when wood is the participant's primary source of heat; and (4-4-13)

v. Tacking down loose rugs and flooring. (4-4-13)

c. These services are only available when neither the participant, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community volunteer, agency, or third-party payer is willing to provide them, or is responsible for their provision. (4-4-13)

d. In the case of rental property, the landlord's responsibility under the lease agreement will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (4-4-13)

03. Respite Care. Respite care includes short-term breaks from care giving responsibilities to non-paid caregivers. The caregiver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other services that are duplicative in nature. Respite care services provided under this waiver do not include room and board payments. Respite care services may be provided in the participant's residence, the private home of the respite provider, the community, a developmental disabilities agency, or an adult day health facility. (4-4-13)

04. Supported Employment. 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 as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work. (4-4-13)

a. Supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation must be maintained in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973 as amended, or the IDEA. (4-4-13)

b. Federal Financial Participation (FFP) cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize the employers' participation in a supported employment program; payments that are 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. (4-4-13)

05. Non-Medical Transportation. Non-medical transportation enables a waiver participant to gain access to waiver and other community services and resources. (4-4-13)

a. Non-medical transportation is offered in addition to medical transportation required in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and will not replace it. (4-4-13)

b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge or public transit providers will be utilized. (4-4-13)

06. Environmental Accessibility Adaptations. Environmental accessibility adaptations include minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization or have a risk to health, welfare, or safety. Such adaptations may include: (4-4-13)

a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but must exclude those adaptations or improvements to the home that are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. (4-4-13)

b. Unless otherwise authorized by the Department, permanent environmental modifications are limited to a home that is the participant's principal residence, and is owned by the participant or the participant's non-paid family. (4-4-13)

c. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (4-4-13)

07. Specialized Medical Equipment and Supplies. (4-4-13)

a. Specialized medical equipment and supplies include: (4-4-13)

i. Devices, controls, or appliances that enable a participant to increase his abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which he lives; and (4-4-13)

ii. Items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. (4-4-13)

b. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid State Plan and exclude those items that are not of direct medical or remedial benefit to the participant. (4-4-13)

08. Personal Emergency Response System (PERS). PERS is an electronic device that enables a waiver participant to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. This service is limited to participants who: (4-4-13)

a. Rent or own a home, or live with unpaid caregivers; (4-4-13)

b. Are alone for significant parts of the day; (4-4-13)

c. Have no caregiver for extended periods of time; and (4-4-13)

d. Would otherwise require extensive, routine supervision. (4-4-13)

09. Home Delivered Meals. Home delivered meals are meals that are delivered to a participant's home to promote adequate participant nutrition. One (1) to two (2) meals per day may be provided to a participant who: (4-4-13)

a. Rents or owns a home; (4-4-13)

b. Is alone for significant parts of the day; (4-4-13)

c. Has no caregiver for extended periods of time; and (4-4-13)

d. Is unable to prepare a meal without assistance. (4-4-13)

10. Skilled Nursing. Skilled nursing includes intermittent or continuous oversight, training, or skilled

care that is within the scope of the Nurse Practice Act. Such care must be provided by a licensed registered nurse, or licensed practical nurse, under the supervision of a registered nurse licensed to practice in Idaho. (4-4-13)

11. Behavior Consultation/Crisis Management. Behavior Consultation/Crisis Management services which provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also provide emergency back-up involving the direct support of the participant in crisis. (3-19-07)

12. Adult Day Health. Adult day health is a supervised, structured service generally furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week. It is provided outside the home of the participant in a non-institutional, community-based setting, and it encompasses health services, social services, recreation, supervision for safety, and assistance with activities of daily living needed to ensure the optimal functioning of the participant. Adult day health services provided under this waiver will not include room and board payments. Adult day health cannot exceed thirty (30) hours per week, either alone or in combination with developmental therapy and occupational therapy. (4-4-13)

13. Self-Directed Community Supports. Participants eligible for the DD Waiver may choose to self-direct their individualized budget rather than receive the traditional waiver services described in this section of rule. The requirements for this option are outlined in IDAPA 16.03.13, "Consumer Directed Services." (3-19-07)

14. Place of Service Delivery. Waiver services may be provided in home and community settings as described in Section 311 of these rules. Approved places of services include 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 waiver services: ~~(3-19-07)~~( )

a. Licensed skilled, or intermediate care facilities, certified nursing facility (NF) or hospital; and (3-19-07)

b. Licensed Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID); and (3-19-07)

c. Residential Care or Assisted Living Facility. (3-19-07)

d. Additional limitations to specific services are listed under that service definition. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

723. TARGETED SERVICE COORDINATION: ELIGIBILITY: INDIVIDUALS WITH A DEVELOPMENTAL DISABILITY.
An individual is eligible to receive targeted service coordination if he meets the following requirements in Subsection 723.01 through 723.03 of this rule. ~~(5-8-09)~~( )

01. Age. An adult eighteen (18) years of age or older. (3-29-10)

02. Diagnosis. Is diagnosed with a developmental disability, defined in Section 66-402, Idaho Code and Section 500 through 506 of these rules, that: (5-8-09)

a. Is attributable to an impairment, such as an intellectual disability, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one (1) of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments; (5-8-09)

b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (3-19-07)

c. Reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and individually planned and coordinated. (5-8-09)

03. Need Assistance. Requires and chooses assistance to access services and supports necessary to maintain his independence in the community. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

727. SERVICE COORDINATION: COVERAGE AND LIMITATIONS.
Service coordination consists of services provided to assist individuals in gaining access to needed services. Service coordination includes the following activities described in Subsections 727.01 through 727.10 of this rule. (3-20-14)

01. Plan Assessment and Periodic Reassessment. Activities that are required to determine the participant's needs by development of a plan assessment and periodic reassessment as described in Section 730 of these rules. These activities include: (5-8-09)

a. Taking a participant's history; (5-8-09)

b. Identifying the participant's needs and completing related documentation; and (5-8-09)

c. Gathering information from other sources such as family members, medical providers, social workers, and educators, to form a complete assessment of the participant. (5-8-09)

02. Development of the Plan. Development and revision of a specific plan, described in Section 731 of these rules that includes information collected through the assessment and specifies goals and actions needed by the participant. The plan must be updated at least annually and as needed to meet the needs of the participant. (3-20-14)

03. Referral and Related Activities. Activities that help link the participant with service providers that are capable of providing needed services to address identified needs and achieve goals specified in the service coordination plan. (3-20-14)

04. Monitoring and Follow-Up Activities. Monitoring and follow-up contacts that are necessary to ensure the plan is implemented and adequately addresses the participant's needs. These activities may be with the participant, family members, providers, or other entities or individuals and conducted as frequently as necessary. These activities must include at least one face-to-face contact with the participant at least every ninety (90) days, to determine whether the following conditions are met: (5-8-09)

a. Services are being provided according to the participant's plan; (5-8-09)

b. Services in the plan are adequate; and (5-8-09)

c. Whether there are changes in the needs or status of the participant, and if so, making necessary adjustments in the plan and service arrangements with providers. (5-8-09)

05. Crisis Assistance. Crisis assistance is service coordination used to assist a participant to access community resources in order to resolve a crisis. Crisis service coordination does not include crisis counseling, transportation to emergency service providers, or direct skill-building services. The need for all crisis assistance hours must meet the definition of crisis in Section 721 of these rules. (5-8-09)

a. Crisis Assistance for Children's Service Coordination. Crisis hours are not available until four and a half (4.5) hours of service coordination have already been provided in the month. Crisis hours for children's service coordination must be authorized by the Department. (5-8-09)

b. Crisis Assistance for Adults With a Developmental Disability. Crisis hours are not available until four and a half (4.5) hours of service coordination have already been provided in the month. Crisis assistance for adults with a developmental disability must be authorized by the Department and is based on community crisis supports as found in Section ~~507~~ 646 through ~~515~~ 648 of these rules. ~~(5-8-09)~~( )

c. Authorization for crisis assistance hours may be requested retroactively as a result of a crisis, defined in Section 721 of these rules, when a participant's service coordination benefits have been exhausted and no other means of support is available to the participant. In retroactive authorizations, the service coordinator must submit a request for crisis services to the Department within seventy-two (72) hours of providing the service. (5-8-09)

06. Contacts for Assistance. Service coordination may include contacts with non-eligible individuals only when the contact is directly related to identifying the needs and supports to help the participant access services. (5-8-09)

07. Exclusions. Service coordination does not include activities that are: (5-8-09)

a. An integral component of another covered Medicaid service; (5-8-09)

b. Integral to the administration of foster care programs; (5-8-09)

c. Integral to the administration of another non-medical program for which a participant may be eligible. This exclusion does not apply to case management provided as part of the individualized education program or individualized family service plan required by the Individuals with Disabilities Education Act. (5-8-09)

08. Limitations on the Provision of Direct Services. Providers of service coordination services may only provide both service coordination and direct services to the same Medicaid participant when the participant is receiving children's service coordination. The service coordination provider must document that the participant has made a free choice of service coordinators and direct service providers. (3-20-14)

09. Limitations on Service Coordination. Service coordination is limited to four and a half (4.5) hours per month. (3-20-14)

10. Limitations on Service Coordination Plan Assessment and Plan Development. Reimbursement for the annual assessment and plan development cannot exceed six (6) hours per year. (3-20-14)

(BREAK IN CONTINUITY OF SECTIONS)

731. SERVICE COORDINATION: PLAN DEVELOPMENT -- WRITTEN PLAN.
The service coordination plan is developed using information collected through the assessment of the participant's service coordination needs. The plan must specify the goals and actions to address the service coordination needs of the participant identified in the assessment process. The plan must include goals developed using the person-centered planning process. (5-8-09)

01. Plan Implementation. The plan must identify activities required to respond to the assessed needs of the participant. (5-8-09)

02. Plan Content. Plans must include the following: (5-8-09)

a. A list of problems and needs identified during the assessment; (5-8-09)

b. Identification of each and any potential risk or substantiation that there are no potential risks. The plan must identify services and actions that will be implemented in case of a participant crisis situation. (5-8-09)

c. Concrete, measurable goals and objectives to be achieved by the participant; (5-8-09)

d. Reference to all services and contributions provided by the participant's supports including the actions, if any, taken by the service coordinator to develop the support system; (5-8-09)

e. Documentation of who has been involved in the service planning, including the participant's involvement; (5-8-09)

f. Schedules for service coordination monitoring, progress review, and reassessment; (5-8-09)

g. Documentation of unmet needs and service gaps including goals to address these needs or gaps; (5-8-09)

h. References to any formal services arranged including costs, specific providers, schedules of service initiation, frequency or anticipated dates of delivery; and (5-8-09)

i. Time frames for achievement of the goals and objectives. (5-8-09)

03. Adult Developmental Disability Service Coordination Plan. The plan for adults with developmental disabilities must comply with and be incorporated into the participant's developmental disability plan of service identified in Section 513 of these rules. ~~(5-8-09)~~( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.13 - CONSUMER-DIRECTED SERVICES

DOCKET NO. 16-0313-1501

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearings concerning this rulemaking will be held as follows:

Monday, October 19, 2015 10:00 a.m. (MDT)	Monday, October 19, 2015 2:00 p.m. (MDT)	Tuesday, October 20, 2015 1:30 p.m. (PDT)
Medicaid Central Office **3232 W. Elder Street** **Conference Room D -- West/East** **Boise, ID**	**Medicaid Region VII Office** **150 Shoup Ave., Suite 20** **Large Conference Room** **Idaho Falls, ID**	**Medicaid Region II Office** **1118 "F" Street** **2nd Floor Conference Room** **Coeur d'Alene, ID**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

These rule changes are needed to align with and implement new requirements in federal regulations that went into effect March 17, 2014, for Idaho's Home and Community Based Services (HCBS) offered through the State Plan, and under the authority of the HCBS 1915(c) waiver and the 1915(i) State Plan Option. The purpose of the regulations is to enhance participants' opportunities to receive services in the most appropriate integrated settings, and to increase their opportunities for choice and access to the benefits of community living.

New rules pertaining to Home and Community Based Services will be added to ensure that participants receiving HCBS services live in and receive services in settings that comply with required qualities of settings, service delivery methods, and person-centered planning processes.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking has no fiscal impact to the state general fund. This rulemaking is intended to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the June 3, 2015, Idaho Administrative Bulletin, **Vol. 15-6, pages 47-48**.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

CONTACT INFORMATION, WEB ADDRESS, ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Stephanie Perry at (208) 364-1878.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 31st Day of August, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5564; fax: (208) 334-6558
e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0313-1501
(Only Those Sections With Amendments Are Shown.)

010. DEFINITIONS.

01. Circle of Supports. People who encourage and care about the participant and provide unpaid supports. (3-30-07)

02. Community Support Worker. An individual, agency, or vendor selected and paid by the participant to provide community support worker services. (3-30-07)

03. Community Support Worker Services. Community support worker services are those identified supports listed in Section 110 of these rules. (3-30-07)

04. Consumer-Directed Community Supports (CDCS). For the purposes of this chapter, consumer-directed supports include Self-Directed Community Supports (SDCS) and Family-Directed Community Supports (FDCS). (7-1-11)

05. Family-Directed Community Supports (FDCS). A program option for children eligible for the Children's Developmental Disabilities (DD) Waiver and the Children's Home and Community Based Services State Plan Option described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-11)

06. Financial Management Services (FMS). Services provided by a fiscal employer agent that include: (3-29-10)

a. Financial guidance and support to the participant by tracking individual expenditures and monitoring overall budgets; (3-30-07)

b. Performing payroll services; and (3-30-07)

c. Handling billing and employment related documentation responsibilities. (3-30-07)

07. Fiscal Employer Agent (FEA). An agency that provides financial management services to participants who have chosen the CDCS option. The fiscal employer agent (FEA) is selected by the participant. The duties of the FEA are defined under Section 3504 of the Internal Revenue Code (26 USC 3504). (7-1-11)

08. Goods. Tangible products or merchandise that are authorized on the support and spending plan. (3-30-07)

09. Guiding Principles for the CDCS Option. Consumer-Directed Community Supports is based upon the concept of self-determination and has the following guiding principles: (7-1-11)

a. Freedom for the participant to make choices and plan his own life; (3-30-07)

b. Authority for the participant to control resources allocated to him to acquire needed supports; (3-30-07)

c. Opportunity for the participant to choose his own supports; (3-30-07)

d. Responsibility for the participant to make choices and take responsibility for the result of those choices; and (3-30-07)

e. Shared responsibility between the participant and his community to help the participant become an involved and contributing member of that community. (3-30-07)

10. Home and Community Based Services (HCBS). HCBS are those long-term services and supports available to assist eligible older adults and people with disabilities to remain in their home and community. ( )

1~~0~~1. **Participant**. A person eligible for and enrolled in the Consumer-Directed Services Programs. (7-1-11)

1~~1~~2. **Readiness Review**. A review conducted by the Department to ensure that each fiscal employer agent is prepared to enter into and comply with the requirements of the provider agreement and this chapter of rules. (3-29-10)

1~~2~~3. **Self-Directed Community Supports (SDCS)**. A program option for adults eligible for the Adult Developmental Disabilities (DD) Waiver described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-11)

1~~3~~4. **Support and Spending Plan**. A support and spending plan is a document that functions as a participant's plan of care when the participant is eligible for and has chosen a consumer-directed service option. This document identifies the goods or services, or both, selected by a participant, including those goods, services, and supports available outside of Medicaid-funded services that can help the participant meet desired goals, and the cost of each of the identified goods and services. The participant uses this document to manage his individualized budget. (3-29-12)

1~~4~~5. **Supports**. Services provided for a participant, or a person who provides a support service. A support service may be a paid service provided by a community support worker, or an unpaid service provided by a natural support, such as a family member, a friend, neighbor, or other volunteer. A person who provides a support service for pay is a paid support. A person who provides a volunteer support service is a natural support. (3-30-07)

1~~5~~6. **Support Broker**. An individual who advocates on behalf of the participant and who is hired by the participant to provide support broker Services. (3-30-07)

1~~6~~7. **Support Broker Services**. Services provided by a support broker to assist the participant with planning, negotiating, and budgeting. (3-30-07)

1~~7~~8. **Traditional Adult DD Waiver Services**. A program option for participants eligible for the Adult Developmental Disabilities (DD) Waiver consisting of the specific Medicaid Enhanced Plan Benefits described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-11)

1~~8~~19. **Traditional Children's DD Waiver Services**. A program option for children eligible for the Children's Developmental Disabilities (DD) Waiver consisting of the specific Medicaid Enhanced Plan Benefits described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-11)

~~19~~20. **Traditional Children's HCBS State Plan Option Services**. A program option for children eligible for the Children's Home and Community-Based Services (HCBS) State Plan Option consisting of the specific Medicaid Enhanced Plan Benefits described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-11)

2~~0~~1. Waiver Services. A collective term that refers to services provided under a Medicaid Waiver program. (3-29-10)

(BREAK IN CONTINUITY OF SECTIONS)

101. ELIGIBILITY.

01. Determination of Medicaid and Home and Community Based Services - DD Requirements. In order to choose the CDCS option, the participant must first be determined Medicaid-eligible and must be determined to meet existing DD waiver programs or HCBS State Plan Option requirements as outlined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-11)

02. Participant Agreement Form. The participant, and his legal representative, if one exists, must agree in writing using a Department-approved form to the following: (3-30-07)

a. Accept the guiding principles for the CDCS option, as defined in Section 010 of these rules; (7-1-11)

b. Agree to meet the participant responsibilities outlined in Section 120 of these rules; (3-30-07)

c. Take responsibility for and accept potential risks, and any resulting consequences, for their support choices~~.~~; and ~~(3-30-07)~~( )

d. Acknowledge and follow the rules in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 310 through 316. ( )

03. Legal Representative Agreement. The participant's legal representative, if one exists, must agree in writing to honor the choices of the participant as required by the guiding principles for the CDCS option. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

120. PARTICIPANT RESPONSIBILITIES.
With the assistance of the support broker and the legal representative, if one exists, the participant is responsible for the following: (3-30-07)

01. Guiding Principles. Accepting and honoring the guiding principles for the CDCS option found in Section 010 of these rules. (7-1-11)

02. Person-Centered Planning. ~~*Participating in*~~ Directing the person-centered planning process in order to identify and document paid and unpaid support and service needs, wants, and preferences. ~~(3-29-12)~~( )

03. Rates. Negotiating payment rates for all paid community supports he wants to purchase, ensuring rates negotiated for supports and services do not exceed the prevailing market rate, and that are cost-effective when comparing them to reasonable alternatives, and including the details in the employment agreements. (3-29-12)

04. Agreements. Completing and implementing agreements for the fiscal employer agent, the support broker and community support workers and submitting the agreements to the fiscal employer agent. These agreements must be submitted on Department-approved forms. (3-30-07)

05. Agreement Detail. Ensuring that employment agreements specifically identify the type of support being purchased, the rate negotiated for the support, and the frequency and duration of the scheduled support or service. The participant is responsible for ensuring that each employment agreement: clearly identifies the

qualifications needed to provide the support or service; includes a statement signed by the hired worker that he possesses the needed skills; and the signature of the participant that verifies the same. Additionally, each employment agreement will include statements that: the participant is the employer even though payment comes from a third party; employees are under the direction and control of the participant; services must be delivered consistent with the rules in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 310 through 316; and no employer-related claims will be filed against the Department. ~~(3-30-07)~~( )

06. Plan. Developing a comprehensive support and spending plan based on the information gathered during the person-centered planning. (3-30-07)

07. Time Sheets and Invoices. Reviewing and verifying that supports being billed were provided and indicating that he approves of the bill by signing the timesheet or invoice. (3-29-10)

08. Quality Assurance and Improvement. Providing feedback to the best of his ability regarding his satisfaction with the supports he receives and the performance of his workers. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

136. SUPPORT BROKER DUTIES AND RESPONSIBILITIES.

01. Support Broker Initial Documentation. Prior to beginning employment for the participant, the support broker must complete the packet of information provided by the fiscal employer agent and submit it to the fiscal employer agent. This packet must include documentation of: (3-30-07)

a. Support broker application approval by the Department; (3-30-07)

b. A completed criminal history check, including clearance in accordance with IDAPA 16.05.06, "Criminal History and Background Checks"; and (3-30-07)

c. A completed employment agreement with the participant that identifies the specific tasks and services that are required of the support broker. The employment agreement must include the negotiated hourly rate for the support broker, and the type, frequency, and duration of services. The negotiated rate must not exceed the maximum hourly rate for support broker services established by the Department. (3-30-07)

02. Required Support Broker Duties. Support broker services may include only a few required tasks or may be provided as a comprehensive service package depending on the participant's needs and preferences. At a minimum, the support broker must: (3-30-07)

a. ~~*Participate in*~~ Assist in facilitating the person-centered planning process as directed by the participant and consistent with the rules in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 315 and 316; ~~(3-30-07)~~( )

b. Develop a written support and spending plan with the participant that includes the paid and unpaid supports that the participant needs and wants, related risks identified with the participant's wants and preferences, and a comprehensive risk plan for each potential risk that includes at least three (3) backup plans should a support fail. This plan must be authorized by the Department; (3-29-12)

c. Assist the participant to monitor and review his budget; (3-30-07)

d. Submit documentation regarding the participant's satisfaction with identified supports as requested by the Department; (3-30-07)

e. Participate with Department quality assurance measures, as requested; (3-30-07)

f. Assist the participant to complete the annual re-determination process as needed, including

updating the support and spending plan and submitting it to the Department for authorization; (3-30-07)

g. Assist the participant, as needed, to meet the participant responsibilities outlined in Section 120 of these rules and assist the participant, as needed, to protect his own health and safety; (7-1-11)

h. Complete the Department-approved criminal history check waiver form when a participant chooses to waive the criminal history check requirement for a community support worker. Completion of this form requires that the support broker provide education and counseling to the participant and his circle of support regarding the risks of waiving a criminal history check and assist with detailing the rationale for waiving the criminal history check and how health and safety will be protected; and (7-1-11)

i. Assist children enrolled in the Family-Directed Community Supports (FDCS) Option as they transition to adult DD services. (7-1-11)

j. Sign the written support and spending plan as required in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 316. ( )

03. Additional Support Broker Duties. In addition to the required support broker duties, each support broker must be able to provide the following services when requested by the participant: (3-30-07)

a. Assist the participant to develop and maintain a circle of support; (3-30-07)

b. Help the participant learn and implement the skills needed to recruit, hire, and monitor community supports; (3-30-07)

c. Assist the participant to negotiate rates for paid community support workers; (3-30-07)

d. Maintain documentation of supports provided by each community support worker and participant's satisfaction with these supports; (3-30-07)

e. Assist the participant to monitor community supports; (3-30-07)

f. Assist the participant to resolve employment-related problems; ~~*and*~~ ~~*(3-30-07)*~~( )

g. Assist the participant to identify and develop community resources to meet specific needs~~.~~; and ~~*(3-30-07)*~~( )

h. Assist the participant in distributing the support and spending plan to community support workers or vendors as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 316. ( )

04. Termination of Support Broker Services. If a support broker decides to end services with a participant, he must give the participant at least thirty (30) days' written notice prior to terminating services. The support broker must assist the participant to identify a new support broker and provide the participant and new support broker with a written service transition plan by the date of termination. The transition plan must include an updated support and spending plan that reflects current supports being received, details about the existing community support workers, and unmet needs. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

160. SUPPORT AND SPENDING PLAN DEVELOPMENT.

01. Support and Spending Plan Requirements. The participant, with the help of his support broker, must develop a comprehensive support and spending plan based on the information gathered during the person-centered planning. The support and spending plan is not valid until authorized by the Department and must include the following: (3-30-07)

a. The participant's preferences and interests by identifying all the supports and services, both paid and non-paid, the participant wants and needs to live successfully in his community. (3-30-07)

b. Paid or non-paid consumer-directed community supports that focus on the participant's wants, needs, and goals in the following areas: (7-1-11)

i. Personal health and safety including quality of life preferences; (3-30-07)

ii. Securing and maintaining employment; (3-30-07)

iii. Establishing and maintaining relationships with family, friends and others to build the participant's circle of supports; (3-30-07)

iv. Learning and practicing ways to recognize and minimize interfering behaviors; and (3-30-07)

v. Learning new skills or improving existing ones to accomplish set goals. (3-30-07)

c. Support needs such as: (3-30-07)

i. Medical care and medicine; (3-30-07)

ii. Skilled care including therapies or nursing needs; (3-30-07)

iii. Community involvement; (3-30-07)

iv. Preferred living arrangements including possible roommate(s); and (3-30-07)

v. Response to emergencies including access to emergency assistance and care. This plan should reflect the wants, preferences, and needs of the whole person, regardless of payment source, if any. (3-30-07)

d. Risks or safety concerns in relation to the identified support needs on the participant's plan. The plan must specify the supports or services needed to address the risks for each issue listed, with at least three (3) backup plans for each identified risk to implement in case the need arises; (3-30-07)

e. Sources of payment for the listed supports and services, including the frequency, duration, and main task of the listed supports and services; ~~*and*~~ ~~*(3-30-07)*~~( )

f. The budgeted amounts planned in relation to the participant's needed supports. Community support worker employment agreements submitted to the fiscal employer agent must identify the negotiated rates agreed upon with each community support worker along with the specific support being purchased, the frequency and duration that the support will be provided, and the payment increment; that is, hourly or daily. The fiscal employer agent will compare and match the employment agreements to the appropriate support categories identified on the initial spending plan prior to processing time sheets or invoices for payment~~.~~; and ~~*(3-30-07)*~~( )

g. Additional HCBS person-centered plan requirements as defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 315 and 316. ( )

02. Support and Spending Plan Limitations. Support and spending plan limitations include: (3-30-07)

a. Traditional Medicaid waiver and traditional rehabilitative or habilitative services must not be purchased under the CDCS option. Because a participant cannot receive these traditional services and consumer-directed services at the same time, the participant, the support broker, and the Department must all work together to assure that there is no interruption of required services when moving between traditional services and the CDCS option; (7-1-11)

b. Paid community supports must not be provided in a group setting with recipients of traditional Medicaid waiver, rehabilitative or habilitative services. This limitation does not preclude a participant who has selected the consumer-directed option from choosing to live with recipients of traditional Medicaid services; (7-1-11)

c. All paid community supports must fit into one (1) or more types of community supports described in Section 110 of these rules. The support and spending plan must not include supports or services that are illegal, that adversely affect the health and safety of the participant, that do harm, or that violate or infringe on the rights of others; (3-29-12)

d. Support and spending plans that exceed the approved budget amount will not be authorized; and (3-30-07)

e. Time sheets or invoices that are submitted to the fiscal employer agent for payment that exceed the authorized support and spending plan amount will not be paid by the fiscal employer agent. (3-30-07)

161. -- 169. (RESERVED)

170. PERSON-CENTERED PLANNING.

01. ~~Participation in~~ Direction of the Person-Centered Planning Process. The participant agrees to ~~participate in~~ direct the person-centered planning process in order to identify and document his support and service needs, wants, and preferences. ~~(3-30-07)~~( )

02. Participant Choice. The participant decides who he wants to participate in the planning sessions in order to ensure the participant's choices are honored and promoted. (3-30-07)

03. Facilitation of Person-Centered Planning Meetings. The participant may ~~direct~~ facilitate his person-centered planning meetings, or these meetings may be facilitated by the chosen support broker. ~~(3-30-07)~~( )

04. Focus of Person-Centered Planning. The person-centered planning should focus on identifying strengths, capacities, preferences, needs, and desired goals of the participant for all life areas. (3-30-07)

05. Timeframes of Person-Centered Planning. The person-centered planning should be completed as timely as possible in order to provide the necessary information required to develop the participant's support and spending plan. Time limitations are not currently mandated in order to allow for extensive, comprehensive planning and thoughtful support and spending plan development. (3-30-07)

06. HCBS Person-Centered Planning Requirements. The person-centered planning process must meet all HCBS requirements as defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 315.( )

(BREAK IN CONTINUITY OF SECTIONS)

200. QUALITY ASSURANCE.
The Department will implement quality assurance processes to assure: access to consumer-directed services, participant direction of plans and services, participant choice and direction of providers, safe and effective environments, and participant satisfaction with services and outcomes. (7-1-11)

01. Participant Experience Survey (PES). Each participant will have the opportunity to provide feedback to the Department about his satisfaction with consumer-directed services utilizing the PES. (7-1-11)

02. Participant Experience Outcomes. Participant experience information will be gathered at least annually in an interview by the Department, and will address the following participant outcomes: (3-30-07)

a. Access to care; (3-30-07)

b. Choice and control; (3-30-07)

c. Respect and dignity; (3-30-07)

d. Community integration; and (3-30-07)

e. Inclusion. (3-30-07)

03. Fiscal Employer Agent Quality Assurance Activities. The fiscal employer agent must participate in quality assurance activities identified by the Department such as readiness reviews, periodic audits, maintaining a list of criminal history check waivers, and timely reporting of accounting and satisfaction data. (3-30-07)

04. Community Support Workers and Support Brokers Quality Assurance Activities. Community support workers and support brokers must participate and comply with quality assurance activities identified by the Department including performance evaluations, satisfaction surveys, quarterly review of services provided by a legal guardian, if applicable, and spot audits of time sheets and billing records. (3-30-07)

05. Participant Choice of Paid Community Support Worker. Paid community support workers must be selected by the participant, or his chosen representative, and must meet the qualifications identified in Section 150 of this rule. (3-30-07)

06. Complaint Reporting and Tracking Process. The Department will maintain a complaint reporting and tracking process to ensure participants, workers, and other supports have the opportunity to readily report instances of abuse, neglect, exploitation, or other complaints regarding the HCBS program. (3-30-07)

07. Quality Oversight Committee. A Quality Oversight Committee consisting of participants, family members, community providers, and Department designees will review information and data collected from the quality assurance processes to formulate recommendations for program improvement. (3-30-07)

08. Quarterly Quality Assurance Reviews. On a quarterly basis, the Department will perform an enhanced review of services for those participants who have waived the criminal history check requirement for a community support worker or who have their legal guardian providing paid services. These reviews will assess ongoing participant health and safety and compliance with the approved support and spending plan. (3-30-07)

09. Home and Community Based Service Specific Reviews. The Department will implement quality assurance and improvement activities to ensure compliance with the rules in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 310 through 316. ( )

(BREAK IN CONTINUITY OF SECTIONS)

301. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES: CONSUMER-DIRECTED COMMUNITY SUPPORTS.

01. Federal Tax ID Requirement. The fiscal employer agent must obtain a separate Federal Employer Identification Number (FEIN) specifically to file tax forms and to make tax payments on behalf of program participants under Section 3504 of the Internal Revenue Code (26 USC 3504). In addition, the provider must: (3-29-10)

a. Maintain copies of the participant's FEIN, IRS FEIN notification letter, and Form SS-4 Request for FEIN in the participant's file. (3-29-10)

b. Retire participant's FEIN when the participant is no longer an employer under consumer-directed community supports (CDCS). (7-1-11)

02. Requirement to Report Irregular Activities or Practices. The provider must report to the Department any facts regarding irregular activities or practices that may conflict with federal or state rules and regulations; (3-29-10)

03. Procedures Restricting FMS to Adult and Children's DD Waiver and Children's HCBS State Plan Option Participants. The provider must not act as a fiscal employer agent and provide fiscal management services to a DD waiver or Children's HCBS State Plan Option participant for whom it also provides any other services funded by the Department. (7-1-11)

04. Policies and Procedures. The provider must maintain a current manual containing comprehensive policies and procedures. The provider must submit the manual and any updates to the Department for approval. (3-29-10)

05. Key Contact Person. The provider must provide a key contact person and at least (2) two other people for backup who are responsible for answering calls and responding to e-mails from Department staff and ensure these individuals respond to the Department within one (1) business day. (3-29-10)

06. Face-to-Face Transitional Participant Enrollment. The provider must conduct face-to-face transitional participant enrollment sessions in group settings or with individual participants in their homes or other designated locations. The provider must work with the regional Department staff to coordinate and conduct enrollment sessions. (3-29-10)

07. SFTP Site. The provider must provide an SFTP site for the Department to access. The site must have the capability of allowing participants and their employees to access individual specific information such as time cards and account statements. The site must be user name and password protected. The provider must have the site accessible to the Department upon commencement of the readiness review. (3-29-10)

08. Required IRS Forms. The provider must prepare, submit, and revoke the following IRS forms in accordance with IRS requirements and must maintain relevant documentation in each participant's file including: (3-29-10)

a. IRS Form 2678; (3-29-10)

b. IRS Approval Letter; (3-29-10)

c. IRS Form 2678 revocation process; (3-29-10)

d. Initial IRS Form 2848; and (3-29-10)

e. Renewal IRS Form 2848. (3-29-10)

09. Requirement to Obtain Power of Attorney. The provider must obtain an Idaho State Tax Commission Power of Attorney (Form TC00110) from each participant it represents and must maintain the relevant documentation in each participant's file. (3-29-10)

10. Requirement to Revoke Power of Attorney. The provider must revoke the Idaho State Tax Commission Power of Attorney (Form TC00110) when the provider no longer represents the participant and must maintain the relevant documentation in the participant's file. (3-29-10)

11. Home and Community Based Person-Centered Service Plan Requirements. The provider must sign the written support and spending plan as required in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 316. ( )