Dear Senators VANORDEN, Zuiderveld, Wintrow, and
Representatives VANDER WOUDE, Erickson, Chew:

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

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits - Temporary and Proposed Rule (Docket No. 16-0310-2101).

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 10/27/2023. 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 11/24/2023.

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 334-4854, or send a written request to the address on the memorandum attached below.

Terri Kondeff
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: Senior Legislative Drafting Attorney - Jill Randolph

DATE: October 10, 2023

SUBJECT: Department of Health and Welfare

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits - Temporary and Proposed Rule (Docket No. 16-0310-2101)

Summary and Stated Reasons for the Rule

The Department of Health and Welfare submits notice of a temporary and proposed rule at IDAPA 16.03.10. This temporary and proposed rule makes technical corrections and implements operations for the end of the COVID-19 public health emergency. This rule also includes updates to comply with the K.W. Settlement and changes to align with federal regulations regarding conflicts of interest. The Department states the reasons for the proposed and temporary rule include decreasing regulatory burden and updating rules to comply with governing law.

Negotiated Rulemaking / Fiscal Impact

The agency states that negotiated rulemaking was conducted and the Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the November 3, 2021 edition of the Idaho Administrative Bulletin. The agency states that a delay in federal approval of changes to the rules delayed the submission of these proposed rules for review by the Legislature. The agency further states that only those portions of the 2021 negotiated rulemaking that do not require federal approval are included in these temporary and proposed rules. There is no anticipated negative impact to the General Fund.

The Governor finds that the temporary rule is appropriate because it confers a benefit, aligns the rules with governing law, and is for the protection of the public health, safety, and wellbeing.

Statutory Authority

This rulemaking appears to be authorized pursuant to Sections 56-202 and 56-264, Idaho Code.

cc: Department of Health and Welfare
Frank Powell and Trinette Middlebrook

***** PLEASE NOTE *****

Per the Idaho Constitution, all administrative rules may be reviewed by the Legislature during the next legislative session. The Legislature has 3 options with this rulemaking docket: **1)** Approve the docket in its entirety; **2)** Reject the docket in its entirety; or **3)** Reject the docket in part.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.10 – MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-2101

NOTICE OF RULEMAKING – TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is September 1, 2023.

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 regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), 56-264, and 56-1610, Idaho Code.

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

VIRTUAL TELECONFERENCE Via WebEx

Wednesday, October 18, 2023
9:00 a.m. (MT)

Join from the meeting link:
https://idhw.webex.com/idhw/j.php?MTID=m22d7402b3e4f05b93a795b6ffd75471a

Join by meeting number:
Meeting number (access code): 2761 907 1160
Meeting password: fMMMepQE333 (36663773 from phones and video systems)

Join by phone:
+1-415-527-5035 United States Toll
+1-303-498-7536 United States Toll (Denver)

VIRTUAL TELECONFERENCE Via WebEx

Wednesday, October 18, 2023
2:00 p.m. (MT)

Join from the meeting link:
https://idhw.webex.com/idhw/j.php?MTID=m24d31b98e8d19db20a8af0d0505f54e6

Join by meeting number:
Meeting number (access code): 2760 176 3901
Meeting password: sVaHVstG774 (78248784 from phones and video systems)

Join by phone:
+1-415-527-5035 United States Toll
+1-303-498-7536 United States Toll (Denver)

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 following changes are made in conjunction with companion Docket No. 16-0313-2101, Consumer-Directed Services.

This rule change will decrease regulatory burdens, make technical corrections, implement operations for the end of the public health emergency, update rules to comply with K.W. Settlement, and align with federal regulations regarding conflicts of interest.

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

The changes in this rulemaking qualify for all the following purposes for a Temporary rulemaking:

(a) Protection of the public health, safety, or welfare; or
(b) Compliance with deadlines in amendments to governing law or federal programs; or
(c) Conferring a benefit.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

This rulemaking and this chapter of rules do not contain any fees.

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:

There is no anticipated fiscal impact to the General Fund, state funds, or any other known funds.

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 November 3, 2021, Idaho Administrative Bulletin, Volume 21-11, pages 42-43.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

A document incorporated by reference in these rules is being updated to reflect the current version (January 17, 2023). The title has changed from “Travel Policies and Procedures of the Idaho State Board of Examiners” to “State Travel Policies and Procedures.”

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact William Deseron, 208-859-0046.

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 25, 2023.

DATED this 1st day of September, 2023.

Trinette Middlebrook and Frank Powell
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5500 phone; (208) 334-6558 fax
dhwrules@dhw.idaho.gov email

THE FOLLOWING IS THE TEMPORARY RULE AND THE PROPOSED TEXT OF DOCKET NO. 16-0310-2101
(Only Those Sections With Amendments Are Shown.)

004. INCORPORATION BY REFERENCE.
The Department has incorporated by reference the following ~~document~~: ~~(3-17-22)~~(9-1-23)T

01. 42 CFR Part 447. 42 CFR Part 447, "Payment for Services," revised as of October 1, 2001, is available from CMS, 7500 Security Blvd, Baltimore, M.D., 21244-1850 or on the Code of Federal Regulations website at http://www.ecfr.gov/cgi-bin/text-idx?SID=3ec1965dbf5044d8f79b25d4d58c4cd1&mc=true&tpl=/ecfrbrowse/Title42/42cfrv4_02.tpl#0. (3-17-22)

02. Estimated Useful Lives of Depreciable Hospital Assets, 2004 Revised Edition, Guidelines Lives. This document may be obtained from American Hospital Publishing, Inc., 211 E. Chicago Ave., Chicago, IL. 60611. (3-17-22)

03. Medicare Region D Durable Medical Equipment Regional Carrier (DMERC) Supplier Manual or Its Successor. The full text of the Medicare Region D DMERC Supplier Manual Chapters IX and X, date April 2001, is available via the Internet at www.cignamedicare.com. A copy is also available at the Idaho State Supreme Court Law Library. (3-17-22)

04. Provider Reimbursement Manual (PRM). The Provider Reimbursement Manual (PRM), Part I and Part II CMS Publication 15-1 and 15-2), is available on the CMS website at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html. (3-17-22)

05. Resource Utilization Groups (RUG) Grouper. The RUG III, version 5.12, 34 Grouper, nursing weights only, with index maximization. The RUG Grouper is available from CMS, 7500 Security Blvd., Baltimore, MD, 21244-1850. (3-17-22)

06. State Travel Policies~~y~~ and Procedures ~~of the Idaho State Board of Examiners~~. The text of "~~Idaho~~ State Travel Policies~~y~~ and Procedures ~~of the Idaho State Board of Examiners~~," and Appendices A and B, ~~June 13, 2000~~ January 17, 2023, is available at the Office of the State Controller, 700 W. State St., 5th Fl., Box 83720, Boise, Idaho 83720-0011 or ~~on the Internet~~ at ~~http://www.sco.idaho.gov/~~ https://www.sco.idaho.gov/LivePages/state-travel-policy-and-procedures.aspx. ~~(3-17-22)~~(9-1-23)T

005. -- 007. (RESERVED)

008. AUDIT, INVESTIGATION AND ENFORCEMENT.
In addition to any actions specified in these rules, the Department may audit, investigate, and take enforcement action under ~~the provisions of~~ IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, ~~or~~ and Misconduct." ~~(3-17-22)~~(9-1-23)T

009. ~~CRIMINAL HISTORY AND~~ BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department ~~Criminal History~~ Background Check. Employees and contractors of ~~A~~agencies ~~must verify that individuals~~ working in the area ~~listed in~~ under Subsection 009.03 of ~~these~~ this rule~~s whom are employed or whom they contract have complied~~ must comply with the provisions in IDAPA 16.05.06, "~~Rules Governing Mandatory~~ Criminal History and Background Checks." ~~Except, through the duration of the declared COVID-19 public health emergency, if the individuals working in the area listed in this rule are unable to complete a criminal background check in accordance with the timeframes set forth in IDAPA 16.05.06, then agencies may allow newly hired direct care staff to begin rendering services prior to completion of the criminal background check in accordance with the requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-~~

~~medicaid providers.~~ ~~(3-17-22)~~(9-1-23)T

~~02. Additional Criminal Convictions. Once an individual has received a criminal history clearance, any additional criminal convictions must be reported by the agency to the Department when the agency learns of the conviction.~~ ~~(3-17-22)~~

0~~3~~2. **Providers Subject to ~~Criminal History and~~ Background Check Requirements**. The following providers are required to ~~have a criminal history and~~ follow background check requirements provided in these rules and any other identified rules: ~~(3-17-22)~~(9-1-23)T

a. Adult Day Health Providers. ~~The criminal history and background check requirements applicable to providers of adult day health as provided in Sections 329 and 705 of these rules.~~ ~~(3-17-22)~~(9-1-23)T

b. Adult Residential Care Providers. ~~The criminal history and background check requirements applicable to adult residential care providers as provided in Section 329 of these rules.~~ ~~(3-17-22)~~(9-1-23)T

c. Attendant Care Providers. ~~The criminal history and background check requirements applicable to attendant care providers as provided in Section 329 of these rules.~~ ~~(3-17-22)~~(9-1-23)T

d. Behavior Consultation or Crisis Management Providers. ~~The criminal history and background check requirements applicable to behavior consultation or crisis management providers as provided in Section 705 of these rules.~~ ~~(3-17-22)~~(9-1-23)T

e. Certified Family Home Providers and All Adults in the Home. ~~The criminal history and~~ See additional background check requirements ~~applicable to certified family homes are found in Sections 305, 329 and 705 of these rules, and as provided in~~ under IDAPA 16.03.19, "~~Rules Governing~~ Certified Family Homes." ~~(3-17-22)~~(9-1-23)T

f. Chore Services Providers. ~~The criminal history and background check requirements applicable to chore services providers as provided in Sections 329 and 705 of these rules.~~ ~~(3-17-22)~~(9-1-23)T

g. Companion Services Providers. ~~The criminal history and background check requirements applicable to companion services providers as provided in Section 329 of these rules.~~ ~~(3-17-22)~~(9-1-23)T

h. Day Habilitation Providers. ~~The criminal history and background check requirements applicable to day habilitation providers as provided in Section 329 of these rules.~~ ~~(3-17-22)~~(9-1-23)T

i. Developmental Disabilities Agencies (DDA). ~~The criminal history and~~ See additional background check requirements for DDA and staff ~~as provided in~~ under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)~~.~~." ~~Section 009.~~ ~~(3-17-22)~~(9-1-23)T

j. Homemaker Services Providers. ~~The criminal history and background check requirements applicable to homemaker services providers as provided in Section 329 of these rules.~~ ~~(3-17-22)~~(9-1-23)T

k. Non-Medical Transportation Providers. (9-1-23)T

~~k~~l. Personal Assistance Agencies Acting ~~A~~as Fiscal Intermediaries. The ~~criminal history and~~ background check requirements applicable to the staff of personal assistance agencies acting as fiscal intermediaries ~~as provided in Subsection 329.02 of these rules~~. ~~(3-17-22)~~(9-1-23)T

~~l~~m. Personal Care Providers. ~~The criminal history and background check requirements applicable to personal care providers as provided in Subsection 305.06 of these rules~~. ~~(3-17-22)~~(9-1-23)T

~~m~~n. Residential Habilitation Providers. ~~The criminal history and~~ See additional background check requirements applicable to residential habilitation providers ~~as provided in Sections 329 and 705 of these rules, and~~ under IDAPA 16.04.17 "~~Rules Governing~~ Residential Habilitation Agencies~~,~~." ~~Sections 202 and 301.~~ ~~(3-17-22)~~(9-1-23)T

~~n~~o. Respite Care Providers. ~~The criminal history and background check requirements applicable to respite care providers as provided in Sections 329, 665, and 705 of these rules.~~ ~~(3-17-22)~~(9-1-23)T

~~o~~p. Service Coordinators and Paraprofessionals. ~~The criminal history and background check requirements applicable to service coordinators and paraprofessionals working for an agency as provided in Section 729 of these rules.~~ ~~(3-17-22)~~(9-1-23)T

~~p~~q. Skilled Nursing Providers. ~~The criminal history and background check requirements applicable to skilled nursing providers as provided in Sections 329 and 705 of these rules.~~ ~~(3-17-22)~~(9-1-23)T

~~q~~r. Supported Employment Providers. ~~The criminal history and background check requirements applicable to supported employment providers as provided in Sections 329 and 705 of these rules.~~ ~~(3-17-22)~~(9-1-23)T

~~r~~s. Therapeutic Consultant Providers. ~~The criminal history and background check requirements applicable to therapeutic consultation providers as provided in Section 685 of these rules.~~ ~~(3-17-22)~~(9-1-23)T

010. DEFINITIONS: A THROUGH D.
~~For the purposes of these rules, the following terms are used as defined below:~~ ~~(3-17-22)~~

01. Accrual Basis. An accounting system based on the principle that revenues are recorded when they are earned; expenses are recorded in the period incurred. (3-17-22)

02. Active Treatment. ~~Active treatment is the c~~Continuous participation, during all waking hours, by an individual in an aggressive, consistently implemented program of specialized and generic training, treatment, health and related services, and provided ~~in accordance with~~ under a treatment plan developed by an interdisciplinary team and monitored by a Qualified Intellectual Disabilities Professional (QIDP) directed toward: (1) the acquisition of the behaviors necessary for the resident to function with as much self-determination and independence as possible; or (2) the prevention or deceleration of regression or loss of current functional status. ~~(3-17-22)~~(9-1-23)T

03. Activities of Daily Living (ADL). The performance of basic self-care activities in meeting an individual's needs for sustaining them in a daily living environment, including bathing, washing, dressing, toileting, grooming, eating, communication, continence, mobility, and associated tasks. (3-17-22)

04. Allowable Cost. ~~Costs that are r~~Reimbursable~~,~~ cost ~~and~~ sufficiently documented to meet the requirements of audit. ~~(3-17-22)~~(9-1-23)T

05. Amortization. The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. (3-17-22)

06. Appraisal. The method of determining the value of property as determined by an Appraisal Institute appraisal. The appraisal must specifically identify the values of land, buildings, equipment, and goodwill. (3-17-22)

07. Assets. Economic resources of the provider recognized and measured in conformity with generally accepted accounting principles. (3-17-22)

08. Attendant Care. Services provided under a Medicaid Home and Community-Based Services waiver that involve personal and medically-oriented tasks dealing with the functional needs of the participants and accommodating the participant's needs for long-term maintenance, supportive care, or ~~activities of daily living (~~ADL~~)~~. These services may include personal assistance and medical tasks that can be done by unlicensed persons or delegated to unlicensed persons by a health care professional or the participant. Services are based on the person's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. This assistance may take the form of hands-on assistance (~~actually~~ performing a task for the person) or cuing to prompt the participant to perform a task. ~~(3-17-22)~~(9-1-23)T

09. **Audit**. An examination of provider records ~~on the basis of~~ based on which an opinion is expressed representing the compliance of a provider's financial statements and records with Medicaid law, regulations, and rules. ~~(3-17-22)~~(9-1-23)T

10. **Auditor**. The individual or entity designated by the Department to conduct the audit of a provider's records. (3-17-22)

11. **Audit Reports**. (3-17-22)

a. Draft Audit Report. A preliminary report of the audit finding sent to the provider for the provider's review and comments. (3-17-22)

b. Final Audit Report. A final written report containing the results, findings, and recommendations, if any, from the audit of the provider, as approved by the Department. (3-17-22)

12. **Bad Debts**. Amounts due to provider ~~as a result~~ because of services rendered, but ~~that~~ are considered uncollectible. ~~(3-17-22)~~(9-1-23)T

13. **Bed-Weighted Median**. A numerical value determined by arraying the average per diem cost per bed of all facilities from high to low and identifying the bed at the point in the array at which half of the beds have equal or higher per diem costs and half have equal or lower per diem costs. The identified bed is the median bed. The per diem cost of the median bed is the bed-weighted median. (3-17-22)

14. **Budget Adjustment Factor (BAF)**. A total budget for nursing facility reimbursement will be established by legislative appropriation and will be effective on July 1 of each year. The budget will be compared to the annual expected Medicaid reimbursement rates for the same rate year. A ~~budget adjustment factor~~ BAF will be established to adjust the expected Medicaid reimbursement rates to meet the approved budget. The BAF may be positive or negative and will apply to all nursing facility rates calculated under the established prospective rate system. The BAF will not be applied to the calculated customary charge for each nursing facility and will not apply to any nursing facility that is retrospectively settled. ~~(3-17-22)~~(9-1-23)T

15. **Capitalize**. The practice of accumulating expenditures related to long-lived assets that will benefit later periods. (3-17-22)

16. **Case Mix Adjustment Factor**. The factor used to adjust a provider's direct care rate component for the difference in the average Medicaid acuity and the average nursing facility-wide acuity. The average Medicaid acuity is from the picture date immediately preceding the rate period. The average nursing facility-wide acuity is the average of the indexes that correspond to the cost reporting period. (3-17-22)

17. **Case Mix Index (CMI)**. A numeric score assigned to each nursing facility resident, based on the resident's physical and mental condition, that projects the amount of relative resources needed to provide care to the resident. (3-17-22)

a. Nursing Facility-Wide Case Mix Index. The average of the entire nursing facility's case mix indexes identified at each picture date during the cost reporting period. If case mix indexes are not available for applicable quarters due to lack of data, case mix indexes from available quarters will be used. (3-17-22)

b. Medicaid Case Mix Index. The average of the weighting factors assigned to each Medicaid resident in the facility on the picture date, based on their RUG classification. Medicaid or non-Medicaid status is based upon information contained in the MDS databases. To the extent that Medicaid identifiers are found to be incorrect, the Department may adjust the Medicaid case mix index and reestablish the reimbursement rate. (3-17-22)

c. State-Wide Average Case Mix Index. The simple average of all nursing facilities "facility-wide" case mix indexes used in establishing the reimbursement limitation July 1st of each year. The state-wide case mix index will be calculated annually during each July 1st rate setting. (3-17-22)

18. **Certified Family Home (CFH)**. ~~A home certified by the Department to provide care to one (1) or~~

~~two (2)adults, who are unable to reside on their own and require help with activities of daily living, protection and security, and need encouragement toward independence~~ A home that meets the requirements under IDAPA 16.03.19, "Certified Family Homes.". ~~(3-17-22)~~(9-1-23)T

~~I~~9. **Chain Organization**. A proprietorship, partnership, or corporation that leases, manages, or owns two (2) or more facilities that are separately licensed. (3-17-22)

20. Claim. An itemized bill for services rendered to one (1) participant by a provider and submitted to the Department for payment. (3-17-22)

21. Clinical Nurse Specialist. An ~~licensed registered nurse~~ RN who meets all the applicable requirements to practice as a clinical nurse specialist under Title 54, Chapter 14, Idaho Code, and IDAPA 24.34.01, "Rules of the Idaho Board of Nursing." ~~(3-17-22)~~(9-1-23)T

22. Common Ownership. An individual(s), ~~individuals,~~ or other entities who have equity or ownership in two (2) or more organizations that conduct business transactions with each other. Common ownership exists if an individual(s) ~~or individuals~~ possesses significant ownership or equity in the provider and the institution or organization serving the provider. ~~(3-17-22)~~(9-1-23)T

23. Compensation. The total of all remuneration received, including cash, expenses paid, salary advances, etc. (3-17-22)

24. Complaint. The process by which an individual registers dissatisfaction with program operations, quality of services, or other relevant concerns. A complaint is separate from an appeal, and an individual is not required to submit a complaint in order to pursue an appeal under these rules. (9-1-23)T

2~~4~~5. Control. ~~Control e~~Exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. ~~(3-17-22)~~(9-1-23)T

2~~5~~6. Cost Center. A "collection point" for expenses incurred in the rendering of services, supplies, or materials that are related or so considered for cost-accounting purposes. (3-17-22)

2~~6~~7. Cost Component. The portion of the nursing facility's rate that is determined from a prior cost report, including property rental rate. The cost component of a nursing facility's rate is established annually ~~at~~ July 1st of each year. ~~(3-17-22)~~(9-1-23)T

2~~7~~8. Cost Reimbursement System. A method of fiscal administration of Title XIX and Title XXI that compensates the provider based on ~~the basis of~~ expenses incurred. ~~(3-17-22)~~(9-1-23)T

2~~8~~9. Cost Report. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. (3-17-22)

~~29~~30. Cost Statements. An itemization of costs and revenues, presented on the accrual basis, that is used to determine cost of care for facility services for a specified period ~~of time~~. These statements are commonly called income statements. ~~(3-17-22)~~(9-1-23)T

3~~0~~1. Costs Related to Patient Care. All necessary and proper costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs that are common and accepted occurrences in the field of the provider's activity. They include costs such as depreciation, interest expenses, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, and normal standby costs. (3-17-22)

3~~1~~2. Costs Not Related to Patient Care. Costs that are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are nonallowable in computing reimbursable costs. They include, for example, cost of meals sold to visitors or employees~~;~~, cost of drugs sold to other than patients~~;~~, cost of operation of a gift shop~~;~~, and similar items. Travel and entertainment expenses are

nonallowable unless it can be ~~specifically~~ shown that they relate to patient care and for the operation of the nursing facility. ~~(3-17-22)~~(9-1-23)T

3~~2~~3. Customary Charges. ~~Customary charges are the r~~Rates charged to Medicare participants and to patients liable for such charges, as reflected in the facility's records. Those charges are adjusted downward, when the provider does not impose such charges on most patients liable for payment on a charge basis or~~,~~ when the provider fails to make reasonable collection efforts. The reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt under PRM, Chapter 3, Sections 310 and 312. ~~(3-17-22)~~(9-1-23)T

3~~3~~4. Day Treatment Services. ~~Day treatment services are d~~Developmental services provided regularly during normal working hours on weekdays by, or on behalf of, the ~~Intermediate Care Facility for Persons with Intellectual Disabilities (~~ICF/IID~~)~~. ~~However, d~~Day treatment services do not include recreational therapy, speech therapy, physical therapy, occupational therapy, or services paid for, or required to be provided by, a school or other entity. ~~(3-17-22)~~(9-1-23)T

3~~4~~5. Department. The Idaho Department of Health and Welfare or ~~a person authorized to act on behalf of the Department~~ its designee. ~~(3-17-22)~~(9-1-23)T

3~~5~~6. Depreciation. The systematic distribution of the cost or other basis of tangible assets, less salvage, over the estimated life of the assets. (3-17-22)

3~~6~~7. Developmental Disability (DD). ~~A developmental disability, as d~~Defined ~~in~~ under Section 66-402, Idaho Code, means a chronic disability of a person that appears before the age of twenty-two (22) years ~~of age~~; and ~~(3-17-22)~~(9-1-23)T

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; (3-17-22)

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 (3-17-22)

c. Reflects the need for a combination or sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and individually planned and coordinated. (3-17-22)

3~~7~~8. Direct Care Costs. Costs directly assigned to the nursing facility or allocated to the nursing facility through the Medicare cost-finding principles and consisting of the following: (3-17-22)

a. Direct nursing salaries that include the salaries of ~~licensed registered nurses (~~RNs~~)~~, certified nurse's aides, and unit clerks; ~~(3-17-22)~~(9-1-23)T

b. Routine nursing supplies; (3-17-22)

c. Nursing administration; (3-17-22)

d. Direct portion of Medicaid-related ancillary services; (3-17-22)

e. Social services; (3-17-22)

f. Raw food; (3-17-22)

g. Employee benefits associated with the direct salaries: and (3-17-22)

h. Medical waste disposal, for rates with effective dates beginning July 1, 2005. (3-17-22)

38~~8~~9. **Director**. The Director of the Department ~~of Health and Welfare~~ or their designee. ~~(3-17-22)~~(9-1-23)T

39~~39~~40. **Durable Medical Equipment (DME)**. Equipment other than prosthetics or orthotics that can withstand repeated use by one (1) or more individuals, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, is appropriate for use in the home, and is reasonable and necessary for the treatment of an illness or injury for a Medicaid participant. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

093. ORGAN TRANSPLANTS: COVERAGE AND LIMITATIONS.

01. **Coverage Limitations**. ~~No organ transplant will be covered by the Medical Assistance Program unless prior authorized by the Department, or its designee.~~ Coverage is limited to organ transplants performed for the treatment of medical conditions ~~in accordance with~~ under evidence-based standards of care. ~~(3-17-22)~~(9-1-23)T

02. **Living Donor Costs**. The transplant costs for actual or potential living donors are fully covered by Medicaid and include all medically necessary preparatory, operation, and post-operation recovery expenses associated with the donation. Payments for post-operation expenses of a donor will be limited to the period of actual recovery. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

200. PRIVATE DUTY NURSING (PDN) SERVICES.

~~01.~~ **~~Description of Private Duty Nursing (PDN) Services~~**. Private Duty Nursing (PDN~~)~~ services are nursing services provided by a~~n licensed registered nurse~~ RN or ~~licensed practical nurse~~ LPN to a non-institutionalized child under the age of twenty-one (21) requiring care for conditions of such medical severity or complexity that skilled nursing care is necessary. Sections 200 through 209 of these rules cover requirements for ~~private duty nursing~~ PDN services. ~~(3-17-22)~~(9-1-23)T

~~02.~~ **~~Temporary Changes to PDN Rules During Declared State of Emergency Related to Novel Coronavirus Disease (COVID-19)~~**. ~~In response to Idaho's declaration on 3/13/20 of a state of emergency related to COVID-19, the Department reserves the right to temporarily alter requirements and processes related to PDN services in order to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS approved 1135 waiver through the duration of the emergency state. Guidance for approved flexibilities is posted on the Medicaid Information Releases website at https://www.idmedicaid.com/default.aspx.~~ ~~(3-17-22)~~

(BREAK IN CONTINUITY OF SECTIONS)

300. PERSONAL CARE SERVICES (PCS).

~~01.~~ **~~Description of Personal Care Services (PCS).~~** Under Sections 39-5601 through 39-5607, Idaho Code, it is the intent of the Department to provide ~~personal care services (~~PCS~~)~~ to eligible participants in their ~~own homes or~~ personal residences to prevent unnecessary institutional placement, to provide for the greatest degree of independence ~~possible~~, to enhance quality of life, ~~to~~ encourage individual choice, and ~~to~~ maintain community integration. ~~(3-17-22)~~(9-1-23)T

~~02.~~ **~~Temporary Changes to PCS Rules During Declared State of Emergency Related to Novel~~**

~~**Coronavirus Disease (COVID-19)**. In response to Idaho's declaration on 3/13/20 of a state of emergency related to COVID-19, the Department reserves the right to temporarily alter requirements and processes related to PCS services, currently and through the duration of the emergency state, in order to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS approved 1135 waiver. Guidance for approved flexibilities is posted on the Medicaid Information Releases website at https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-medicaid-providers.~~ ~~(3-17-22)~~

(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 Assisted Living Facilities are ~~described in~~ under IDAPA 16.03.22, "Residential Assisted Living Facilities." The requirements for the NSA for participants in C~~ertified F~~amily H~~omes~~ are described in IDAPA 16.03.19, "Certified Family Homes." The Personal Assistance Agency and the participant who lives in their own home are responsible to prepare the plan of care. ~~(3-17-22)~~(9-1-23)T

a. The plan of care for participants who live in their own homes or in a PCS Family Alternate Care Home is based on: (3-17-22)

i. The physician's or authorized provider's information, if applicable; (3-17-22)

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 (3-17-22)

iii. Information obtained from the participant. (3-17-22)

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. (3-17-22)

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. ~~(3-17-22)~~(9-1-23)T

d. The plan of care or NSA must meet the person-centered planning requirements ~~described in Sections 316 and 317 of~~ under these rules. ~~(3-17-22)~~(9-1-23)T

02. Service Supervision. The delivery of PCS is overseen by an ~~licensed registered nurse (~~RN~~)~~ or Qualified Intellectual Disabilities Professional (QIDP). The ~~BLTC~~ Department will identify the need for supervision. ~~(3-17-22)~~(9-1-23)T

a. Oversight must include ~~all of~~ the following: ~~(3-17-22)~~(9-1-23)T

i. Assistance in the development of the written plan of care; (3-17-22)

ii. Review of the treatment given by the personal assistant through a review of the participant's PCS record as maintained by the provider; (3-17-22)

iii. Re-evaluation of the plan of care as necessary; and (3-17-22)

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. (3-17-22)

b. All participants who are developmentally disabled, other than those with only a physical disability as determined by the ~~BLTC~~ Department, may receive oversight by a QIDP as defined in 42 CFR 483.430. Oversight

must include: ~~(3-17-22)~~(9-1-23)T

i. Assistance in the development of the plan of care for those aspects of active treatment that are provided in the participant's personal residence by the personal assistant; (3-17-22)

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; (3-17-22)

iii. Re-evaluation of the plan of care as necessary, but at least annually; and (3-17-22)

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. (3-17-22)

03. Prior Authorization Requirements. All PCS services must be prior authorized by the Department. Authorizations will be based on the information from: (3-17-22)

a. The children's PCS assessment or ~~Uniform Assessment Instrument (~~UAI~~)~~ for adults; ~~(3-17-22)~~(9-1-23)T

b. The individual service plan developed by the Personal Assistance Agency; and (3-17-22)

c. Any other medical information that supports the medical need. (3-17-22)

04. ~~PCS~~ Record Requirements for a Participant's ~~in Their Own~~ Home. PCS records must be maintained for all participants receiving PCS in their own homes or in a PCS Family Alternate Care Home. ~~(3-17-22)~~(9-1-23)T

a. ~~Documentation Requirements.~~ PCS provider must maintain documentation of every visit made to the participant's home and ~~must~~ record the following ~~minimum~~ information: ~~(3-17-22)~~(9-1-23)T

i. Date and time of visit; (3-17-22)

ii. Length of visit; (3-17-22)

iii. Services provided during the visit; and (3-17-22)

iv. Documentation of any changes noted in the participant's condition or any deviations from the plan of care. (3-17-22)

b. ~~Participant's Signature.~~ The participant or legal guardian must verify services were delivered by signing the documentation. ~~(3-17-22)~~(9-1-23)T

c. ~~Provider Signature.~~ The Plan of Care must be signed by the provider indicating that they will deliver services according to the authorized service plan and consistent with home and community-based requirements. ~~(3-17-22)~~(9-1-23)T

d. ~~Copy Requirement.~~ A copy of the information required in Subsection 304.04 of ~~these~~ this rule~~s~~ must be maintained and available in a format accessible to the participant in their home. Failure to maintain this information may result in recovery of funds paid for undocumented services. ~~(3-17-22)~~(9-1-23)T

e. Electronic Visit Verification (EVV) ~~S~~systems. ~~EVV systems~~ as described in Section 041 of these rules will not take the place of documentation requirements of Subsection 304.04 of ~~these~~ this rule~~s~~ but may be used to generate documentation retained in the participant's home. ~~(3-17-22)~~(9-1-23)T

05. PCS Record Requirements for a Participant in a Residential Assisted Living Facility (RALF) or C~~ertified F~~amily H~~ome~~. The PCS records must be maintained on all participants who receive PCS in a

~~Residential Assisted Living Facility (~~RALF~~)~~ or ~~Certified Family Home (~~CFH~~)~~. ~~(3-17-22)~~(9-1-23)T

a. ~~Participant in a RALF. The a~~Additional PCS record requirements for RALF participants ~~in RALF are described in~~ are under IDAPA 16.03.22, "Residential Assisted Living Facilities." ~~(3-17-22)~~(9-1-23)T

b. ~~Participant in a CFH. The a~~Additional PCS record requirements for CFH participants ~~in CFHs are described in~~ are under IDAPA 16.03.19, "Certified Family Homes." ~~(3-17-22)~~(9-1-23)T

c. ~~Participant's Signature.~~ The participant or legal guardian must sign the NSA agreeing to the delivery of services as specified. ~~(3-17-22)~~(9-1-23)T

d. ~~Provider Signature.~~ The NSA must be signed by the supervisory nurse or agency personnel responsible for developing the NSA with the participant~~,~~ and must indicate that they will deliver services according to the authorized NSA and consistent with home and community-based requirements. ~~(3-17-22)~~(9-1-23)T

06. Provider Responsibility for Notification. The Personal Assistance Agency is responsible to notify the ~~BLTC~~ Department and the 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. ~~(3-17-22)~~(9-1-23)T

~~**07. COVID-19**. The sections of this rule may be subject to amendment by the BLTC for the duration of the COVID-19 state of emergency. Please consult Medicaid Information Release MA20-15 for additional guidance.~~ ~~(3-17-22)~~

305. PERSONAL CARE SERVICES: PROVIDER QUALIFICATIONS.

01. Provider Qualifications for Personal Assistants. All personal assistants must have at least one (1) of the following qualifications: (3-17-22)

a. ~~Licensed Registered Nurse (~~RN~~). A person currently licensed by the Idaho State Board of Nursing as a licensed registered nurse~~; ~~(3-17-22)~~(9-1-23)T

b. ~~Licensed Practical Nurse (~~LPN~~). A person currently licensed by the Idaho State Board of Nursing as a licensed practical nurse~~; or ~~(3-17-22)~~(9-1-23)T

c. Personal Assistant. A person who meets the standards of Section 39-5603, Idaho Code, and receives training to ensure the quality of services. The assistant must be at least age eighteen (18) years of age. The ~~BLTC~~ Department may require a certified nursing assistant (CNA) if, in their professional judgment, the participant's medical condition warrants a CNA. ~~(3-17-22)~~(9-1-23)T

02. Provider Training Requirements. In the case where care is provided in the participant's own home, and the participant has a developmental disability that is not physical only and requires more than physical assistance, all those who provide care must have: (3-17-22)

a. Completed one (1) of the Department-approved developmental disabilities training courses; or (3-17-22)

b. Experience providing direct services to people with developmental disabilities. (3-17-22)

c. ~~BLTC determines~~Department approval of whether developmental disability training is required. Providers who are qualified as QIDPs are exempted from the Department-approved developmental disabilities training course. ~~(3-17-22)~~(9-1-23)T

d. ~~In order~~Regional approval. ~~t~~To serve a participant with a developmental disability, a region may temporarily approve a PCS provider who meets all qualifications except for the required training course or experience, if all the following conditions are met: ~~(3-17-22)~~(9-1-23)T

i. The ~~BLTC~~ Department verifies that there are no other qualified providers available; ~~(3-17-22)~~(9-1-23)T

ii. The provider is enrolled in the next available training course with a graduation date no later than six (6) months from the date of the request for temporary provider status; and (3-17-22)

iii. The supervising QIDP makes monthly visits until the provider graduates from the training program. (3-17-22)

03. Provider Exclusion. If PCS is paid for by Medicaid, except in extraordinary circumstances as defined by the Department, a PCS service provider cannot be the spouse of any participant or be the parent of a participant if the participant is a minor child. ~~(3-17-22)~~(9-1-23)T

04. Care Delivered in Provider's Home for a Child. When care for a child is delivered in the provider's home, the provider must be licensed or certified for the appropriate level of child foster care or day care. The provider must be licensed for care of individuals under age eighteen (18), ~~as defined in~~ under Section 39-1213, Idaho Code. Noncompliance with these standards is cause for termination of the ~~provider's~~ provider agreement. ~~(3-17-22)~~(9-1-23)T

05. Care Delivered in Provider's Home for an Adult. When care for an adult is provided in a home owned or leased by the provider, the provider must be certified as a C~~ertified F~~amily H~~ome~~ under IDAPA 16.03.19, "Certified Family Homes." ~~(3-17-22)~~(9-1-23)T

06. ~~Criminal History~~Background Check. All PCS providers, including service coordinators, RN supervisors, QIDP supervisors, and personal assistants~~,~~ must ~~participate in~~ obtain a ~~criminal history~~ background check as required by Section 39-5604, Idaho Code. The ~~criminal history~~ background check must be conducted ~~in accordance with~~ under IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~(9-1-23)T

07. Health Screen. Each Personal Assistance Agency employee who serves as a personal assistant must complete a health questionnaire. Personal Assistance Agencies must retain the health questionnaire in their personnel files. If the personal assistant indicates on the questionnaire that they have a medical problem, they are required to submit a statement from a physician or authorized provider that their medical condition does not prevent them from performing all the duties required of a personal care provider. Misrepresentation of information submitted on the health questionnaire may be cause for termination of employment for the personal assistant and would disqualify the employee to provide services to Medicaid participants. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

308. PERSONAL CARE SERVICES (PCS): QUALITY ASSURANCE.

01. Responsibility for Quality. Personal Assistance Agencies, RALFs, and CFHs furnishing PCS are responsible for ~~assuring that they~~ provid~~e~~ing quality services in compliance with applicable rules. ~~(3-17-22)~~(9-1-23)T

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. (3-17-22)

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. (3-17-22)

04. HCBS Compliance. Personal Assistance Agencies are responsible for ensuring they meet the setting requirements ~~described in~~ under Section 313 of these rules. RALFs~~,~~ and CFHs are responsible for ensuring that they meet the setting requirements ~~described in~~ under Sections 313 and 314 of these rules. All providers furnishing PCS are responsible for ensuring they meet the person-centered planning requirements ~~described in~~ under

Sections 316 through 317 of these rules. PCS providers must comply with associated Department quality assurance activities. The Department may take enforcement actions ~~as described in~~ under 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. ~~(3-17-22)~~(9-1-23)T

~~**05. COVID-19**. The sections of this rule may be subject to amendment by the BLTC for the duration of the COVID-19 state of emergency. Please consult Medicaid Information Release MA20-15 for additional guidance. (3-17-22)~~

(BREAK IN CONTINUITY OF SECTIONS)

314. RESIDENTIAL PROVIDER-OWNED OR CONTROLLED SETTING QUALITIES.
In addition to the setting requirements ~~described in~~ under Section 313 of these rules, provider-owned or controlled settings, including R~~esidential~~ A~~ssisted~~ L~~iving~~ F~~acilitie~~s and C~~ertified~~ F~~amily~~ H~~ome~~s that provide services to HCBS participants, must ~~also~~ meet the following conditions: ~~(3-17-22)~~(9-1-23)T

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. (3-17-22)

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: (3-17-22)

a. The right to entrance doors that are lockable by the individual, with only appropriate staff having keys to doors. (3-17-22)

b. Participants sharing units have a choice of roommates in that setting. (3-17-22)

03. Décor. Participants have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement. (3-17-22)

04. Schedules and Activities. Participants have the freedom and support to control their own schedules and activities. (3-17-22)

05. Access To Food. Participants have access to food at any time. (3-17-22)

~~**06. Visitors**. Participants are able to have visitors of their choosing at any time in accordance with the applicable requirements under IDAPA 16.03.19, "Certified Family Homes," and IDAPA 16.03.22, "Residential Assisted Living Facilities." Except, through the duration of the declared COVID-19 public health emergency, CFH providers may restrict visitation to minimize the spread of the COVID-19 infection. (3-17-22)~~

07. Accessibility. The setting is physically accessible to the participant. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

317. HOME AND COMMUNITY-BASED PERSON-CENTERED SERVICE PLAN REQUIREMENTS.
All person-centered service plans must reflect the following components: (3-17-22)

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. (3-17-22)

02. Service Delivery Preferences. Indication of what is important to the participant ~~with regard to~~

about the service provider and preferences for the delivery of such services and supports. ~~(3-17-22)~~(9-1-23)T

03. Setting Selection. HCBS settings selected by the participant or the participant's decision-making authority are chosen from among a variety of setting options, as required in Section 313 of these rules. The person-centered service plan must identify and document the alternative home and community setting options that were considered by the participant, or the participant's decision-making authority. (3-17-22)

04. Participant Strengths and Preferences. (3-17-22)

05. Individually Identified Goals and Desired Outcomes. (3-17-22)

06. Paid and Unpaid Services and Supports. ~~Paid and unpaid services and supports that will a~~Assist the participant to achieve identified goals, and the providers of those services and supports, including natural supports. ~~(3-17-22)~~(9-1-23)T

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. (3-17-22)

08. Understandable Language. Be understandable to the participant receiving services and supports, and the individuals important in supporting them. ~~At a minimum, t~~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~~ have limited English proficien~~t~~cy, consistent with 42 CFR 435.905(b). ~~(3-17-22)~~(9-1-23)T

09. Plan Monitor. Identify the name of the individual or entity responsible for monitoring the plan. (3-17-22)

10. Plan Signatures. Be finalized and agreed to, by the participant, or the participant's decision-making authority, in writing, indicating informed consent. The plan must also be signed by the plan developer and all individuals and providers responsible for its implementation indicating they will deliver services according to the authorized plan of service and consistent with home and community-based requirements. ~~(3-17-22)~~(9-1-23)T

a. Children's DD service providers responsible for implementation of the plan include the providers of those services ~~defined in~~ under Section 523 of these rules. ~~(3-17-22)~~(9-1-23)T

b. Adult DD service providers responsible for implementation of the plan include those required to develop a provider implementation plan ~~as defined in~~ under Sections 513 and 654 of these rules. ~~(3-17-22)~~(9-1-23)T

c. Consumer-directed service providers responsible for implementation of the plan include the participant, Support Broker, and Fiscal Employment Agency ~~as identified in~~ under IDAPA 16.03.13, "Consumer-Directed Services." ~~(3-17-22)~~(9-1-23)T

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~~ under Sections 303 and 326 of these rules. Alternate format signatures may be used; refer to Medicaid Information Release MA20-15 for guidance. ~~(3-17-22)~~(9-1-23)T

11. Plan Distribution. Be distributed to the participant and the participant's decision-making authority, if applicable, and other people involved in the implementation of the plan. ~~At a minimum, t~~The following providers will receive a copy of the plan: ~~(3-17-22)~~(9-1-23)T

a. Children's DD providers of services ~~defined in~~ under Section 523 of these rules as identified on the plan of service developed by the family-centered planning team. ~~(3-17-22)~~(9-1-23)T

b. Adult DD service providers required to develop a provider implementation plan ~~as defined in~~ under 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. ~~(3-17-22)~~(9-1-23)T

c. Consumer-Directed service providers ~~as defined in~~ under IDAPA 16.03.13, "Consumer-Directed Services," Section 110. Additionally, the participant, or the participant's decision-making authority will determine during the person-centered planning process whether the service plan, in whole or in part, will be distributed to any other community support worker or vendors. ~~(3-17-22)~~(9-1-23)T

d. Personal Care and Aged and Disabled Waiver service providers furnishing those services ~~defined in~~ under Sections 303 and 326 of these rules. ~~(3-17-22)~~(9-1-23)T

12. Residential Requirements. For participants living in residential provider~~-~~-owned or controlled settings ~~as described in~~ under Section 314 of these rules, the following additional requirements apply: ~~(3-17-22)~~(9-1-23)T

a. Options ~~described in~~ under Subsection 317.03 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. ~~(3-17-22)~~(9-1-23)T

b. Any exception to residential provider~~-~~-owned or controlled setting qualities ~~as described in~~ under Section 314 of these rules must be documented in the person-centered plan ~~as described in~~ under Section 315 of these rules. ~~(3-17-22)~~(9-1-23)T

(BREAK IN CONTINUITY OF SECTIONS)

320. AGED AND DISABLED WAIVER SERVICES.

~~**01. Description of Aged and Disabled Services**.~~ Idaho's elderly and physically disabled citizens should be able to maintain self-sufficiency, individuality, independence, dignity, choice, and privacy in a cost-effective home-like setting. When possible, services should be available in the participant's own home and community regardless of their age, income, or ability and should encourage the involvement of natural supports, such as family, friends, neighbors, volunteers, church, and others. ~~(3-17-22)~~(9-1-23)T

~~**02. Temporary Changes to Aged and Disabled Rules During Declared State of Emergency Related to Novel Coronavirus Disease (COVID-19)**. In response to Idaho's declaration on 3/13/20 of a state of emergency related to COVID-19, the Department reserves the right to temporarily alter requirements and processes related to Aged and Disabled waiver services, currently and through the duration of the emergency state, in order to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS approved 1135 waiver or HCBS Attachment K amendment to the existing Aged and Disabled waiver. Guidance for approved flexibilities is posted at https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-medicaid-providers.~~ ~~(3-17-22)~~

(BREAK IN CONTINUITY OF SECTIONS)

326. AGED AND DISABLED WAIVER SERVICES: COVERAGE AND LIMITATIONS.

01. Adult Day Health. ~~Adult day health is a~~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~~ ADL needed to ensure the optimal functioning of the participant. Adult day health services provided under this waiver will not include room and board payments. ~~(3-17-22)~~(9-1-23)T

02. Adult Residential Care Services. ~~Adult residential care services c~~Consist of a range of services provided in a homelike, non-institutional setting that includes RALFs and CFHs. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep, and improvement. ~~(3-17-22)~~(9-1-23)T

a. ~~Adult residential care services consist of a range of~~These services are provided in a congregate setting licensed under IDAPA 16.03.22, "Residential Assisted Living Facilities," that include: ~~(3-17-22)~~(9-1-23)T

i. Medication assistance, to the extent permitted under State law; (3-17-22)

ii. Assistance with ~~activities of daily living~~ ADL; ~~(3-17-22)~~(9-1-23)T

iii. Meals, including special diets; (3-17-22)

iv. Housekeeping; (3-17-22)

v. Laundry; (3-17-22)

vi. Transportation; (3-17-22)

vii. Opportunities for socialization; (3-17-22)

viii. Recreation; and (3-17-22)

ix. Assistance with personal finances. (3-17-22)

x. Administrative oversight must be provided for all services provided or available in this setting. (3-17-22)

xi. A documented individual service plan must be negotiated between the participant or their legal representative, and a facility representative. (3-17-22)

b. ~~Adult residential care services also consist of a range of~~These services are provided in a setting licensed under IDAPA 16.03.19, "Certified Family Homes," that include: ~~(3-17-22)~~(9-1-23)T

i. Medication assistance, to the extent permitted under State law; (3-17-22)

ii. Assistance with ~~activities of daily living~~ ADL; ~~(3-17-22)~~(9-1-23)T

iii. Meals, including special diets; (3-17-22)

iv. Housekeeping; (3-17-22)

v. Laundry; (3-17-22)

vi. Transportation; (3-17-22)

vii. Recreation; and (3-17-22)

viii. Assistance with personal finances. (3-17-22)

ix. Administrative oversight must be provided for all services provided or available in this setting. (3-17-22)

x. A documented individual service plan must be negotiated between the participant or their legal representative, and a facility representative. (3-17-22)

03. Specialized Medical Equipment and Supplies. (3-17-22)

~~**a.** Specialized medical equipment and supplies include:~~ ~~(3-17-22)~~

~~i~~**a.** Devices, controls, or appliances that enable a participant to increase their abilities to perform ~~activities of daily living~~ ADL, or to perceive, control, or communicate with the environment in which they live; and ~~(3-17-22)~~(9-1-23)T

~~ii~~**b.** 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. (3-17-22)

~~b~~**c.** 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. (3-17-22)

04. Non-Medical Transportation. ~~Non-medical transportation e~~Enables a waiver participant to gain access to waiver and other community services and resources. ~~(3-17-22)~~(9-1-23)T

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. (3-17-22)

b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge, or public transit providers will be utilized. (3-17-22)

05. Attendant Care. Services provided under a Medicaid Home and Community-Based Services waiver 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 ~~activities of daily living (~~ADL~~)~~. These services may include personal assistance and medical tasks that can be done by unlicensed persons, or delegated to an unlicensed person by a licensed health care professional or the participant. Services are based on the participant's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. This assistance may take the form of hands-on assistance (~~actually~~ performing a task for the person) or cuing to prompt the participant to perform a task. ~~(3-17-22)~~(9-1-23)T

06. Chore Services. ~~Chore services i~~Include the following~~ services~~ when necessary to maintain the functional use of the home, or to provide a clean, sanitary, and safe environment: ~~(3-17-22)~~(9-1-23)T

a. Intermittent assistance may include the following: (3-17-22)

i. Yard maintenance; (3-17-22)

ii. Minor home repair; (3-17-22)

iii. Heavy housework; (3-17-22)

iv. Sidewalk maintenance; and (3-17-22)

v. Trash removal to assist the participant to remain in the home. (3-17-22)

b. Chore activities may include the following: (3-17-22)

i. Washing windows; (3-17-22)

ii. Moving heavy furniture; (3-17-22)

iii. Shoveling snow to provide safe access inside and outside the home; (3-17-22)

iv. Chopping wood when wood is the participant's primary source of heat; and (3-17-22)

v. Tacking down loose rugs and flooring. (3-17-22)

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. (3-17-22)

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. (3-17-22)

07. Companion Services. ~~Companion services i~~Include non-medical care, supervision, and socialization provided to a functionally impaired adult. Companion services are in-home services to ensure the safety and well-being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergency situations, or other conditions that would require a person on-site. The service provider, who may live with the participant, may provide voice cuing and occasional assistance with toileting, personal hygiene, dressing, and other ~~activities of daily living~~ ADL. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. However, the primary responsibility is to provide companionship and be there in case they are needed. ~~(3-17-22)~~(9-1-23)T

08. Consultation. ~~Consultation services are s~~Services to a participant or family member~~. Services~~ that are provided by a Personal Assistance Agency to a participant or family member to increase their skills as an employer or manager of their own care. Such services are directed at achieving the highest level of independence and self-reliance possible for the participant and the participant's family. Services include consulting with the participant and family to gain a better understanding of the special needs of the participant and the role of the caregiver. ~~(3-17-22)~~(9-1-23)T

09. Home~~-~~Delivered Meals. ~~Home delivered meals are m~~Meals that are delivered to the participant's home to promote adequate participant nutrition. One (1) to two (2) meals per day may be provided to a participant who: ~~(3-17-22)~~(9-1-23)T

a. Rents or owns a home; (3-17-22)

b. Is alone for significant parts of the day; (3-17-22)

c. Has no caregiver for extended periods of time; and (3-17-22)

d. Is unable to prepare a meal without assistance. (3-17-22)

10. Homemaker Services. ~~Homemaker services c~~Consist of performing for the participant, or assisting them with, or both, the following tasks: laundry, essential errands, meal preparation, and other routine housekeeping duties if there is no one else in the household capable of performing these tasks. ~~(3-17-22)~~(9-1-23)T

11. Environmental Accessibility Adaptations. ~~Environmental accessibility adaptations i~~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: ~~(3-17-22)~~(9-1-23)T

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. (3-17-22)

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. (3-17-22)

c. Portable or non-stationary modifications may be made when such modifications can follow the participant to their next place of residence or be returned to the Department. (3-17-22)

12. Personal Emergency Response System ~~(PERS)~~. ~~PERS is a~~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: ~~(3-17-22)~~(9-1-23)T

a. Rent or own a home, or live with unpaid caregivers; (3-17-22)

b. Are alone for significant parts of the day; (3-17-22)

c. Have no caregiver for extended periods ~~of time~~; and ~~(3-17-22)~~(9-1-23)T

d. Would otherwise require extensive, routine supervision. (3-17-22)

13. Respite Care. ~~Respite care i~~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, a CFH, a ~~developmental disabilities agency~~ DDA, a RALF, or an adult day health facility. ~~(3-17-22)~~(9-1-23)T

14. Skilled Nursing. ~~Skilled nursing i~~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 an ~~licensed registered nurse~~ RN, or ~~licensed practical nurse~~ LPN under the supervision of an ~~licensed registered nurse~~ RN, licensed to practice in Idaho. These services are not appropriate if they are less cost-~~-~~effective than a Home Health visit. ~~(3-17-22)~~(9-1-23)T

15. Habilitation Services. ~~Habilitation services a~~Assist the participant to reside as independently as possible in the community~~,~~ or maintain family unity. ~~(3-17-22)~~(9-1-23)T

a. ~~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~~ CFHs. The number of residents in a setting will be limited by an amount in the Idaho Medicaid Provider Handbook, unless otherwise authorized by the Department. The services and supports that may be furnished consist of the following: ~~(3-17-22)~~(9-1-23)T

i. Self-direction consists of identifying and responding to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (3-17-22)

ii. Money management consists of training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (3-17-22)

iii. Daily living skills consist of training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self-administration of medications, and other areas of daily living including proper use of adaptive and assistive devices~~,~~ and appliances, as well as following home safety, first aid, and emergency procedures; ~~(3-17-22)~~(9-1-23)T

iv. Socialization consists of training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to their community. Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities, and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities that are merely diversional or recreational in nature; (3-17-22)

v. Mobility consists of training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; ~~or~~ ~~(3-17-22)~~(9-1-23)T

vi. Behavior shaping and management consist of training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors, or extension of therapeutic services that consist of reinforcing physical, occupational, speech, and other therapeutic programs. (3-17-22)

vii. Personal assistance services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the person or the person's primary caregiver(s) ~~are~~ is unable to accomplish on their own behalf. Personal assistance activities include direct assistance with grooming, bathing, and eating, assistance with medications that are ordinarily self-administered, supervision, communication assistance, reporting changes in the waiver participant's condition and needs, household tasks essential to health care at home to include general cleaning of the home, laundry, meal planning and preparation, shopping, and correspondence. ~~(3-17-22)~~(9-1-23)T

b. ~~Day habilitation.~~ Day habilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting, separate from the home or facility in which the participant resides. Services will normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, unless provided as an adjunct to other day activities included in a participant's plan of care. Day habilitation services will focus on enabling the participant to attain or maintain their maximum functional level and will be coordinated with any physical therapy, occupational therapy, or speech-language pathology services listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings. ~~(3-17-22)~~(9-1-23)T

16. Supported Employment. ~~Supported employment c~~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~~ because 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. ~~(3-17-22)~~(9-1-23)T

a. Supported employment services rendered under this 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. (3-17-22)

b. Federal Financial Participation (FFP) cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: (1) incentive payments made to an employer of waiver participants to encourage or subsidize the employer's participation in a supported employment program, (2) payments that are passed through to beneficiaries of a supported employment program, or (3) payments for vocational training that is not directly related to a waiver participant's supported employment program. ~~(3-17-22)~~(9-1-23)T

17. Transition Services. ~~Transition services i~~Include goods and services that enable a participant residing in a nursing facility, hospital, IMD, or ICF/IID to transition to a community-based setting. A participant is eligible to receive transition services immediately following discharge from a qualified institution after residing within that institution for a minimum of forty-five (45) days. ~~(3-17-22)~~(9-1-23)T

a. Qualified Institutions include the following: (3-17-22)

i. Skilled, or Intermediate Care Facilities; (3-17-22)

ii. Nursing Facilities; (3-17-22)

iii. ~~Licensed Intermediate Care Facilities for Persons with Intellectual Disabilities (~~ICF/IID~~)~~; ~~(3-17-22)~~(9-1-23)T

iv. Hospitals; and (3-17-22)

v. Institutions for Mental Diseases (IMDs). (3-17-22)

b. Transition services may include the following goods and services: (3-17-22)

i. Security deposits that are required to obtain a lease on an apartment or home; (3-17-22)

ii. Cost of essential household furnishings, including furniture, window coverings, food preparation items, and bed/bath linens; (3-17-22)

iii. Set-up fees or deposits for utility or service access, including telephone, electricity, heating, and water; (3-17-22)

iv. Services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (3-17-22)

v. Moving expenses; and (3-17-22)

vi. Activities to assess need~~,~~ and arrange for and procure transition services. ~~(3-17-22)~~(9-1-23)T

c. Excluded goods and services. Transition services do not include ongoing expenses, real property, ongoing utility charges, décor, or diversion/recreational items such as televisions, DVDs, and computers. (3-17-22)

d. ~~Service limitations.~~ Transition services are limited to a total cost of two thousand dollars ($2,000) per participant and can be accessed every two (2) years, contingent upon a qualifying transition from an institutional setting. Transition services are furnished only to the extent that the participant is unable to meet such expense or when the support cannot be obtained from other sources. ~~(3-17-22)~~(9-1-23)T

(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. ~~(3-17-22)~~(9-1-23)T

a. Services that are not in the individual service plan approved by the Department ~~or its contractor~~ are not eligible for Medicaid payment. ~~(3-17-22)~~(9-1-23)T

b. Services ~~in excess of~~ more than those in the approved individual service plan are not eligible for Medicaid payment. ~~(3-17-22)~~(9-1-23)T

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 their designee. ~~(3-17-22)~~(9-1-23)T

02. Pre-Authorization Requirements. All waiver services must be pre-authorized by the Department. Authorization will be based on the information from: (3-17-22)

a. The UAI; (3-17-22)

b. The individual service plan developed by the Department ~~or its contractor~~; and ~~(3-17-22)~~(9-1-23)T

c. Any other medical information that verifies the need for nursing facility services in the absence of the waiver services. (3-17-22)

03. UAI Administration. The UAI will be administered, and the initial individual service plan developed, by the Department ~~or its contractor~~. ~~(3-17-22)~~(9-1-23)T

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 documented individual service plan. ~~(3-17-22)~~(9-1-23)T

a. The initial individual service plan is developed by the Department ~~or its contractor~~, based on the UAI, in conjunction with: ~~(3-17-22)~~(9-1-23)T

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 them with information and education regarding their rights~~)~~; ~~(3-17-22)~~(9-1-23)T

ii. The guardian, when appropriate; (3-17-22)

iii. The supervising nurse or case manager, when appropriate; and (3-17-22)

iv. Others identified by the waiver participant. (3-17-22)

b. The individual service plan must include the following: (3-17-22)

i. The specific type, amount, frequency, and duration of Medicaid-reimbursed waiver services to be provided; (3-17-22)

ii. Supports and service needs that are to be met by the participant's family, friends, neighbors, volunteers, church, and other community services; (3-17-22)

iii. The providers of waiver services when known; (3-17-22)

iv. Documentation that the participant has been given a choice between waiver services and institutional placement; and (3-17-22)

v. The signature of the participant or their legal representative, agreeing to the plan. (3-17-22)

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. (3-17-22)

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. ~~(3-17-22)~~(9-1-23)T

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~~. ~~(3-17-22)~~(9-1-23)T

05. Service Delivered Following a Documented Plan of Care. All services that are provided must be based on a documented plan of care. (3-17-22)

a. The plan of care is developed by the plan of care team that includes: (3-17-22)

i. The waiver participant with efforts made to maximize their participation on the team by providing them with information and education regarding their rights; (3-17-22)

ii. The guardian when appropriate; (3-17-22)

iii. Service provider identified by the participant or guardian; and (3-17-22)

iv. May include others identified by the waiver participant. (3-17-22)

b. The plan of care must be based on an assessment process approved by the Department. (3-17-22)

c. The plan of care must include the following: (3-17-22)

i. The specific types, amounts, frequency, and duration of Medicaid-reimbursed waiver services to be provided; (3-17-22)

ii. Supports and service needs that are to be met by the participant's family, friends, and other community services; (3-17-22)

iii. The providers of waiver services; (3-17-22)

iv. Goals to be addressed within the plan year; (3-17-22)

v. Activities to promote progress, maintain functional skills, or delay or prevent regression; ~~and~~ ~~(3-17-22)~~(9-1-23)T

vi. The signature of the participant or their legal representative~~.~~; and ~~(3-17-22)~~(9-1-23)T

vii. The signature of the agency or provider indicating that they will deliver services according to the authorized service plan and consistent with home and community-based requirements. (3-17-22)

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. (3-17-22)

e. The Department's Nurse Reviewer monitors the plan of care and all waiver services. (3-17-22)

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. (3-17-22)

06. Individual Service Plan and Plan of Care. The development and documentation of the individual service plan and plan of care must meet the person-centered planning requirements described in Sections 316 and 317 of these rules. (3-17-22)

07. Provider Records. Records will be maintained on each waiver participant. (3-17-22)

a. Each service provider must document each visit made or service provided to the participant, and will record ~~at a minimum~~ the following ~~information~~: ~~(3-17-22)~~(9-1-23)T

i. Date and time of visit; (3-17-22)

ii. Services provided during the visit; (3-17-22)

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 (3-17-22)

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. ~~(3-17-22)~~(9-1-23)T

b. The provider is required to keep the original service delivery record. A copy of the service delivery

record will be maintained and available in a format accessible to the participant. Failure to maintain documentation according to these rules will result in the recoupment of funds paid for undocumented services. (3-17-22)

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~~ this rule~~s~~ 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. ~~(3-17-22)~~(9-1-23)T

d. Record requirements for participants in RALFs are ~~described in~~ under IDAPA 16.03.22, "Residential Assisted Living Facilities." ~~(3-17-22)~~(9-1-23)T

e. Record requirements for participants in CFHs are ~~described in~~ under IDAPA 16.03.19, "Certified Family Homes." ~~(3-17-22)~~(9-1-23)T

f. EVV Systems as described in Section 041 of these rules will not take the place of documentation requirements of Subsection 328.07 of this rule, but maybe used to generate documentation retained in the participant's home. (3-17-22)

08. 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. ~~(3-17-22)~~(9-1-23)T

09. Records Retention. Personal Assistance Agencies, and other providers are responsible to retain their records for five (5) years following the date of service. (3-17-22)

10. Requirements for a~~n~~ Fiscal Intermediary (FI). Participants of PCS will have one (1) year from the date that 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~~ under Section 329 of these rules. ~~(3-17-22)~~(9-1-23)T

~~**11. COVID-19**. The sections of this rule may be subject to amendment by the BLTC for the duration of the COVID-19 state of emergency. Please consult Medicaid Information Release MA20-15 for additional guidance. (3-17-22)~~

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. (3-17-22)

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. (3-17-22)

02. Fiscal Intermediary Services. An agency that has responsibility for the following: (3-17-22)

a. ~~To d~~Directly assure compliance with legal requirements related to employment of waiver service providers; ~~(3-17-22)~~(9-1-23)T

b. ~~To o~~Offer supportive services to enable participants or their families to perform the required employer tasks themselves; ~~(3-17-22)~~(9-1-23)T

c. ~~To b~~Bill the Medicaid program for services approved and authorized by the Department; ~~(3-17-22)~~(9-1-23)T

d. ~~To c~~Collect any participant participation due; ~~(3-17-22)~~(9-1-23)T

e. ~~To p~~Pay personal assistants and other waiver service providers for service; ~~(3-17-22)~~(9-1-23)T

f. ~~To p~~Perform all necessary withholding as required by state and federal labor and tax laws, rules, and regulations; ~~(3-17-22)~~(9-1-23)T

g. ~~To a~~Assure that personal assistants providing services meet the standards and qualifications under in this rule; ~~(3-17-22)~~(9-1-23)T

h. ~~To m~~Maintain liability insurance coverage; ~~(3-17-22)~~(9-1-23)T

i. ~~To c~~Conduct, at least annually, participant satisfaction or quality control reviews that are available to the Department and the ~~general~~ public; and ~~(3-17-22)~~(9-1-23)T

j. ~~To o~~Obtain such ~~criminal~~ background checks and health screens on new and existing employees of record and fact as required. ~~(3-17-22)~~(9-1-23)T

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. (3-17-22)

a. A waiver provider cannot be a relative of any participant to whom the provider is supplying services except for extraordinary circumstances as defined by the Department. ~~(3-17-22)~~(9-1-23)T

b. For the purposes of Section 329 of ~~these~~ this rule~~s~~, a relative is defined as a spouse or parent of a minor child. ~~(3-17-22)~~(9-1-23)T

c. Individuals who provide direct care or services must ~~satisfactorily~~ complete a ~~criminal history and~~ background check ~~in accordance with~~ and receive a clearance under IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~(9-1-23)T

04. Quality Assurance. Providers of Aged and Disabled waiver services are responsible for ensuring that they provide quality services in compliance with applicable rules. (3-17-22)

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. (3-17-22)

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. (3-17-22)

c. 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. (3-17-22)

05. HCBS Setting 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~~ under Sections 311 through 318 of these rules, as applicable, and must comply with associated Department quality assurance activities. ~~(3-17-22)~~(9-1-23)T

06. 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. (3-17-22)

07. Skilled Nursing Service Providers. ~~Skilled nursing service providers m~~Must be licensed in Idaho as a~~n licensed registered nurse~~ RN or~~ licensed practical nurse~~ LPN 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~~ and receive a clearance under IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~(9-1-23)T

08. Consultation Services. ~~Consultation services m~~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. ~~(3-17-22)~~(9-1-23)T

09. Adult Residential Care Providers. ~~Adult residential care providers w~~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~~ and receive a clearance appropriate to the setting under IDAPA 16.03.19, "Certified Family Homes," or IDAPA 16.03.22, "Residential Assisted Living Facilities." ~~(3-17-22)~~(9-1-23)T

10. Providers of Home~~-~~Delivered Meals. ~~Providers of home delivered meals m~~Must be a public agency or private business, and must exercise supervision to ensure that: ~~(3-17-22)~~(9-1-23)T

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; (3-17-22)

b. Meals are delivered~~ in accordance with~~ under the service plan, in a sanitary manner, and at the correct temperature for the specific type of food; ~~(3-17-22)~~(9-1-23)T

c. Documentation is maintained demonstrating that the meals served are made from the highest USDA grade for each specific food served; (3-17-22)

d. The agency or business is inspected and licensed as a food establishment under IDAPA 16.02.19, "Idaho Food Code"; (3-17-22)

e. A Registered Dietitian documents the review and approval of menus, menu cycles, and any changes or substitutions; and (3-17-22)

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~~ under Subsection 329.03 of this rule have been met. ~~(3-17-22)~~(9-1-23)T

11. Personal Emergency Response Systems. ~~Personal emergency response system providers m~~Must demonstrate that the devices installed in a waiver participant's home meet Federal Communications Standards,~~ or~~ Underwriter's Laboratory Standards, or equivalent standards. ~~(3-17-22)~~(9-1-23)T

12. Adult Day Health Providers. ~~Providers of adult day health m~~Must meet the following requirements: ~~(3-17-22)~~(9-1-23)T

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)." (3-17-22)

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, "Certified Family Homes." (3-17-22)

c. Services provided in a RALF must be provided in a facility that meets the standards identified in IDAPA 16.03.22, "Residential Assisted Living Facilities." (3-17-22)

d. Adult day health providers who provide direct care or services must ~~satisfactorily~~ complete a ~~criminal history~~ background check ~~in accordance with~~ and receive a clearance under IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~(9-1-23)T

e. Providers of adult day health must notify the Department on behalf of the participant, if the adult day health is provided in a CFH 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. (3-17-22)

f. Adult day health providers who provide direct care or services must be free from communicable disease. (3-17-22)

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~~ under Subsection 329.03 of this rule. ~~(3-17-22)~~(9-1-23)T

13. Non-Medical Transportation Services. Providers of non-medical transportation services must: (3-17-22)

a. Possess a valid driver's license; (3-17-22)

b. Complete a background check and receive a clearance under IDAPA 16.05.06, "Criminal History and Background Checks." (9-1-23)T

~~b~~c. Possess valid vehicle insurance; and (3-17-22)

~~e~~d. 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~~ under Subsection 329.03 of this rule. ~~(3-17-22)~~(9-1-23)T

14. Attendant Care Providers. ~~Attendant care providers who p~~Provide direct care and services and must ~~satisfactorily~~ complete a ~~criminal history and~~ background check ~~in accordance with~~ and receive a clearance under 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~~ under Subsection 329.03 of this rule. ~~(3-17-22)~~(9-1-23)T

15. Homemaker Services Providers. ~~The homemaker m~~Must be ~~an~~ employees 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~~ and receive a clearance under IDAPA 16.05.06, "Criminal History and Background Checks." All ~~providers of~~ homemaker services providers 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~~ under Subsection 329.03 of this rule. ~~(3-17-22)~~(9-1-23)T

16. Environmental Accessibility Adaptations. All services must be provided ~~in accordance with~~ under applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. ~~(3-17-22)~~(9-1-23)T

17. 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, "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: (3-17-22)

a. ~~Direct service s~~Staff who provide direct care or services must ~~meet the following minimum qualifications~~: ~~(3-17-22)~~(9-1-23)T

i. Be at least eighteen (18) years of age; (3-17-22)

ii. Be a high school graduate, or have a GED, or demonstrate the ability to provide services according to a plan of service; (3-17-22)

iii. Have current CPR and First Aid certifications; (3-17-22)

iv. Be free from communicable disease; (3-17-22)

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. (3-17-22)

vi. ~~Residential habilitation service providers who provide direct care or services must satisfactorily e~~Complete a ~~criminal history and~~ background check ~~in accordance with~~ and receive a clearance under IDAPA 16.05.06, "Criminal History and Background Checks;" ~~(3-17-22)~~(9-1-23)T

vii. Have appropriate certification or licensure if required to perform tasks that require certification or licensure. Direct service staff must also have taken a traumatic brain injury training course approved by the Department. (3-17-22)

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. (3-17-22)

c. Prior to delivering services to a participant, agency direct service staff must complete an orientation program. ~~The orientation program must~~ that includes the following subjects: ~~(3-17-22)~~(9-1-23)T

i. Purpose and philosophy of services; (3-17-22)

ii. Service rules; (3-17-22)

iii. Policies and procedures; (3-17-22)

iv. Proper conduct in relating to waiver participants; (3-17-22)

v. Handling of confidential and emergency situations that involve the waiver participant; (3-17-22)

vi. Participant rights; (3-17-22)

vii. Methods of supervising participants; (3-17-22)

viii. Working with individuals with traumatic brain injuries; and (3-17-22)

ix. Training specific to the needs of the participant. (3-17-22)

d. Additional training requirements must be completed within six (6) months of employment with the residential habilitation agency and include ~~at a minimum~~: ~~(3-17-22)~~(9-1-23)T

i. ~~Instructional techniques:~~ Methodologies for training in a systematic and effective manner; ~~(3-17-22)~~(9-1-23)T

ii. ~~Managing behaviors:~~ Techniques and strategies for teaching adaptive behaviors; ~~(3-17-22)~~(9-1-23)T

iii. Feeding; (3-17-22)

iv. Communication; (3-17-22)

v. Mobility; (3-17-22)

vi. ~~Activities of daily living~~ADL; ~~(3-17-22)~~(9-1-23)T

vii. Body mechanics and lifting techniques; (3-17-22)

viii. Housekeeping techniques; and (3-17-22)

ix. Maintenance of a clean, safe, and healthy environment. (3-17-22)

e. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed. (3-17-22)

18. Day Habilitation Providers. ~~Providers of day habilitation services m~~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~~ and receive a clearance under IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~(9-1-23)T

19. Respite Care Providers. ~~Providers of respite care services m~~Must meet the following ~~minimum qualifications~~: ~~(3-17-22)~~(9-1-23)T

a. Have received care-giving instructions in the needs of the person who will be provided the service; (3-17-22)

b. Demonstrate the ability to provide services according to a plan of service; (3-17-22)

c. Be free of communicable disease; and (3-17-22)

d. Respite care service providers who provide direct care and services must ~~satisfactorily~~ complete a ~~criminal history and~~ background check ~~in accordance with~~ and receive a clearance under IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~(9-1-23)T

20. Supported Employment Services. ~~Supported employment services m~~Must be provided by an agency that supervises the direct service and is accredited by the Commission on Accreditation of Rehabilitation Facilities, 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~~ and receive a clearance under IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~(9-1-23)T

21. Chore Services Providers. ~~Providers of chore services m~~Must meet the following ~~minimum qualifications~~: ~~(3-17-22)~~(9-1-23)T

a. Be skilled in the type of service to be provided~~; and~~. ~~(3-17-22)~~(9-1-23)T

b. Demonstrate the ability to provide services according to a plan of service. (3-17-22)

c. Chore service providers who provide direct care and services must ~~satisfactorily~~ complete a ~~criminal history and~~ background check ~~in accordance with~~ and receive a clearance under IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~(9-1-23)T

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~~ under Subsection 329.03 of this rule. ~~(3-17-22)~~(9-1-23)T

22. Transition Services. Transition managers as described in Section 350.01 of these rules are

responsible for administering transition services. (3-17-22)

~~**23. COVID-19**. The sections of this rule may be subject to amendment by the BLTC for the duration of the COVID-19 state of emergency. Please consult Medicaid Information Release MA20-15 for additional guidance. (3-17-22)~~

(BREAK IN CONTINUITY OF SECTIONS)

350. TRANSITION MANAGEMENT.
Transition management provides relocation assistance and intensive service coordination activities to assist nursing facility, hospital, IMD, and ICF/IID residents to transition to community settings of their choice. Transition managers provide oversight and coordination activities for participants during a transitional period up to twelve (12) months following a return to the community. This provider type will function as a liaison between the participant, institutional or facility discharge staff, and other individuals as designated by the participant and the Department to support a successful and sustainable transition to the community. A participant is eligible to receive transition management when planning to discharge from a qualifying institution after residing within that institution for a minimum of forty-five (45) days. (3-17-22)

01. Provider Qualifications. Transition managers must: (3-17-22)

a. ~~Satisfactorily c~~Complete a ~~criminal history and~~ background check ~~in accordance with~~ and receive a clearance under IDAPA 16.05.06, "Criminal History and Background Checks"; ~~(3-17-22)~~(9-1-23)T

b. Have documented successful completion of the Department-approved Transition Manager training prior to providing any transition management and transition services; (3-17-22)

c. Have a Bachelor's Degree in a human services field from a nationally accredited university or college, or three (3) years' supervised work experience with the population being served; and (3-17-22)

d. Be employed with a provider type approved by the Department. (3-17-22)

02. Service Description. Transition management includes the following activities: (3-17-22)

a. A comprehensive assessment of health, social, and housing needs; (3-17-22)

b. Development of housing options with each participant, including assistance with housing choices, applications, waitlist follow-up, roommate selection, and introductory visits; (3-17-22)

c. Assistance with tasks necessary to accomplish a move from the institutional setting; (3-17-22)

d. Securing Transition Services ~~in accordance with~~ under Subsection 326.17 or Subsection 703.15 of these rules ~~in order~~ to make arrangements necessary to move, including: ~~(3-17-22)~~(9-1-23)T

i. Obtaining durable medical equipment, assistive technology, and medical supplies, if needed; (3-17-22)

ii. Arranging for home modifications, if needed; (3-17-22)

iii. Applying for public assistance, if needed; (3-17-22)

iv. Arranging household preparations including scheduling moving and/or cleaning services, utility set-up, purchasing furniture, and household supplies, if needed. (3-17-22)

e. Coordinating with others involved in plan development for the participant to ensure successful transition and establishment in a community setting; (3-17-22)

f. Providing post-transition support, including assistance with problem solving, dependency and isolation concerns, consumer-directed services and supports, post-secondary educational institutions and proprietary schools when applicable, and community inclusion. ~~(3-17-22)~~(9-1-23)T

03. Service Limitations. Transition management is limited to seventy-two (72) hours per participant per qualifying transition. (3-17-22)

~~**04. Temporary Changes to Transition Management Rules During Declared State of Emergency Related to Novel Coronavirus Disease (COVID-19)**. In response to Idaho's declaration on 3/13/20 of a state of emergency related to COVID-19, the Department reserves the right to temporarily alter requirements and processes related to Transition Management services, currently and through the duration of the emergency state, in order to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS approved 1135 waiver. Guidance for approved flexibilities is posted at https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-medicaid-providers.~~ ~~(3-17-22)~~

(BREAK IN CONTINUITY OF SECTIONS)

504. -- 506~~5~~. (RESERVED)

506. ADULT DEVELOPMENTAL DISABILITY SERVICES: ADMINISTRATIVE APPEALS.

01. Appealable Decisions. Applicants to or participants in the Adult DD Services Program may file an administrative appeal if they disagree with a Department decision affecting individual rights, including final decisions made under the following: (9-1-23)T

a. Program eligibility determinations under these rules; (9-1-23)T

b. Program assessment results under these rules; (9-1-23)T

c. Budget assignments under these rules; (9-1-23)T

d. Exception review decisions under these rules; and (9-1-23)T

e. Authorization of services, plans of service, or both, under these rules. (9-1-23)T

02. Appeals Process. Administrative appeal processes are under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." (9-1-23)T

(BREAK IN CONTINUITY OF SECTIONS)

508. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: DEFINITIONS.
~~For the purposes of these rules the following terms are used as defined below.~~ ~~(3-17-22)~~

01. Adult. A person ~~who is~~ eighteen (18) years ~~of age~~ old or older. ~~(3-17-22)~~(9-1-23)T

02. Assessment. A process ~~that is described in~~ under Section 509 of these rules for program eligibility and ~~in~~ Section 512 of these rules for plan of service. ~~(3-17-22)~~(9-1-23)T

03. Clinical Review. A process of professional review that validates the need for continued services. (3-17-22)

04. Community Crisis Support. Intervention for participants who are at risk of losing housing, employment, or income, or who are at risk of incarceration, physical harm, family altercations, or other emergencies. (3-17-22)

05. Concurrent Review. A clinical review to determine the need for continued prior authorization of services. (3-17-22)

06. Department-Approved Assessment Tool. Any standardized assessment tool approved by the Department for use in determining ~~developmental disability~~ DD eligibility, waiver eligibility, skill level to identify the participant's needs for the plan of service, and for determining the participant's budget. ~~(3-17-22)~~(9-1-23)T

07. Duplication of Services. When goals are not separate and unique to each service provided, or when more than one (1) service is provided at the same time, unless otherwise authorized. (9-1-23)T

0~~7~~8. Exception Review. A clinical review of a plan that falls outside the established standards due to a health or safety risk. ~~(3-17-22)~~(9-1-23)T

09. Health. The prevention of deterioration of one's physical or mental health condition, cognitive functioning, or an increase in maladaptive behavior, and is related to the effects of one's disability. (9-1-23)T

10. Health Risks. Must be established through written documentation and current treatment recommendations from a licensed practitioner of the healing arts under these rules, or other professional licensed by the State of Idaho whose recommendation is within the scope of their license. Such documentation must establish: (9-1-23)T

a. The current physical or mental condition, or cognitive functioning that will likely deteriorate, or the current maladaptive behavior(s) that will likely increase; and (9-1-23)T

b. The specific supports or services being requested, including type and frequency if applicable, that will address the identified need. (9-1-23)T

c. To comply with the documentation requirement, the Department may require the participant to obtain additional consultation or assessment, available to the participant and covered by Medicaid, from a professional licensed by the State of Idaho acting within the scope of their license. If the Department requires additional consultation or assessment, the Department will specify the nature of the consultation or assessment and the necessary documentation. (9-1-23)T

0~~8~~11. Interdisciplinary Team. ~~For purposes of these rules, the interdisciplinary team is a~~A team of professionals, determined by the Department, that reviews requests for reconsideration. ~~(3-17-22)~~(9-1-23)T

0~~9~~12. Level of Support. An assessment score derived from a Department-approved assessment tool that indicates types and amounts of services and supports necessary to allow the individual to live independently and safely in the community. (3-17-22)

1~~0~~13. Person-Centered Planning Process. A meeting facilitated by the participant or plan developer, comprised of family and individuals significant to the participant who collaborate with the participant to develop the plan of service. (3-17-22)

1~~1~~14. Person-Centered Planning Team. The group who develops the plan of service. This group includes~~, at a minimum,~~ the participant and the service coordinator or plan developer chosen by the participant. The person-centered planning team may include others identified by the participant or agreed upon by the participant and the Department as important to the process. ~~(3-17-22)~~(9-1-23)T

1~~2~~15. 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 person-centered planning process. ~~(3-17-22)~~(9-1-23)T

~~13~~16. **Plan Monitor**. A person who oversees the provision of services on a paid or non-paid basis. (3-17-22)

~~14~~17. **Plan of Service**. An initial or annual plan that identifies all services and supports based on a person-centered planning process. Plans are authorized ~~annually~~ every three hundred sixty-five (365) days. ~~(3-17-22)~~(9-1-23)T

~~15~~18. **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 these rules. (3-17-22)

~~16~~19. **Provider Status Review**. The written documentation that identifies the participant's progress toward goals defined in the plan of service. (3-17-22)

~~17~~20. **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. (3-17-22)

~~18~~21. **Right Place**. Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. (3-17-22)

~~19~~22. **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. (3-17-22)

~~20~~23. **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. (3-17-22)

24. **Safety**. Prevention of criminal activity, destruction of property, or injury or harm to self or others. (9-1-23)T

25. **Safety Risks**. Must be documented by the following: (9-1-23)T

a. Current incident reports; (9-1-23)T

b. Police reports; (9-1-23)T

c. Assessments from a licensed practitioner of the healing arts under these rules or a professional licensed in Idaho and whose assessment is within the scope of their license; or (9-1-23)T

d. Status reports and implementation plans that reflect the type and frequency of intervention(s) in place to prevent the risk and the participant's progress under such intervention(s). (9-1-23)T

e. Such documentation must establish: (9-1-23)T

i. An imminent or likely safety risk; and (9-1-23)T

ii. The specific supports or services that are being requested, including the type and frequency if applicable, that are likely to prevent that risk. (9-1-23)T

~~21~~26. **Service Coordination**. ~~Service coordination is a~~An activity ~~which~~ that assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual. ~~(3-17-22)~~(9-1-23)T

~~22~~27. **Service Coordinator**. An individual who provides service coordination to a Medicaid-eligible participant, is employed by a service coordination agency, and meets the training, experience, and other requirements under Sections 729 through 732 of these rules. (3-17-22)

~~23~~28. **Services**. Services paid for by the Department that enable the individual to reside safely and

effectively in the community. (3-17-22)

~~24~~29. **Supports**. Formal or informal services and activities, not paid for by the Department, that enable the individual to reside safely and effectively in the setting of their choice. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

511. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: COVERAGE AND LIMITATIONS.
The~~is scope of these~~ rule~~s~~ defines prior authorization for the following Medicaid~~ developmental disability~~ DD services for adults: ~~(3-17-22)~~(9-1-23)T

01. DD Waiver Services. ~~DD Waiver s~~Services~~ as~~ described in Sections 700 through 719 of these rules~~; and~~. ~~(3-17-22)~~(9-1-23)T

02. Developmental Therapy. ~~Developmental t~~Therapy~~ as~~ described in Sections 649 through 657 of these rules and IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)."~~; and~~ ~~(3-17-22)~~(9-1-23)T

03. Service Coordination. Service~~ Coordination~~ for persons with developmental disabilities as described in Sections 720 through 779 of these rules. ~~(3-17-22)~~(9-1-23)T

04. Residential Habilitation - Supported Living. The number of residents in a setting is limited by an amount in the Idaho Medicaid Provider Handbook, unless otherwise authorized by the Department. (9-1-23)T

(BREAK IN CONTINUITY OF SECTIONS)

513. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PLAN OF SERVICE.
In collaboration with the participant, the Department will assure that the participant has one (1) plan of service~~. This plan of service~~ that 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. ~~(3-17-22)~~(9-1-23)T

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. (3-17-22)

02. Plan Development. All participants must direct the development of their service plan through a person-centered planning process. 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. (3-17-22)

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. ~~(3-17-22)~~(9-1-23)T

b. The plan development process must meet the person-centered planning requirements described in

Section 316 of these rules. (3-17-22)

c. The participant may facilitate their own person-centered planning meeting or designate a paid or non-paid plan developer to facilitate the meeting. Individuals responsible for facilitating the person-centered planning meeting cannot be providers of direct services to the participant. (3-17-22)

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: (3-17-22)

a. Durable Medical Equipment (DME); (3-17-22)

b. Transportation; and (3-17-22)

c. Physical therapy, occupational therapy, and speech-language pathology services. (3-17-22)

04. No Duplication of Services. The plan developer will ensure that there is no duplication of services. Duplicate services will not be authorized. (3-17-22)

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: (3-17-22)

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. The face-to-face encounter may occur via synchronous interaction ~~telehealth~~ virtual care, as defined in Title 54, Chapter 57, Idaho Code; ~~(3-17-22)~~(9-1-23)T

b. Contact with service providers to identify barriers to service provision; (3-17-22)

c. Discuss with participant satisfaction regarding quality and quantity of services; and (3-17-22)

d. Review of provider status reviews. (3-17-22)

e. The provider will immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, ~~as well as~~ and 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. ~~(3-17-22)~~(9-1-23)T

06. Provider Status Reviews. Service providers, with exceptions identified in Subsection 513.09 of ~~these~~ this rule~~s~~, 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 review is due fifteen (15) days before the end of the six (6) month period. The annual review is due thirty (30) days before plan's end. The semi-annual and annual reviews must include: ~~(3-17-22)~~(9-1-23)T

a. The status of supports and services to identify progress; (3-17-22)

b. Maintenance; or (3-17-22)

c. Delay or prevention of regression. (3-17-22)

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. (3-17-22)

a. The written plan of service must meet the person-centered planning requirements described in

Section 317 of these rules. (3-17-22)

b. The written plan of service must be finalized and agreed to ~~according to~~ under procedural requirements described in Section 704 of these rules. ~~(3-17-22)~~(9-1-23)T

c. The Department will distribute a copy of the plan of service to adult DD service providers defined in Section 317 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~~ DD service provider identified by the participant during the person-centered planning process. ~~(3-17-22)~~(9-1-23)T

08. Informed Consent. Unless the participant has a guardian who retains full decision-making authority, the participant must make decisions regarding the type and amount of services required. Prior to plan development, the plan developer must document that they have provided information and support to the participant to maximize their ability to make informed choices regarding the services and supports they receive and from whom. 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 there is a conflict that cannot be resolved among person-centered planning members or if a member does not believe the plan meets the participant's needs or represents the participant's choice, the plan or amendment may be referred to the Bureau of Developmental Disability Services to negotiate a resolution with members of the planning team. (3-17-22)

09. Provider Implementation Plan. Each provider of Medicaid services 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. (3-17-22)

a. Exceptions. An implementation plan is not required for waiver providers of: (3-17-22)

i. Specialized medical equipment; (3-17-22)

ii. Home-delivered meals; (3-17-22)

iii. Environmental accessibility adaptations; (3-17-22)

iv. Non-medical transportation; (3-17-22)

v. Personal emergency response systems ~~(PERS)~~; ~~(3-17-22)~~(9-1-23)T

vi. Respite care; ~~and~~ ~~(3-17-22)~~(9-1-23)T

vii. Chore services~~.~~; ~~(3-17-22)~~(9-1-23)T

viii. Community crisis support services; and (9-1-23)T

ix. Adult DD service coordination. (9-1-23)T

b. Time for Completion. Implementation plans must be completed within fourteen (14) days of receipt of the authorized plan of service or the service start date, whichever is later. (3-17-22)

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. (3-17-22)

ii. Implementation plan revision must be based on changes to the needs of the participant. (3-17-22)

c. Documentation of Changes. Documentation of Implementation Plan changes will be included in the participant's record~~. This documentation~~, and 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 the date and title. ~~(3-17-22)~~(9-1-23)T

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~~ under Section 317 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 requirements. Each HCBS provider responsible for the implementation of the plan must maintain their signed plan in the participant's record. Documentation of signature must include the signature of the professional responsible for service provision complete with their title and the date signed. Provider signature ~~will~~ is to be completed each time an initial or annual plan of service is implemented. ~~(3-17-22)~~(9-1-23)T

11. Addendum to the Plan of Service. (3-17-22)

a. 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 or increase of a service ~~or increase to a service~~, or a change of provider, addition of a restrictive intervention, or addition of alone time. Additional assessments or information may be clinically necessary. Adjustment of the plan of service is subject to prior authorization by the Department. ~~(3-17-22)~~(9-1-23)T

b. When a service plan has been adjusted, the Department will distribute a copy of the addendum to HCBS providers responsible for the implementation of the plan of service ~~as identified in~~ under Section 317 of these rules. ~~(3-17-22)~~(9-1-23)T

c. Upon receipt of the addendum, the HCBS provider must sign the addendum indicating they have reviewed the plan adjustment and will deliver services accordingly. Documentation must include the signature of the professional responsible for service provision complete with their title and the date signed, and must be maintained in the participant's record. Provider signature ~~will~~ is to be completed each time an addendum is authorized. ~~(3-17-22)~~(9-1-23)T

12. Annual Reauthorization of Services. A participant's plan of service must be reauthorized annually. The Department will review and authorize the new plan of service prior to the expiration of the current plan. (3-17-22)

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 unless delayed because of participant unavailability due to extenuating circumstances. If the plan is not submitted within the period, authorization for provider payments may be terminated. Prior to ~~this~~ submission, the plan developer must: ~~(3-17-22)~~(9-1-23)T

i. Notify the providers who appear on the plan of service of the annual review date. (3-17-22)

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 513.06 of the~~se~~is rule~~s~~. ~~(3-17-22)~~(9-1-23)T

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. (3-17-22)

b. ~~Evaluation and Prior Authorization of the Plan of Service.~~ The plan of service will be evaluated and prior authorized ~~in accordance with~~ under the requirements in Sections 507 and 513 of these rules. ~~(3-17-22)~~(9-1-23)T

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. ~~(3-17-22)~~(9-1-23)T

d. ~~Annual Status Reviews Requirement.~~ If the provider's annual status reviews are not submitted to the plan developer with the annual plan, services ~~will~~ may 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~~ under Subsection 513.10 of the~~se~~is rule~~s~~. ~~(3-17-22)~~(9-1-23)T

e. ~~Reapplication After a Lapse in Service.~~ For participants who are re-applying for service after a lapse in service, the assessor will evaluate whether assessments are current and accurately describe the status of the participant. ~~(3-17-22)~~(9-1-23)T

f. ~~Annual Assessment Results.~~ An annual assessment will be completed ~~in accordance with~~ under Section 512 of these rules. ~~(3-17-22)~~(9-1-23)T

13. ~~**Complaints and Administrative Appeals**~~**Participant Plan of Service Notifications**. The Department will notify each participant whether their plan of service was approved in whole, in part, or denied. The notification will include an individualized explanation of the decision and how the participant may appeal the service plan decision. ~~(3-17-22)~~(9-1-23)T

~~**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. (3-17-22)~~

~~**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, "Contested Case Proceedings and Declaratory Rulings." (3-17-22)~~

514. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PROVIDER REIMBURSEMENT.
Providers are reimbursed on a fee-for-service basis based on a participant budget. (3-17-22)

01. Individualized Budget Beginning on October 1, 2006. Beginning October 1, 2006, for DD waiver participants, and beginning January 1, 2007, for all other adult DD participants, the Department sets an individualized budget for each participant according to an individualized measurement of the participant's functional abilities, behavioral limitations, and medical needs related to the participant's disability. Using these specific participant factors, the budget-setting methodology will correlate a participant's characteristics with the participant's individualized budget amount, so participants with higher needs will be assigned a higher individualized budget amount. (3-17-22)

a. The Department notifies each participant of their set budget amount as part of the eligibility determination process or annual redetermination process. The notification will include how the participant may appeal the set budget amount. (3-17-22)

b. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes in the participant's condition resulting in a need for services that meet medical necessity criteria, and this is not reflected on the current inventory of individual needs. (3-17-22)

02. Residential Habilitation - Supported Living Acuity-Based Levels of Support. Reimbursement for residential habilitation - supported living is based on the participant's assessed level of support need. All plans of service that include supported living must include community integration goals that provide for maintained or enhanced independence, quality of life, and self-determination. The number of residents in a setting will be limited by an amount in the Idaho Medicaid Provider Handbook, unless otherwise authorized by the Department. As a participant's independence increases and they are less dependent on supports, they must transition to less intense supports. ~~(3-17-22)~~(9-1-23)T

a. High support is for those participants who require twenty-four (24) hour per day supports and supervision as determined by a Department-approved assessment tool. High support allows for a blend of one-to-one and group staffing. Participants authorized at the high support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the high

support daily rate. (3-17-22)

b. Intense support is for those exceptional participants who require intense, twenty-four (24) hour per day supports and supervision. This support level typically requires one-on-one staffing, but requests for a blend of one-on-one and group staffing will be reviewed on a case-by-case basis. Participants authorized at the intense support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the intense support daily rate. To qualify for this level of support, participants must be evaluated to meet one (1) or more of the following criteria: (3-17-22)

i. Recent felony convictions or charges for offenses related to the serious injury or harm of another person. These participants must have been placed in a supported living setting directly from incarceration or directly after being diverted from incarceration. (3-17-22)

ii. History of predatory sexual offenses and are at high risk to re-offend based on a sexual offender risk assessment completed by an appropriate professional. (3-17-22)

iii. Documented, sustained history of serious aggressive behavior showing a pattern of causing harm to themselves or others. The serious aggressive behavior must be such that the threat or use of force on another person makes that person reasonably fear bodily harm. The participant must also have the capability to carry out such a threat. The frequency and intensity of this type of aggressive behavior must require continuous monitoring to prevent injury to themselves or others. (3-17-22)

iv. Chronic or acute medical conditions that are so complex or unstable that one-to-one staffing is required to provide frequent interventions and constant monitoring. Without this intervention and monitoring the participant would require placement in a nursing facility, hospital, or ICF/IID with twenty-four (24) hour on-site nursing. Verification of the complex medical condition and the need for this level of service requires medical documentation. (3-17-22)

c. Hourly support is for those individuals ~~that~~ who do not meet criteria for either high or intense supports or those individuals who qualify for a daily rate but whose needs can be met with less than twenty-four (24) hour per day support. The combination of hourly supported living, developmental therapy, community ~~-~~supported employment, and adult day care will not be authorized to exceed the maximum set daily amount established by the Department, except when all of the following ~~conditions~~ are met: ~~(3-17-22)~~(9-1-23)T

i. The participant is eligible to receive the high support daily rate; (3-17-22)

ii. Community-supported employment is included in the plan and is causing the combination to exceed the daily limit; (3-17-22)

iii. There is documentation that the Person-Centered Planning team has explored other options including using lower-cost services and natural supports; and (3-17-22)

iv. The participant's health and safety needs will be met using hourly services despite having been assessed to qualify for twenty-four (24) hour care. (3-17-22)

515. ADULT DEVELOPMENTAL DISABILITY SERVICES: QUALITY ASSURANCE AND IMPROVEMENT.

01. Quality Assurance. ~~Quality Assurance c~~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 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.~~ ~~(3-17-22)~~(9-1-23)T

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. (3-17-22)

03. Exception Review. The Department will complete an exception review of plans or addend~~ums~~a 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~~ is met: ~~(3-17-22)~~(9-1-23)T

a. Services are needed to assure the health or safety of participants and the services requested on the plan or addendum are ~~required based on medical necessity as defined in Section 012 of these rules~~ needed to mitigate a documented health risk or safety risk. ~~(3-17-22)~~(9-1-23)T

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: (3-17-22)

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; (3-17-22)

ii. The participant's plan of service was developed by the participant and their 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 (3-17-22)

iii. An acknowledgment signed by the participant and their 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. (3-17-22)

04. Concurrent Review. The Department will obtain the necessary information to determine that participants continue to meet eligibility criteria, participant rights are maintained, services continue to be clinically necessary, services continue to be the choice of the participant, services support participant integration, and services constitute appropriate care to warrant continued authorization or need for the service. (3-17-22)

05. Participant Complaints. Participant complaints about program operations, quality of services, or other relevant concerns may be referred to the Division of Medicaid and will be tracked and routed for follow-up as warranted. (9-1-23)T

0~~5~~6. 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. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

645. HOME AND COMMUNITY-BASED SERVICES (HCBS) STATE PLAN OPTION.

~~Home and community based services~~HCBS are provided through the HCBS State Plan option as allowed in Section 1915(i) of the Social Security Act for adults with ~~developmental disabilities~~ DD who do not meet the ICF/IID level of care. HCBS ~~s~~State ~~p~~Plan option services must comply with Sections 310 through 319, and Sections 645 through 657 of these rules. ~~Through the duration of the COVID-19 public health emergency, the Department reserves the right to temporarily alter requirements and processes related to the Adult Developmental Disabilities HCBS State Plan Option program to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS approved 1135 waiver or a state plan amendment to the existing Adult Developmental Disabilities HCBS State Plan Option benefit. In the event additional changes are required in the~~

~~future, guidance will be posted on the Medicaid Information Releases webpage.~~ ~~(3-17-22)~~(9-1-23)T

(BREAK IN CONTINUITY OF SECTIONS)

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. (3-17-22)

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. (3-17-22)

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. (3-17-22)

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 ~~seventy-two (72) hours~~ five (5) business days of providing the service. ~~(3-17-22)~~(9-1-23)T

(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. (3-17-22)

01. Requirements to Deliver Developmental Therapy. Developmental therapy may be delivered in a ~~developmental disabilities agency~~ DDA center-based program, the community, or the home of the participant. Developmental therapy includes individual developmental therapy and group developmental therapy. Developmental therapy must be delivered by Developmental Specialists or paraprofessionals qualified ~~in accordance with~~ under these rules, based on an assessment completed prior to the delivery of developmental therapy. ~~(3-17-22)~~(9-1-23)T

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. ~~(3-17-22)~~(9-1-23)T

b. ~~Age-Appropriate.~~ Developmental therapy includes instruction in daily living skills the participant has not gained at the normal developmental stages in their life~~,~~ or is not likely to develop without training or therapy. Developmental therapy must be age-appropriate. ~~(3-17-22)~~(9-1-23)T

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. ~~(3-17-22)~~(9-1-23)T

d. ~~Settings for Developmental Therapy.~~ Developmental Therapy may be provided in home and community-based settings as described in Section 312 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. ~~(3-17-22)~~(9-1-23)T

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. ~~(3-17-22)~~(9-1-23)T

02. Excluded Services. The following services are excluded for Medicaid payments: (3-17-22)

a. Vocational services; (3-17-22)

b. Educational services; and (3-17-22)

c. Recreational services. (3-17-22)

03. Limitations on Developmental Therapy. Developmental therapy may not exceed the limitations as ~~follows~~ specified below: ~~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.~~ ~~(3-17-22)~~(9-1-23)T

a. Developmental therapy must not exceed twenty-two (22) hours per week. (9-1-23)T

b. Developmental therapy provided in combination with supported employment services under these rules must not exceed forty (40) hours per week. (9-1-23)T

c. When a participant receives adult day health as provided in these rules, the combination of adult day health and developmental therapy must not exceed thirty (30) hours per week. (9-1-23)T

d. Only one (1) type of therapy will be reimbursed during a single period by the Medicaid program. Developmental therapy will not be reimbursed during periods when the participant is being transported to and from the agency. (9-1-23)T

(BREAK IN CONTINUITY OF SECTIONS)

655. DEVELOPMENTAL THERAPY: PROVIDER QUALIFICATIONS AND DUTIES.

01. Developmental Specialist for Adults. To be qualified as a Developmental Specialist for adults, a person must have a minimum of two hundred forty (240) hours of professionally supervised experience with individuals who have developmental disabilities and either: (3-17-22)

a. Possess a bachelor's or master's degree in special education, early childhood special education, speech and language pathology, applied behavioral analysis, psychology, physical therapy, occupational therapy, social work, or therapeutic recreation; or (3-17-22)

b. Possess a bachelor's or master's degree in an area not listed ~~above~~ in Subsection 65~~7~~5.0~~5~~1.a. of this rule and have: ~~(3-17-22)~~(9-1-23)T

i. Completed a competency course jointly approved by the Department and the Idaho Association of Developmental Disabilities Agencies that relates to the job requirements of a Developmental Specialist; and (3-17-22)

ii. Passed a competency examination approved by the Department. (3-17-22)

c. Any person employed as a Developmental Specialist in Idaho prior to May 30, 1997, unless previously disallowed by the Department, will be allowed to continue providing services as a Developmental Specialist as long as there is not a gap of more than three (3) years of employment as a Developmental Specialist. (3-17-22)

~~**d.** Through the duration of the COVID-19 public health emergency, Development Specialists for~~

~~adults may begin rendering services prior to completing the training requirements provided that they complete the training requirements within thirty (30) days of first rendering services, advise the participant or legal guardian that the individual has not yet completed the applicable trainings, and comply with any other requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx.~~ ~~(3-17-22)~~

02. Developmental Therapy Paraprofessionals. Paraprofessionals, such as aides or therapy technicians, may be used by an agency to provide developmental therapy if they are under the supervision of a Developmental Specialist. A developmental therapy paraprofessional must be at least seventeen (17) years ~~of age~~ old. ~~(3-17-22)~~(9-1-23)T

03. Requirements for Collaboration with Other Providers. When participants are receiving rehabilitative or habilitative services from other providers, each DDA must coordinate each participant's DDA program with these providers to maximize skill acquisition and generalization of skills across environments, and to avoid duplication of services. The DDA must maintain documentation of this collaboration~~. This documentation~~ that includes other plans of services such as the Individual Education Plan (IEP), Personal Care Services (PCS) plan, Residential Habilitation plan, and the outpatient behavioral health service plan. The participant's file must also reflect how these plans have been integrated into the DDA's plan of service for each participant. ~~(3-17-22)~~(9-1-23)T

(BREAK IN CONTINUITY OF SECTIONS)

~~**658. COVID-19 PUBLIC HEALTH EMERGENCY RESIDENTIAL HABILITATION.**~~
~~Through the duration of the COVID-19 public health emergency, the Department will pay for residential habilitation services, as described in Subsection 703.01 of these rules, provided by facilities that have entered into a provider agreement with the Department and are certified as developmental disabilities agencies by the Department. Prior to receiving residential habilitation services from a DDA, 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. DDA's providing residential habilitation services must comply with any additional requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx.~~ ~~(3-17-22)~~

65~~9~~8. -- 699. (RESERVED)

ADULTS WITH DEVELOPMENTAL DISABILITIES WAIVER SERVICES
(Sections 700-719)

700. ADULTS WITH D~~EVELOPMENTAL D~~ISABILITIES WAIVER SERVICES.
Under 42 CFR Section 440.180, it is the intention of the Department to provide waiver services to eligible adult participants to prevent unnecessary institutional placement, provide for the greatest degree of independence possible, enhance the quality of life, encourage individual choice, and achieve and maintain community integration. For an adult participant to be eligible, the Department must find that the participant requires services due to a developmental disability that impairs their 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/IID. ~~Through the duration of the COVID-19 public health emergency, the Department reserves the right to temporarily alter requirements and processes related to the Adult DD waiver program to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS approved 1135 waiver or HCBS Attachment K amendment to the existing Adult Developmental Disability waiver. In the event additional changes are required in the future, guidance will be posted on the Medicaid Information Releases webpage.~~
~~(3-17-22)~~(9-1-23)T

701. (RESERVED)

702. ADULT DD WAIVER SERVICES: ELIGIBILITY.
Waiver eligibility will be determined by the Department as described in Section 509 of these rules. The participant

must be financially eligible for Medical Assistance ~~as described in~~ under IDAPA 16.03.05, "Eligibility for Aid for the Aged, Blind, and Disabled (AABD)," Section 787. The cited chapter implements ~~and is in accordance with~~ the Financial Eligibility Section of the Idaho State Plan. In addition, waiver participants must meet the following ~~requirements~~: ~~(3-17-22)~~(9-1-23)T

01. Age of Participants. DD waiver participants must be eighteen (18) years ~~of age~~ old or older. ~~(3-17-22)~~(9-1-23)T

02. Eligibility Determinations. The Department must determine that: (3-17-22)

a. The participant would qualify for ICF/IID level of care ~~as set forth in~~ under Section 584 of these rules, if the waiver services listed in Section 703 of these rules were not made available; and ~~(3-17-22)~~(9-1-23)T

b. The participant could be safely and effectively maintained in the requested or chosen community residence with appropriate waiver services. This determination must: (1) be made by a team of individuals with input from the person-centered planning team~~;~~, and (2) prior to any denial of services on this basis, be determined by the plan developer that services to correct the concerns of the team are not available. ~~(3-17-22)~~(9-1-23)T

c. The average annual cost of waiver services and other medical services to the participant would not exceed the average annual cost to Medicaid ~~of~~ for ICF/IID care and other medical costs. ~~(3-17-22)~~(9-1-23)T

03. H~~ome and C~~ommunity B~~ased S~~ervices Waiver ~~-~~Eligible Participants. A participant who is determined by the Department to be eligible for services under the H~~ome and C~~ommunity B~~ased S~~ervices ~~W~~waivers for DD may elect not to utilize waiver services but may choose admission to an ICF/IID. ~~(3-17-22)~~(9-1-23)T

04. Processing Applications. The participant's self-reliance staff will process the application ~~in accordance with~~ under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," as if the application was for admission to an ICF/IID, except that the self-reliance staff will forward potentially eligible applications immediately to the Department for review. The Medicaid application process cited above conforms to all statutory and regulatory requirements relating to the Medicaid application process. ~~(3-17-22)~~(9-1-23)T

05. Transmitted Decisions to Self-Reliance Staff. The decisions of the Department regarding the acceptance of the participants into the waiver program will be transmitted to the self-reliance staff. (3-17-22)

06. Case Redetermination. (3-17-22)

a. Financial redetermination will be conducted ~~pursuant to~~ under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." Medical redetermination will be made at least annually or sooner by the Department~~, or sooner~~ at the request of the participant, the self-reliance staff, provider agency, or physician. The ~~sections~~ chapters cited implement ~~and are in accordance with~~ Idaho's approved State Plan ~~with the exception of~~ except for deeming of income provisions. ~~(3-17-22)~~(9-1-23)T

b. The redetermination process will assess the following factors: (3-17-22)

i. The participant's continued need and eligibility for waiver services; and (3-17-22)

ii. Discharge from the waiver services program. (3-17-22)

07. Participant Eligibility Notifications. The Department will notify each participant of their eligibility decision as part of the initial eligibility determination, annual redetermination, or other reassessment process. The notification includes an individualized explanation of the decision and how the participant may appeal the eligibility decision. (9-1-23)T

07. H~~ome and C~~ommunity B~~ased~~S Waiver Participant Limitations. The number of Medicaid participants to receive waiver services under the ~~home and community based~~ HCBS waiver for ~~developmentally disabled~~ DD participants will be limited to the projected number of users contained in the Department's approved

waiver. Individuals who apply for waiver services after the waiver maximum has been reached will be placed on a waiting list and will have their applications processed after September 30th for the DD waiver of each new waiver year. ~~(3-17-22)~~(9-1-23)T

(BREAK IN CONTINUITY OF SECTIONS)

704. ADULT DD WAIVER SERVICES: PROCEDURAL REQUIREMENTS.

01. Authorization of Services on a Written Plan. All waiver services must be identified on the plan of service and authorized by the process ~~described in~~ under Sections 507 through 520 of these rules. The plan of service must be reviewed by a plan monitor or targeted service coordinator at a frequency determined by the person-centered planning team, but at least every ninety (90) days. ~~(3-17-22)~~(9-1-23)T

02. Provider Records. ~~Three (3) types of record~~ The following information will be maintained on all participants receiving waiver services: ~~(3-17-22)~~(9-1-23)T

a. Direct ~~S~~service ~~P~~provider ~~I~~information that includes written documentation of each visit made or service provided to the participant, and will record ~~at a minimum~~ the following information: ~~(3-17-22)~~(9-1-23)T

i. Date and time of visit; ~~and~~ ~~(3-17-22)~~(9-1-23)T

ii. Services provided during the visit; ~~and~~ ~~(3-17-22)~~(9-1-23)T

iii. A statement of the participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and (3-17-22)

iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the participant is determined by the Service Coordinator to be unable to do so, the delivery will be verified by the participant as evidenced by their signature on the service record. (3-17-22)

v. A copy of the above information will be maintained in the participant's home unless authorized to be kept elsewhere by the Department. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. (3-17-22)

b. The plan of service developed by the plan developer and the person-centered planning team must specify which services are required by the participant. The plan of service must contain all elements required by Subsection 704.01 of this rule and a copy of the most current plan of service must be maintained in the participant's home and must be available to all service providers and the Department. (3-17-22)

c. The provider implementation plan if required by these rules. (9-1-23)T

~~e~~**d.** In addition to the plan of service, all providers ~~, with the exception of chore, non-medical transportation, and enrolled Medicaid vendors,~~ that are required to develop an implementation plan must submit a provider status review six (6) months after the start date of the plan of service and annually to the plan monitor as described in Sections 507 through 520 of these rules. ~~(3-17-22)~~(9-1-23)T

03. Provider Responsibility for Notification. ~~It is the responsibility of t~~The service provider is responsible to notify the service coordinator or plan developer when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. ~~(3-17-22)~~(9-1-23)T

04. Records Maintenance. ~~In order t~~To provide continuity of services, when a participant changes service providers, plan developers, or service coordinators, all of the foregoing participant records will be delivered to and held by the Department until a replacement service provider, plan developer, or service coordinator is selected by the participant. When a participant leaves the waiver services program, the records will be retained by the

Department as part of the participant's closed case record. Provider agencies will be responsible to retain their participant's records for five (5) years following the date of service. ~~(3-17-22)~~(9-1-23)T

705. ADULT DD WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
All providers of waiver services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (3-17-22)

01. 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, "Residential Habilitation Agencies," and must 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: (3-17-22)

a. Direct service staff must meet the following ~~minimum qualifications~~: ~~(3-17-22)~~(9-1-23)T

i. Be at least eighteen (18) years ~~of age~~ old; ~~(3-17-22)~~(9-1-23)T

ii. Be a high school graduate, ~~or~~ have a GED, or demonstrate the ability to provide services according to a plan of service; ~~(3-17-22)~~(9-1-23)T

iii. Have current CPR and First Aid certifications; (3-17-22)

iv. Be free from communicable disease; (3-17-22)

v. If transporting participants, have a valid driver's license and vehicle insurance; (9-1-23)T

vi. Each staff person assisting with participant medications has ~~successfully completed~~ passed the "Assistance with Medications" course available through the Idaho ~~Professional~~ Division of Career-Technical Education ~~Program approved by the Idaho State Board of Nursing~~ or other Department-approved training. ~~(3-17-22)~~(9-1-23)T

vii. Residential habilitation service providers who provide direct care or services ~~satisfactorily~~ complete~~d~~ a ~~criminal~~ background check ~~in accordance with~~ and receive a clearance under Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~(9-1-23)T

viii. Have appropriate certification or licensure if required to perform tasks that require certification or licensure. (3-17-22)

b. All skill training for agency direct service staff must be provided by a Qualified Intellectual Disabilities Professional (QIDP) who has demonstrated experience in writing skill training programs. (3-17-22)

c. Prior to delivering services to a participant, agency direct service staff must complete an orientation program. ~~The orientation program must~~ that includes the following ~~subjects~~: ~~(3-17-22)~~(9-1-23)T

i. Purpose and philosophy of services; (3-17-22)

ii. Service rules; (3-17-22)

iii. Policies and procedures; (3-17-22)

iv. Proper conduct in relating to waiver participants; (3-17-22)

v. Handling of confidential and emergency situations that involve the waiver participant; (3-17-22)

vi. Participant rights; (3-17-22)

vii. Methods of supervising participants; (3-17-22)

viii. Working with individuals with developmental disabilities; and (3-17-22)

ix. Training specific to the needs of the participant. (3-17-22)

d. Additional training requirements must be completed within six (6) months of employment with the residential habilitation agency and include ~~at a minimum~~: ~~(3-17-22)~~(9-1-23)T

i. ~~Instructional techniques:~~ Methodologies for training in a systematic and effective manner; ~~(3-17-22)~~(9-1-23)T

ii. ~~Managing behaviors:~~ Techniques and strategies for teaching adaptive behaviors; ~~(3-17-22)~~(9-1-23)T

iii. Feeding; (3-17-22)

iv. Communication; (3-17-22)

v. Mobility; (3-17-22)

vi. Activities of daily living; (3-17-22)

vii. Body mechanics and lifting techniques; (3-17-22)

viii. Housekeeping techniques; and (3-17-22)

ix. Maintenance of a clean, safe, and healthy environment. (3-17-22)

e. The provider agency will be responsible for providing ongoing training specific to the needs of the participant as needed. (3-17-22)

~~**f.** Through the duration of the COVID-19 public health emergency, agency direct service staff may begin rendering services prior to completing the training requirements, provided that they complete the training requirements within thirty (30) days of first rendering services, advise the participant or legal guardian that the individual has not yet completed the applicable trainings, and comply with any other requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. (3-17-22)~~

02. Residential Habilitation -- ~~Certified Family Home (~~CFH~~)~~. ~~(3-17-22)~~(9-1-23)T

a. An individual who provides direct residential habilitation services in their own home must be certified ~~by the Department~~ to operate a ~~certified family home~~ CFH under IDAPA 16.03.19, "Certified Family Homes," and ~~must~~ receive residential habilitation program coordination services provided through the Department~~, or its contractor,~~ for the residential habilitation services they provide. ~~(3-17-22)~~(9-1-23)T

b. CFH providers providing residential habilitation services as a DD Waiver provider must meet the following ~~minimum qualifications~~: ~~(3-17-22)~~(9-1-23)T

i. Be at least eighteen (18) years ~~of age~~ old; ~~(3-17-22)~~(9-1-23)T

ii. Be a high school graduate, have a GED, or demonstrate the ability to provide services according to a plan of service; (3-17-22)

iii. Have current CPR and First Aid certifications; (3-17-22)

iv. Be free from communicable disease; (3-17-22)

v. If transporting participants, have a valid driver's license and vehicle insurance; (9-1-23)T

vi. Each CFH provider of residential habilitation services assisting with participant medications has ~~successfully completed 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~~ met the requirements of IDAPA 16.03.19, "Certified Family Homes. ~~(3-17-22)~~(9-1-23)T

vii. CFH providers of residential habilitation services who provide direct care and services ~~have satisfactorily~~ must complete~~d~~ a ~~criminal history~~ background check ~~in accordance with~~ and receive a clearance under Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks;" and ~~(3-17-22)~~(9-1-23)T

viii. Have appropriate certification or licensure if required to perform tasks that require certification or licensure. (3-17-22)

c. All skill training for CFH providers who are providing residential habilitation services must be provided through the Department ~~or its contractor~~ by qualified intellectual disabilities professional (QIDP) who has demonstrated experience in writing skill training programs. ~~(3-17-22)~~(9-1-23)T

d. Prior to delivering residential habilitation services to a participant, the CFH provider must complete an orientation training in the following areas as provided by ~~either~~ the Department~~, or its contractor or both, and include the following areas~~: ~~(3-17-22)~~(9-1-23)T

i. Purpose and philosophy of services; (3-17-22)

ii. Service rules; (3-17-22)

iii. Policies and procedures; (3-17-22)

iv. Proper conduct in relating to waiver participants; (3-17-22)

v. Handling of confidential and emergency situation that involve the waiver participant; (3-17-22)

vi. Participant rights; (3-17-22)

vii. Methods of supervising participants; (3-17-22)

viii. Working with individuals with developmental disabilities; and (3-17-22)

ix. Training specific to the needs of the participant. (3-17-22)

e. Additional training requirements for CFH providers providing residential habilitation waiver services must be completed by the CFH provider within six (6) months of certification date and include ~~a minimum of~~ the following: ~~(3-17-22)~~(9-1-23)T

i. ~~Instructional Techniques:~~ Methodologies for training in a systematic and effective manner; ~~(3-17-22)~~(9-1-23)T

ii. ~~Managing behaviors: t~~Techniques and strategies for teaching adaptive behaviors; ~~(3-17-22)~~(9-1-23)T

iii. Feeding; (3-17-22)

iv. Communication; (3-17-22)

v. Mobility; (3-17-22)

vi. Activities of daily living; (3-17-22)

vii. Body mechanics and lifting techniques; (3-17-22)

viii. Housekeeping techniques; and (3-17-22)

ix. Maintenance of a clean, safe, and healthy environment. (3-17-22)

f. The Department ~~or its contractor~~ will be responsible for providing on-going training to the CFH provider of residential habilitation specific to the needs of the participant as needed. ~~(3-17-22)~~(9-1-23)T

~~**g.** Through the duration of the COVID-19 public health emergency, CFH providers may begin rendering services prior to completing the training requirements, provided that they complete the training requirements within thirty (30) days of first rendering services, advise the participant or legal guardian that the individual has not yet completed the applicable trainings, and comply with any other requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. (3-17-22)~~

03. Chore Services~~.~~ Providers. ~~of chore services m~~Must meet the following ~~minimum qualifications~~: ~~(3-17-22)~~(9-1-23)T

a. Be skilled in the type of service to be provided; and (3-17-22)

b. Demonstrate the ability to provide services according to a plan of service. (3-17-22)

c. Chore service providers who provide direct care and services ~~have satisfactorily~~ must complete~~d~~ a ~~criminal history and~~ background check ~~in accordance with~~ and receive a clearance under Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~(9-1-23)T

04. Respite Care~~.~~ Providers. ~~of respite care services m~~Must meet the following ~~minimum qualifications~~: ~~(3-17-22)~~(9-1-23)T

a. Have received care giving instructions in the needs of the person who will ~~be provided~~ receive the service; ~~(3-17-22)~~(9-1-23)T

b. Demonstrate the ability to provide services according to a plan of service; (3-17-22)

c. Be free of communicable disease; and (3-17-22)

d. Respite care service providers who provide direct care and services ~~have satisfactorily~~ must complete~~d~~ a ~~criminal history and~~ background check ~~in accordance with~~ and receive a clearance under Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~(9-1-23)T

05. Supported Employment~~.~~ ~~Supported employment s~~**S**ervices. ~~m~~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 meets 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~~ and receive a clearance under Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~(9-1-23)T

06. Non-Medical Transportation~~.~~ Providers. ~~of non-medical transportation services m~~Must: ~~(3-17-22)~~(9-1-23)T

a. Possess a valid driver's license~~;~~ and vehicle insurance. ~~(3-17-22)~~(9-1-23)T

~~**b.** Possess valid vehicle insurance. (3-17-22)~~

b. Complete a background check and receive a clearance under Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." (9-1-23)T

07. Environmental Accessibility Adaptations. All services must be provided ~~in accordance with~~ under applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. ~~(3-17-22)~~(9-1-23)T

08. Specialized Medical Equipment and Supplies~~.~~ Providers. ~~of specialized medical equipment and supplies m~~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. ~~(3-17-22)~~(9-1-23)T

09. Personal Emergency Response System~~.~~ ~~Personal emergency response system p~~**Providers**. ~~m~~Must demonstrate that the devices installed in a waiver participant's home meet Federal Communications Standards, or Underwriter's Laboratory standards, or equivalent standards. ~~(3-17-22)~~(9-1-23)T

10. Home~~-~~ Delivered Meal~~s.~~ Providers. ~~of home-delivered meals m~~Must be a public agency or private business~~,~~ and ~~must~~ exercise supervision to ensure that: ~~(3-17-22)~~(9-1-23)T

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; (3-17-22)

b. Meals are delivered ~~in accordance with~~ under the service plan, in a sanitary manner, and at the correct temperature for the specific type of food; ~~(3-17-22)~~(9-1-23)T

c. A Registered Dietitian documents the review and approval of menus, menu cycles, and any changes or substitutions; and (3-17-22)

d. The agency or business is inspected and licensed as a food establishment under IDAPA 16.02.19, "Idaho Food Code." (3-17-22)

11. Skilled Nursing~~.~~ ~~Skilled nursing service p~~**Providers**. ~~m~~Must be licensed in Idaho as an ~~licensed registered nurse~~ RN or ~~licensed practical nurse~~ LPN 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~~ and receive a clearance under Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~(9-1-23)T

12. Behavior Consultation or Crisis Management~~.~~ ~~Behavior Consultation or Crisis Management~~ **Providers**. ~~m~~Must meet the following: ~~(3-17-22)~~(9-1-23)T

a. Work under the direct supervision of a licensed psychologist or Ph~~.~~D~~.~~ in Special Education~~,~~ with training and experience in treating severe behavior problems and ~~training and experience~~ in applied behavior analysis; and ~~(3-17-22)~~(9-1-23)T

b. Have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education, or a closely related course of study; or (3-17-22)

c. Be a licensed pharmacist; or (3-17-22)

d. Be a Qualified Intellectual Disabilities Professional (QIDP). (3-17-22)

e. Emergency back-up providers must meet the ~~minimum~~ residential habilitation provider qualifications ~~described~~ under IDAPA 16.04.17, "Residential Habilitation Agencies." ~~(3-17-22)~~(9-1-23)T

f. Behavior consultation or crisis management providers who provide direct care or services must ~~satisfactorily~~ complete a ~~criminal history and~~ background check ~~in accordance with~~ and receive a clearance under

Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~(9-1-23)T

13. Adult Day Health~~.~~ Providers~~.~~ ~~of adult day health m~~Must meet the following requirements: ~~(3-17-22)~~(9-1-23)T

a. Services provided in a facility must be provided in a facility that meets the building and health standards ~~identified in~~ under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)"; ~~(3-17-22)~~(9-1-23)T

b. Services provided in a home must be provided in a home that meets the standards ~~of home certification identified in~~ under IDAPA 16.03.19, "Certified Family Homes"; ~~(3-17-22)~~(9-1-23)T

c. Adult day health providers who provide direct care or services must ~~satisfactorily~~ complete a ~~criminal history~~ background check ~~in accordance with~~ and receive a clearance under Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks"; ~~(3-17-22)~~(9-1-23)T

d. ~~Providers of a~~Adult day health providers must notify the Department on behalf of the participant, if the adult day health is provided in a ~~certified family home~~ CFH 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. ~~(3-17-22)~~(9-1-23)T

e. Adult day health providers who provide direct care or services must be free from communicable disease. (3-17-22)

14. Service Supervision. The plan of service that includes all waiver services is monitored by the plan monitor or targeted service coordinator. (3-17-22)

15. Transition Services. Transition managers as described in Subsection 350.01 of these rules are responsible for administering transition services. ~~(3-17-22)~~(9-1-23)T

(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~~, and includes the following ~~activities described in Subsections 727.01 through 727.10 of this rule~~. ~~(3-17-22)~~(9-1-23)T

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: (3-17-22)

a. Taking a participant's history; (3-17-22)

b. Identifying the participant's needs and completing related documentation; and (3-17-22)

c. Gathering information from other sources such as family members, medical providers, social workers, and educators to form a complete assessment of the participant. (3-17-22)

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 ~~(or extended through the duration of the declared COVID-19 public health emergency)~~ and as needed to meet the needs of the participant. ~~(3-17-22)~~(9-1-23)T

03. Referral and Related Activities. Activities that help link the participant with service providers ~~that are capable of providing needed~~ able to provide services to address identified needs and achieve goals specified in the service coordination plan. ~~(3-17-22)~~(9-1-23)T

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 (1) face-to-face contact with the participant at least every ninety (90) days. (tThe face-to-face encounter may occur via synchronous interaction telehealth virtual, as defined in Title 54, Chapter 57, Idaho Code), to determine whether the following conditions are met: (3-17-22)(9-1-23)T

a. Services are being provided according to the participant's plan; (3-17-22)

b. Services in the plan are adequate; and (3-17-22)

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. (3-17-22)

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; it 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. (3-17-22)(9-1-23)T

a. Crisis Assistance for Children's Service Coordination. Crisis hours are not unavailable until four and a half (4.5) all available hours of service coordination have already been provided in the month. Crisis hours for children's service coordination must be authorized by the Department. (3-17-22)(9-1-23)T

b. Crisis Assistance for Adults With a Developmental Disability. Crisis hours are not unavailable until four and a half (4.5) all available 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 under Section 646 through 648 of these rules. (3-17-22)(9-1-23)T

c. Authorization for crisis assistance hours may be requested retroactively as a result because of a crisis, defined in under 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 complete a crisis resolution plan and submit a request for crisis services to the Department within seventy-two (72) hours five (5) business days of the last day of providing the service. (3-17-22)(9-1-23)T

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. (3-17-22)

07. Exclusions. Service coordination does not include activities that are: (3-17-22)

a. An integral component of another covered Medicaid service; (3-17-22)

b. Integral to the administration of foster care programs; (3-17-22)

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. (3-17-22)

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. (3-17-22)

09. Limitations on Service Coordination. Service coordination is limited to four and a half (4.5) hours per month, except when utilizing unused hours in the individual's current plan of service from previous months. (3-17-22)(9-1-23)T

10. Limitations on Service Coordination Plan Assessment and Plan Development. Reimbursement for the annual assessment and plan development cannot exceed ~~six~~ twelve (~~6~~12) hours per year. ~~(3-17-22)~~(9-1-23)T

728. SERVICE COORDINATION: PROCEDURAL REQUIREMENTS.

01. Prior Authorization for Service Coordination Services. Services must be prior authorized by the Department ~~according to the direction~~ as provided in the Medicaid Provider Handbook available at www.idmedicaid.com. ~~(3-17-22)~~(9-1-23)T

02. Service Coordination Plan Development. (3-17-22)

a. A written plan~~, described in~~ under Section 731 of these rules~~,~~ must be developed and implemented within sixty (60) days after the participant chooses a service coordinator. ~~(3-17-22)~~(9-1-23)T

b. The plan must be updated at least annually ~~(or extended through the duration of the declared COVID-19 public health emergency)~~ and amended as necessary. ~~(3-17-22)~~(9-1-23)T

c. The plan must address the service coordination needs of the participant as identified in the assessment ~~described in~~ under Section 730 of these rules. ~~(3-17-22)~~(9-1-23)T

d. The plan must be developed prior to ongoing service coordination being provided. (3-17-22)

03. Documentation of Service Coordination. Agencies must maintain records that contain documentation describing the services provided, review of the continued need for service coordination, and progress toward each service coordination goal. Documentation must be completed as ~~required~~ described in Section 56-209(h), Idaho Code. All active records must be immediately available. Documentation must include ~~all of~~ the following: ~~(3-17-22)~~(9-1-23)T

a. The name of the eligible participant. (3-17-22)

b. The name of the provider agency and the person providing the services. (3-17-22)

c. The date, time, duration, and place the service was provided. (3-17-22)

d. The nature, content, units of the service coordination received, and whether goals specified in the plan have been achieved. (3-17-22)

e. Whether the participant declined any services in the plan. (3-17-22)

f. The need for and occurrences of coordination with any non-Medicaid case managers. (3-17-22)

g. The timeline for obtaining needed services. (3-17-22)

h. The timeline for re-evaluation of the plan. (3-17-22)

i. A copy of the assessment or prior authorization from the Department that documents eligibility for service coordination services, and a dated and signed plan. (3-17-22)

j. Agency records must contain documentation describing details of the service provided, signed by the person who delivered the service. (3-17-22)

k. Documented review of participant's continued need for service coordination and progress toward each service coordination goal. A review must be completed at least every one hundred eighty (180) days after the plan development or update. Progress reviews must include the date of the review, and the signature of the service coordinator completing the review. (3-17-22)

l. Documentation of the participant's, family's, or legal guardian's satisfaction with service. (3-17-22)

m. A copy of the informed consent form signed by the participant, parent, or legal guardian that documents that the participant has been informed of the purposes of service coordination, their rights to refuse service coordination, and their right to choose their service coordinator and other service providers. (3-17-22)

n. A plan that is signed by the participant, parent, or legal guardian, and the service coordinator. The plan must reflect person-centered planning principles and document the participant's inclusion in the development of the plan. The service coordinator must also document that a copy of the plan was given to the participant or their legal representative. The plan must be updated and authorized when required, but at least annually. Children's service coordination plans cannot be effective before the date that the child's parent or legal guardian has signed the plan. (3-17-22)

04. Documentation Completed by a Paraprofessional. Each entry completed by a paraprofessional must be reviewed by the participant's service coordinator and include the date of review and the service coordinator's signature on the documentation. (3-17-22)

05. Participant Freedom of Choice. A participant must have freedom of choice when selecting from the service coordinators available to them. The service coordinator cannot restrict the participant's choice of other health care or HCBS providers. ~~(3-17-22)~~(9-1-23)T

06. Service Coordinator Contact and Availability. The frequency of contact, mode of contact, and person or entity to be contacted must be identified in the plan and ~~must~~ meet the needs of the participant. The contacts must verify the participant's well being and whether services are being provided according to the written plan. At least every ninety (90) days, service coordinators must have face-to-face contact with each participant. The face-to-face encounter may occur via synchronous interaction ~~telehealth~~ virtual care, as defined in Title 54, Chapter 57, Idaho Code. ~~(3-17-22)~~(9-1-23)T

a. When it is necessary for the children's service coordinator to conduct a face-to-face contact with a child participant without the parent or legal guardian present, the service coordinator must notify the parent or legal guardian prior to the face-to-face contact with the participant. Notification must be documented in the participant's file. (3-17-22)

b. Service coordinators do not have to be available on a twenty-four (24) hour basis, but must include an individualized objective on the plan describing what the participant, families, and providers should do in an emergency situation. The individualized objective must include how the service coordinator will coordinate needed services after an emergency situation. (3-17-22)

07. ~~Service Coordinator Responsibility Related to~~ Conflict of Interest. ~~Service coordinators have a primary responsibility to the participant whom they serve, to respect and promote the right of the participant to self-determination, and preserve the participant's freedom to choose services and providers. In order to assure that participant rights are being addressed, service coordinators must~~ Individuals and agency employees or contractors who develop a participant's plan of service under these rules cannot: ~~(3-17-22)~~(9-1-23)T

a. ~~Be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment.~~Be related by blood or marriage to the participant or to any paid caregiver or the participant; ~~(3-17-22)~~(9-1-23)T

b. ~~Inform the participant parent, or legal guardian when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the participant's interests primary and protects the participant's interests to the greatest extent possible.~~Be financially responsible for the participant; ~~(3-17-22)~~(9-1-23)T

c. Be empowered to make financial or health-related decisions on behalf of the participant; (9-1-23)T

d. Hold financial interests in any entity that is paid to provide care for the participant; or (9-1-23)T

c. Be a provider of the State Plan HCBS or waiver services for the participant or have an interest in or are employed by a provider of State Plan HCBS or waiver services. (9-1-23)T

08. Service Coordinator Responsibilities Related to Conflict of Interest. The service coordinator will: (9-1-23)T

a. Be alert to, and avoid, conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. (9-1-23)T

b. Inform the participant, parent, or legal guardian when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the participant's interests primary and protects their interests to the greatest extent possible. (9-1-23)T

089. Agency Responsibility~~y~~ies Related to Conflict of Interest. ~~To assure that participants are protected from restrictions to their self-determination rights because of conflict of interest, the agency must guard against conflict of interest, and inform all participants and guardians of the risk. Each agency must have a document in each participant's file that contains the following information:~~ The agency must guard against conflicts of interest and inform all participants and guardians of any risks. The agency must: ~~(3-17-22)~~(9-1-23)T

a. Ensure its employees and contractors meet the conflict of interest standards as defined in these rules; and (9-1-23)T

b. Have a document in each participant's file that contains: (9-1-23)T

~~a~~i. The definition of "conflict of interest" as defined in Section 721 of these rules; ~~(3-17-22)~~(9-1-23)T

~~b~~ii. A signed statement by the agency representative verifying that the concept of conflict of interest was reviewed and explained to the participant's parent~~,~~ or legal guardian; and ~~(3-17-22)~~(9-1-23)T

~~c~~iii. The participant's, parent's, or legal guardian's signature on the document. (3-17-22)

INCORPORATION BY REFERENCE SYNOPSIS

In compliance with Section 67-5223(4), Idaho Code, the following is a synopsis of the differences between the materials previously incorporated by reference in this rule that are currently in full force and effect and newly revised or amended versions of these same materials that are being proposed for incorporation by reference under this rulemaking.

The following agency of the State of Idaho has prepared this synopsis as part of the proposed rulemaking for the chapter cited here under the docket number specified:

DEPARTMENT OF HEALTH AND WELFARE
IDAPA 16.03.10 – "Medicaid Basic Plan Benefits"
Proposed Rulemaking -- Docket No. 16-0310-2101

Incorporated Document Version/URL	IDAPA Section Number	Current Version of Incorporated Document	Substantive Changes in New Incorporation by Reference Version
State Travel Policy and Procedures Updated January 17, 2023 https://www.sco.idaho.gov/LivePages/state-travel-policy-and-procedures.aspx	16.03.10. 004.06	**Travel Policies and Procedures of the Idaho State Board of Examiners –** includes Appendices A and B, version dated June 13, 2000.	Title changed to: **State Travel Policy and Procedures**
Document is the same – only the name has been revised. The name was unclear before and made determining the correct document confusing.			

State Travel Policy and Procedures

SBEX Policy No. 442-50
Adopted: July 1,1996
Last Amended: January 17, 2023

Authority Idaho Code Section 67-2004

Table of Contents

Statement of Philosophy

The State Board of Examiners, as established by the Constitution of the State of Idaho (Article IV, section 18), is authorized by Idaho Code Title 67, Chapter 20, to adopt policy and procedures for travel and related expenses claimed against the State.

This State Travel Policy, as adopted by the State Board of Examiners, was developed in accordance with Sections 67-1001, 67-2004, 67-2005, 67-2006, 67-2007, 67-2008 Idaho Code, and shall apply to every individual at all agencies, elected offices, boards, commissions, institutions, and any and all other forms of Idaho State Government or its agents who can incur travel and related expenses paid for from State government resources, unless specifically exempt by Idaho Code.

This State Travel Policy is intended to establish guidelines and limits that promote cost-effective and efficient methods for incurring travel and related expenses while performing official business of the State of Idaho. All travel costs and related expenses claimed to the State must be properly authorized, actually incurred, essential in achieving the goals or fulfilling the responsibilities of the State government entity, and conducted in the most economical and practical manner for the State.

When determining the most cost-effective and efficient method for conducting travel, the entity should also consider any additional actual costs of the traveler's compensation from wages or contract services fees, including the value of any accrued compensatory time by State employees.

These policies may not cover every possible situation, but the intention is that all travelers and approving authorities within each entity of Idaho State Government embrace the concepts of "cost-effective" and "efficient methods" when deciding the nature, type, timing, and necessity of travel and related expenses while performing official business of the State of Idaho.

It remains the responsibility of each entity's management to develop, document, and implement appropriate internal control procedures over travel and related expenses that assure compliance with these policies, and to develop and retain sufficient and appropriate documentation and evidence to show that compliance to these policies was maintained.

No entity may authorize the payment of claims for travel and related expenses that are not specifically allowed or exceed the rates established by these policies, or institute internal controls or documentation requirements that are more liberal than those provided in these policies. Entities may authorize internal policies and internal controls that are more restrictive than those provided in these policies if the entity's management determine that such more restrictive policies are in the best interest of the entity to carry out its authorized mission. Each entity's management shall make certain that all individuals who travel for official purposes which results in claims against the State are aware of this State Travel Policy and any internal entity policies if applicable.

Policy

1. Approval and Authorization

A. Designation of Authority

All payments of claims for travel and related expenses must be authorized by the Idaho State Government entity's senior management or by a duly authorized and designated representative(s). Written evidence of the delegated authority must be on file at the entity, dated, and signed by the senior management and designated representative(s).

B. Requirements and Methods for Approval

The method for granting and documenting this authorization is left to the discretion of the Idaho State Government entity's senior management.

C. Eligibility

A traveler is eligible for travel cost reimbursement only when they are on official travel.

2. Payment Methods, Forms, and Documentation

A. Payment Methods

To the extent practical, all costs for travel shall be incurred originally with State funds or through the use of a State P-card or other methods to minimize the need for the traveler to incur costs prior to being reimbursed.

B. Travel Expense Voucher Form

It is the duty of the State Controller, as authorized by Idaho Code 67-2005, to prescribe forms of vouchers on which all requests for expenditure of State moneys must be submitted, and when such forms of vouchers have been prescribed, no request for expenditure of State moneys shall be received and filed by the State Controller unless the same shall be presented on the proper form.

Idaho Code 67-2006 further requires that on all vouchers submitted for travel expenses, there must appear a certificate signed by the head of the entity, or their designee, for which travel was performed, stating that the travel was performed under competent orders, the purpose for which it was undertaken, and that the same was necessary in the public service. The person submitting a voucher for travel expenses must sign thereon a certificate that the account is correct and just.

C. Documentation

All travel and related costs must be documented and itemized on a travel expense voucher and identify the following elements:

1) Identification of the traveler's official primary work station
2) Specific reason for travel which demonstrates a direct relationship to the State Government entity'smission
3) Sequential and logical order of dates of travel, including departure and arrivaltimes
4) Mode of travel identified and consistent with the itinerary, locations, purpose andcost
5) License plate number of State-owned vehicle
6) Costs incurred for each day of travel, including, mileage, meals, and lodging
7) Explanations for any gaps in the days or locations of travel or when the final destination is not the traveler's official primary work station.
8) Explanations or other evidence for omitted costs or those costs shared with othertravelers
9) Signatures of the traveler and designated approver with the requiredcertifications

D. Evidence of Expenditure

Specific evidence, such as an invoice or receipt, is required for the following travel costs and must be attached to the travel voucher or specifically identified if paid through direct bill, P-card, third party, or other traveler:

1) Lodging expense
2) Airfare
3) Airline baggage fee
4) Taxi, airport shuttle, or other public transportation
5) Rental vehicle
6) Fuel purchase for rental vehicle
7) Parking fees at airport, lodging facility, or work related location
8) Conference registration fee and agenda
9) Telephone, internet access, or other communication fees
10) Laundry and dry cleaning costs
11) All other expenses not specifically described but are reasonable and necessary in the conduct of official State business.

Evidence of expenditure must contain the date of transaction, vendor name and location, description and individual cost of each item or service that is claimed. The traveler is expected to clearly document this information if the original invoice or receipt does not contain all required information. If an original

invoice or receipt is not provided by the vendor or is lost, the traveler must provide an explanation and document the required information to the extent possible.

E. Evidence Not Required

Specific evidence is not required for the following:

1) Meals and related costs covered under Section 6 - "Per Diem Allowance."
2) Tips, gratuity, and other items covered under Section 7 - "Incidental Expenses."

F. Internal Audit of Travel Voucher

Each entity shall develop and follow procedures for auditing all claims for travel and related expenses for compliance with the standards and limits established by these policies or those more restrictive standards and limits adopted by the entity's internal policies and procedures. At a minimum, these auditing procedures should include verification of the following items:

1) The specific purpose of the travel is documented on the voucher.
2) Travel duration does not exceed the trip requirements, and the beginning and ending hours and dates are shown for each location or component of the trip.
3) Mileage claimed for using a personal vehicle is properly calculated and supported, and any vicinity mileage is reasonable and based on the purpose and location of the workassignment.
4) Meals claimed do not exceed the allowance established by these policies and any meals provided at conferences or other official activities as shown on an official agenda or schedule are properly excluded from the amounts claimed.
5) Daily lodging costs are supported by a detailed invoice and any allowable costs other than the daily rate plus taxes are detailed separately in the "Miscellaneous Expenses" section of the voucher. Any costs on the lodging invoice for meals, beverages, entertainment, or items of a personal nature must be excluded from the costs claimed for reimbursement.
6) The purpose and nature of each item in the "Miscellaneous Expenses" section is clearly identified and supported.
7) The details of all P-card transactions and any cash advances related to the trip are listedin the "P-Card or Cash Advance" section of the voucher.
8) All sub-totals and the grand total are mathematically correct.
9) Documentation of all costs incurred and claimed are attached or properly referenced on the voucher.
10) Any additional expensesresulting when travel deviates from the authorized purpose are not claimed or are properly approved and documented by the approving authority.

The entity shall maintain all records of travel expense vouchers and supporting documentation for a period of three (3) years or until the next audit is completed.

G. Costs Paid Through Direct Billing, P-Card, Third Party, or OtherTraveler

All costs of official State travel must be specifically identified on the travel expense voucher even if the amount was paid through direct billing, P-Card, third party, or other traveler. A full and complete accounting of the costs incurred and paid by other methods, and any funds advanced to the traveler, is necessary to identify the net amount owed to or due from the traveler. The travel expense voucher must be completed, even if the net amount due to or owed by the traveler is zero, in order to satisfy the certification requirements of Idaho Code 67-2006 by the traveler and approving authority.

H. Documentation When Travel Deviates From Authorized Purposes

A traveler may be authorized to extend the duration of a trip or deviate from the most direct and cost effective route and mode of travel for personal or other non-official business purposes. In these situations, the traveler must document the actual costs incurred with a detailed comparison to the amounts that would have been incurred had the trip included only the authorized and required duration, destinations, and followed the most direct and cost effective route and mode of travel.

If the deviation from the authorized purpose of the travel involves airfare, the cost without the deviation must be documented within a reasonable time frame of the date the actual airfare reservation was made, preferably the same day. In no event will the total allowed costs exceed the actual costs incurred.

3. Mode and Route of Travel

A. Mode of Travel

Travelers shall use the most cost-effective and efficient mode of travel. Exceptions to this requirement may be allowed due to unusual or unforeseen circumstances that are properly documented and authorized by the approving authority. Supporting documentation must be attached to the travel expense voucher.

When for personal reasons the mode of travel used is not the most cost-effective and efficient mode available and such a deviation is specifically authorized by the approving authority, only those costs which would have been incurred using the most cost-effective and efficient mode available will be allowed. Any costs associated with excess travel time resulting from the use of other modes of travel for personal

reasons shall not be allowed. If the traveler is a State employee, the excess time shall be charged to accrued leave balances or other leave types.

B. Route of Travel

Travelers must use the most direct and/or efficient route of travel that considers actual costs and travel time. Additional factors can be considered when selecting the route of travel, such as weather conditions or other issues which could increase travel time or hazards to the traveler.

C. Private Vehicle Mileage Reimbursement

Mileage for using a private vehicle for official State business shall be computed according to MapQuest, Yahoo or Google Maps, or other source which supports the distance as the most direct and/or efficient route. Mileage will be reimbursed at the rate established by the State Board of Examiners. Odometer readings are permissible only when mileage computations cannot be readily or easily determined from these independent sources. Under no circumstance is the purchase of gasoline dispensed into a private vehicle an allowable expense in-lieu of mileage reimbursement for using a private vehicle for official State business.

COMMUTING: Expenses are not allowed for travel between home and office or for other non-official purposes, except for expenses incurred by a state employee to participate in an approved agency commuting plan. Commuting plans must be submitted by a state agency in writing and approved by the Office of the Governor.

Mileage from the official primary work station to the airport is reimbursable. Mileage from the traveler's home to the airport is not reimbursable unless it is a shorter distance.

If a State-owned vehicle is available to the traveler but for personal reasons a private vehicle is used, the mileage reimbursement shall be limited to one-half the established rate, unless the full rate is authorized by the approving authority with documentation supporting the reason for authorizing the full rate.

D. Vicinity Mileage

Mileage incurred for official State business within the traveler's official primary work station area or other locations are allowable and may be consolidated on a daily basis and reported as "vicinity travel" on the travel expense voucher and reimbursed at the allowed rate.

E. Vehicle Parking Fees

Fees for vehicle parking are an allowable expense based on the proximity to the temporary work location and are usual and customary, such as parking meters or garages, airports, or hotels that include parking fees in their published fee schedules.

F. State Vehicle Usage

The use of a State vehicle for personal or other non-official business is strictly prohibited. Commuting from the traveler's primary work location and declared residence using a State vehicle is permissible only when the official travel purpose begins or ends outside the traveler's usual daily work schedule, such as before 7am or after 6pm, or for other reasons considered in the best interest of the State that are specifically documented and authorized by the approving authority.

State vehicles shall not be operated by or used to transport individuals who are not directly involved in the official State travel purpose unless prior approval has been granted by the approving authority. State vehicles shall be operated only by individuals who possess a valid operator's license.

The names and an explanation of the responsibilities of administrative personnel determined by the Idaho State Government entity's senior management to require the permanent assignment of a state vehicle shall be furnished to the Board of Examiners for approval.

G. Rental Vehicle

A rental vehicle may be authorized by the approving authority when such use is determined and documented to be the most effective and cost efficient means of transportation for performing official business. The size and style of the rental vehicle shall be consistent with the travel needs. The selection of a rental vehicle vendor shall consider the overall cost, location, convenience, vehicle type, and the availability of vendors enrolled in statewide contracts. Additional insurance should not be purchased when using a vendor enrolled in statewide contracts. The coverage is included in the contract.

H. State-owned or Private Aircraft

The use of State-owned or private aircraft may be appropriate when it is more cost-effective or efficient

than other modes of transportation. The specific issues considered that support the decision must be documented, including the travel itinerary, scheduling challenges, accessibility, number of travelers, and overall costs as compared to other modes of travel. When using a private aircraft, evidence of public liability and property damage insurance must be on-hand pursuant to Idaho Code.

I. Traffic Violations
Any infractions of traffic laws and resulting fines are the sole responsibility of the traveler and are not a reimbursable expense by the State. Traffic and parking tickets are an infraction of state or local traffic laws and are not reimbursable regardless of whether you are in a personal or state vehicle.

J. Taxi and Other Public Transit
Taxi services, airport shuttles, or other public transit while traveling for official State business are allowable expenses. Evidence must be submitted that identifies the itinerary of each use whichcoincides with the official travel requirements.

K. Commercial Airfare and Related Costs
The cost for commercial airfare shall be limited to the lowest available class of passage rate, such as "coach" or similar classification. Airfare at other classes and seat selection or other upgrade fees are not allowed unless properly documented that the seat selection, upgrade fees, or class of passage at a higher rate was necessary due to availability, physical limitations or other factors, and that the ticket was purchased at the earliest opportunity. Baggage fees charged by commercial airlines are allowable not to exceed one checked bag and one carry-on bag per departure unless additional baggage costs are necessary and approved in advance. Any additional costs, such as in-flight services, internet access or entertainment, are not allowable and are the responsibility of the traveler,unless a valid business purpose is identified and approved in advance by the designatedauthority.

4. Travel Status

A. Duration
The duration of official travel shall not exceed the maximum time necessary to conduct State business for the stated purpose of the travel. It is appropriate for the traveler to leave their official primary work station or declared residence in sufficient time to arrive at an airport or other point of public transit by the recommended pre-departure time. Actual time while in official travel status for any and all reasons must be documented on the voucher.

B. Personal Leave While in Official Travel Status
A traveler who has been granted leave while on official travel status shall identify on the travel voucher the exact dates and times of departure and return to official State business. If official travel includes personal travel components, allowable travel costs shall not exceed the amounts that would have been incurred had the traveler not combined personal travel with business travel. Combining personal travel with official State travel is not justification for using a private vehicle and receiving full mileage reimbursement when a State-owned vehicle is available. Use of the State
P-Card for personal portions of a business trip is prohibited.

C. Changes to Official Travel Status for Unusual Circumstances
Any changes to the duration of official travel resulting from unusual circumstances, such as severe weather, road conditions, airline delays, illness, or other situations beyond the traveler's control, must be fully documented and approved by the approving authority to support the increase or decrease of allowable costs and time resulting from the unusual circumstance.

5. Lodging

A. Selection Process
The process for selecting a lodging vendor for each official travel day shall consider the proximity to the required work location, room type, and daily rate. Other amenities or premiums offered by lodging vendors can be considered in the selection process, such as on-site restaurants, internet access availability, free breakfasts and beverages, or other services, but the proximity and daily rate should be the primary consideration. At the time a reservation is made or when registering on-site, travelers should request the "government rate" if available.

Lodging provided by relatives or other individuals is not an allowable expense unless they are in the business of providing such services which are publicly advertised and a formal invoice is provided.

No claim will be paid for lodging if the traveler is not in official travel status.

6. Per Diem Allowance

A. Daily Per Diem Allowance Rates

A daily Per diem allowance shall be paid to the traveler in accordance with the amounts and hours of the day as established by the State Board of Examiners pursuant to Appendix B. The Per diem allowance is a fixed amount for a full day of official travel status and is not a reimbursement for actual costs incurred. No receipt or other evidence of expenditure is required. The Per diem allowance is intended to cover the cost of food, beverages, and related gratuities and no portion of these costs shall be reimbursed as separate items. The Per diem allowance shall be based on the rate at the temporary work location, and on the final day of travel the allowance shall be the rate for the location where the traveler last stayed the night prior to returning to their official primary work station.

B. Timeframes for Partial Day Per Diem Allowance

The amount of the Per diem allowance for official State travel that does not involve an overnight stay, or for the first and last day of a multiple day trip, shall be calculated based on the percentages of the daily Per diem allowance as established by the State Board of Examiners.

1) 25% for breakfast (leave at 7:00am or earlier/return at 8:00am or later)
2) 35% for lunch (leave at 11:00am or earlier/return at 2:00pm or later)
3) 55% for dinner (leave at 5:00pm or earlier/return at 7:00pm orlater)

Each entity of State government may adopt an internal policy regarding the time frames for allowing partial day Per diem allowance in order to consider the effects of swing shifts and other flexible work schedules that are usual and customary to the entity.

C. Meals Provided by Others and at Conferences

When meals are furnished by others or as part of a meeting or conference and are identified on an official agenda, the Per diem allowance for the day shall be calculated for only those meals not provided. The allowable amount shall use the following percentages applied to the allowable Per diem allowance for each meal not provided by others or as part of a meeting or conference:

1) 25% for breakfast
2) 35% for lunch
3) 55% for dinner

Complimentary meals or beverages provided by lodging vendors, commercial airlines, or other commercial entities will not be considered when determining Per diem allowances.

7. Incidental Expenses

A. Communications While in Travel Status

1) Telephone - The cost of personal telephone calls to others within the U.S. while on official travel status is allowable. Travelers are allowed to incur the cost of one phone call for each full or partial day of official travel through commercial telephone service or calling card not to exceed ten (10) minutes per call.
2) Internet Access - The cost to gain access to the internet at the temporary work location or lodging vendor for official State business is allowable. The cost to access the internet aboard airplanes, or other locations may be allowable, provided that a justification is attached to the travel voucher that such access at the time and location is essential in the performance of official State business and is not predominately for personal convenience orentertainment.

B. Tips and Gratuity

Tips and gratuity are included in the Per diem allowance amount and cannot be claimed separately, even if the gratuity is unrelated to a meal expense. This includes all amounts related to taxi or airport shuttle services, baggage handling, hotel services, or for which gratuities are usual and customary for the services provided.

C. Laundry and Dry Cleaning Services

The costs for laundry and dry cleaning services are allowable if the duration of the official travel exceeds five (5) calendar days.

D. Entertainment

The costs for entertainment, such as in-room movies, video games, pay-per-view television programs or similar items, are not allowable.

E. Other

Expenses not specifically described in these policies but which are necessary in the performance of official State business and properly authorized and documented, are allowable.

8. Travel Premiums

A. Travel Premiums

Travel premiums and benefits, such as frequent flyer miles or hotel points, awarded as a result of official State travel are the property of the traveler and will not be claimed by the State.

9. Third Party Funded Travel

A. Reimbursements

Each entity is charged with the responsibility of identifying any travel costs paid for or reimbursed by outside sources to ensure that all travel is justified by the entity's mission. When a third party has directly paid or reimbursed the cost of any part of the travel costs, the name and billing address of the third party must be identified and attached to the travel voucher. Any reimbursement must be paid directly to the entity or endorsed over to the entity by the traveler.

Each entity is charged with the responsibility of identifying all employee travel for business purposes to ensure that all travel is justified by the entity's mission. When a third party has reimbursed the cost of any part of previously paid State travel costs the name and billing address of the third party must be identified and attached to the travel voucher. Any reimbursement must be paid directly to the entity or endorsed over to the entity by the traveler. Any third party reimbursement that exceeds allowable costs of these policies should be returned to the third party or retained by the State government entity if the third party does not provide for partial refunds. Under no circumstance shall the traveler retain any excess over allowable costs.

B. Direct Pay

Each entity is charged with the responsibility of identifying all employee travel for business purposes to ensure that all travel is justified by the entity's mission. If the business travel is covered 100% by the third party and the State has no financial liability for the travel costs, is not providing a travel advance, not providing travel reimbursement, and a state P-card is not used for the travel; then an approved travel authorization will serve as documentation for the travel and a travel expense voucher is not required.

Any employee's travel for business purposes that is covered in whole or part by a Third Party is required to adhere to all State Laws covering ethics in government, including the Bribery and Corrupt Influence Act, the Prohibition Against Contracts with Officers Act, and the Ethics in Government Act. (For further information, employees are encouraged to read and understand the Idaho Ethics in Government Manual, produced by the Idaho Office of the Attorney General.)

10. Other Items

A. Meals and Refreshments at Entity-Sponsored Meetings

The State Board of Examiners recognizes the importance of sponsoring meetings and training sessions for specific purposes, and that refreshments and meals may be provided to ensure the best utilization of attendee time under the following criteria:

1) Refreshments:

a) The meeting has a published agenda where attendance is mandatory.

b) The meeting has an intended duration of three (3) hours or more as shown on the agenda.

c) There are five (5) or more attendees.

d) The total cost per attendee PER DAY cannot exceed the partial day Per diem allowance for breakfast as established by the Board.

2) Meals:

a) The meeting has a published agenda and attendance is mandatory, for an identified business purpose.

b) The meeting has an intended duration of six (6) hours or more as shown on the agenda.

c) There are five (5) or more attendees.

d) The meeting's purpose is furthered by presentations or interpersonal exchange during the meal period.

e) The total cost per attendee cannot exceed the partial day Per diem allowance for the period of the meal as established by the Board.

f) Location or scheduling conflicts are not sufficient grounds for a meal recess.

Routine employee, staff meetings, department-sponsored social gatherings or similar gatherings shall not qualify for refreshment or meal costs.

B. Foreign Travel, Currency Exchange, and Other Costs

The State of Idaho foreign travel policy, pursuant to Idaho Code §67-2008A, shall be as follows:

The foreign travel per diem allowance (FTPDA) is a payment in lieu of reimbursement for actual expenses. The FTPDA is intended to cover the costs of meals at adequate, suitable and moderately priced facilities including costs of mandatory service charges, taxes, laundry and dry cleaning. The FTPDA will be based on the most current publication of U.S. Department of State Maximum Travel Per Diem Allowances for Foreign Areas. The daily FTPDA will be 100% of the listed M & IE rate in the above publication. The actual cost of lodging plus applicable tax and service charge will be allowed to the traveler.

C. Travelers with Disabilities

With prior approval of the State government entity's approving authority, travelers with disabilities are allowed payments of certain additional travel expenses to accommodate their disabilities, such as but not limited to subsistence and transportation of an attendant when the employee requires assistance, cost of specialized transportation, increased cost of specialized services for public carriers, or special baggage handling fees.

For travelers with disabilities, reasonable accommodations regarding specific situations not addressed by these policies are allowable if properly documented and authorized by the approving authority.

D. Use of Statewide Open Contracts Relating to Travel Services

Approving authorities shall inform all travelers about the availability of statewide open contracts relating to travel services, as issued by the Department of Administration, Division of Purchasing, and that these vendors should be considered to the extent possible.

E. Commuting Expenses

Expenses for commuting between the traveler's declared residence and official primary work station are not allowable, except for expenses incurred by a State employee to participate in an approved agency commuting plan submitted by a State agency in writing and approved by the Office of the Governor.

F: Compensatory Time for Travel

Compensatory time for travel will be granted in accordance with Fair Labor Standards Act (FLSA) Regulations 29 C.F.R. Section 785.38, 785.39, 785.40, 785.41, to all employees except those listed as "non-covered" under the FLSA, elected officials, those included in the definition of section 67-5303(j) and 67-5302(12) Idaho Code, bona fide volunteers, independent contractors, prisoners, and "trainees".

11. Definitions

Daily Per Diem

The daily per diem is the amount given to a traveler to cover expenses such as meals, meal gratuities, and fees and tips give to porters, baggage carriers, bellhops, hotel maids, stewards or stewardess on ships, and hotel servants in foreign countries.

Employee

An employee is a person, other than a patient, inmate or student employed in a state institution, who receives a payroll warrant or direct deposit from the State Controller as payment of wages for services rendered to, and on behalf of, a department or agency legally recognized as an entity of Idaho State government or local health district.

Official Primary Work Station

The official primary work station is the location where the employee regularly performs his or her duties. If the employee's work involves recurring travel or varies on a recurring basis, an area defined by the agency that includes the location where the employee regularly performs his or her duties is considered the official primary work station.

Official Travel

Travel performed the purpose for which it was undertaken was necessary in the public service.

Official Travel Status

Official travel status is when the traveler is physically away from their official primary work station by a distance of 50 miles or more or includes an overnight stay.

Traveler
A traveler is any person traveling on behalf of the State of Idaho for the purpose of official State business.

Vicinity Travel
Travel for official purposes in and about a city, including travel within a traveler's official primary work station, when not constituting a trip between two communities is considered vicinity travel.

12. Idaho Code References Relating to State Travel

A. Regulation of Per Diem: 67-2004

The state board of examiners is hereby authorized to adopt regulations fixing the daily, half-day and quarter-day allowances to be made to state officials and employees traveling on official business, within the lawful maximum daily subsistence allowance rate, and to require, by such regulations, such proofs in support of travel subsistence claims as may be deemed by it conducive to public economy.

B. Voucher Forms: 67-2005

It is the duty of the state controller to prescribe forms of vouchers on which all requests for expenditure of state moneys must be submitted, and when such forms of vouchers have been prescribed no request for expenditure of state moneys shall be received and filed by the state controller unless the same shall be presented on the proper form.

C. Travel Expense Vouchers: 67-2006

On all vouchers submitted for travel expenses, there must appear a certificate signed by the head of the department for which the travel was performed, stating that the travel was performed under competent orders, the purpose for which it was undertaken, and that the same was necessary in the public service. The person submitting a voucher for travel expenses must sign thereon a certificate that the account is correct and just.

D. Standard Travel Pay and Allowances: 67-2007

This act may be cited as the "Standard Travel Pay and Allowance Act of 1949." It is the express intention of this act that the provisions hereof shall supersede and control the language of any statute heretofore enacted relating to the allowance of requests for reimbursement for travel and/or subsistence, including, but without limitation, statutes which provide for the payment of actual and necessary expenses to any officer, agent, employee, clerk, board, or commission of the state; and it is further intended that the provisions of this act, and regulations issued hereunder, shall apply to and govern all acts authorizing the payment for travel and/or subsistence which may be enacted hereafter unless the same shall be expressly exempted from the terms of this act. Such acts shall be construed as being subject to the provisions of this act unless an express exemption shall be set forth in such subsequent act.

E. Determination of rate of allowance: 67-2008

(1) At its first meeting after the effective date of this act, and thereafter as it shall deem appropriate, the board of examiners shall by regulation fix a rate of allowance for per diem subsistence for officers, agents and all other employees of the state who are absent from their post of duty on official business, which shall be effective for the year in which such allowance is fixed, and shall fix a rate of allowance for mileage for official travel executed by privately owned means of conveyance, which rate of allowance shall be effective for the year in which it is fixed; provided, however, that the board shall fix no rate of per diem allowance which is higher than:

(a) Actual lodgings (maximum to be set by board of examiners) and per diem allowance which is no higher than allowed under the Internal Revenue Code for travel within the state;and
(b) Actual lodgings (maximum to be set by board of examiners) and per diem allowance which is no higher than allowed under the Internal Revenue Code without the state; and
(c) A rate of mileage allowance which is no higher than the standard mileage rate for the business use of an automobile allowed under the Internal Revenue Code for income tax purposes; and
(d) The mileage allowance for private aircraft travel shall be set by the board and shall be no higher than that allowed for automobile travel, calculated as if the travel had been by highway route.

(2) In fixing rates of allowance under this act, the board shall consider the prevailing cost of executing such travel, generally prevailing economic conditions, and the rates of allowance made applicable to similar travel by the Federal Government and private employers within the state.

(3) For a period where employees are to be absent from their post on official business for less than twenty-four (24) hours the board's regulations shall provide for partial days' subsistencerates.

F: Rates of Allowance Foreign Travel

The board of examiners shall determine reasonable rates of allowance for per diem subsistence for officers, agents and employees of the state who are absent from their post of duty on official business in a foreign country. In determining such rates of allowance, the limitations of section 67-2008, Idaho Code, shall not apply. The board shall determine rates of allowance which are reasonable based upon factors such as the prevailing cost of executing such travel, generally prevailing economic conditions, and the rates of allowance made applicable to similar travel by the federal government and private employers within the state.

Appendix A: History of Rate Changes

History of Rate Changes:			
Effective Date	Private Vehicle	MEALS In-State	MEALS Out-State
7-1-74	15 cents car		
7-1-75		$10.00	$14.00
7-1-78	15 cents car 17 cents air	$12.00	$15.00
7-1-79			$17.00
8-15-79	17 cents car		
5-1-80	18 cents car	$15.00	$20.00
7-1-84	22 cents car		
1-1-85	20.5 cents car		
12-13-88	22 cents pvt vehicle/aircraft		
7-1-90	26 cents car	$20.00	$30.00
7-1-96	31 cents pvt vehicle/aircraft	$20.00	$30.00
2-13-00	32.5 cents pvt vehicle/aircraft	$20.00	$30.00
1-2-01	34.5 cents pvt vehicle/aircraft	$20.00	$30.00
7-1-01	34.5 cents pvt vehicle/aircraft	$30.00	$30.00 or Federal Rate
1-1-02	36.5 cents pvt vehicle/aircraft	$30.00	$30.00 or Federal Rate
1-1-03	36.0 cents pvt vehicle/aircraft	$30.00	$30.00 or Federal Rate
1-1-04	37.5 cents private vehicle/aircraft	$30.00	$31.00 or Federal Rate
4-12-05	40.5 cents private vehicle/aircraft	$30.00	$31.00 or Federal Rate
9-1-05	48.5 cents private vehicle/aircraft	$30.00	$31.00 or Federal Rate
1-1-06	44.5 cents private vehicle/aircraft	$30.00	$39.00 or Federal Rate

1-1-07	48.5 cents private vehicle/aircraft	$30.00	$39.00 or Federal Rate
1-1-08	50.5 cents private vehicle/aircraft	$30.00	$39.00 or Federal Rate
7-1-08	58.5 cents private vehicle/aircraft	$30.00	$39.00 or Federal Rate
1-1-09	45.5 cents private vehicle/aircraft	$30.00	$39.00 or Federal Rate
10-1-09 (Approved on 12-15-09)	45.5 cents private vehicle/aircraft	$30.00	$46.00 or Federal Rate
7-1-12	55.5 cents private vehicle/aircraft	$30.00	$46.00 or Federal Rate
10-1-15	55.5 cents private vehicle/aircraft	$45.00	$51.00 or Federal Rate
1-1-16	54 cents private vehicle/aircraft	$45.00	$51.00 or Federal Rate
1-1-17	53.5 cents private vehicle/aircraft	$45.00	$51.00 or Federal Rate
10-1-18	53.5 cents private vehicle/aircraft	$45.00	$55.00 or Federal Rate
2-19-19	58 cents private vehicle/aircraft	$49.00	$55.00 or Federal Rate
1-1-20	57.5 cents private vehicle/aircraft	$49.00	$55.00 of Federal Rate
1-1-21	56 cents private vehicle/aircraft	$49.00	$55.00 of Federal Rate
1-1-22	56 cents private vehicle/aircraft	$55.00	$59.00 of Federal Rate
1-18-22	58.5 cents private vehicle/aircraft	$55.00	$59.00 of Federal Rate
7-19-22	62.5 cents private vehicle/aircraft	$55.00	$59.00 of Federal Rate
1-17-23	65.5 cents private vehicle/aircraft	$55.00	$59.00 of Federal Rate

Change to Mileage Rate

(a) If the Federal Mileage rate is set below the current State of Idaho mileage rate, then the State of Idaho mileage rate will automatically decrease to match the Federal rate.
(b) If the Federal Mileage rate is set above the current State of Idaho mileage rate, then the Board of Examiners will review the change at their next meeting to see whether a change is merited.
(c) If the State of Idaho updates the State mileage rate, the Secretary to the Board of Examiners will send notification to all agencies.

Appendix B: Examples

Maximum Per Diem Allowance

Daily Per Diem Allowance (see definition of "per diem" in Section 11)
(a) In State $55.00 day

(b) Out-of-State Per Diem Allowance $59.00 per day is the base, but would allow the higher federal rate

Partial Day Per Diem Allowance
Where employees are to be absent from their primary official station on official business for less than twenty four (24) hours, partial day per diem allowance is equal to a maximum of twenty-five percent (25%) of the total per diem allowance for breakfast, thirty-five percent (35%) for the total per diem allowance for lunch, and fifty-five percent (55%) of the total per diem allowance for dinner.

Partial Day Per Diem Allowance		
	In-State	Out-of-State
Breakfast – 25%	$13.75	$14.75 or 25% of Federal Rate

Lunch – 35%	$19.25	$20.65 or 35% of Federal Rate
Dinner – 55%	$30.25	$32.45 or 55% of Federal Rate

Official Conferences or Conventions
For meals not included in the registration, the above limits upon partial day per diem reimbursements do not apply to official conferences or conventions as described in Section 6. C. herein whether at the official station or not. As to such conferences or conventions, only the statutory daily limits of I.C. §67-2008 will apply.

Agenciesmay adopt maximums of lesser amounts than those established by the Board of Examiners.

Appendix C: Examples

Per Diem examples

A. Employee attends a conference at their home station and lunch is provided as part of the conference registration fee (registration fee was paid by the employer). The meal is allowable and no reimbursement for the meal cost is due back to the employer from the employee. Providing the conference meets the definition listed in Section 6. C. of the Board of Examiners Travel Policy. (Please note on this example the employee is not in travel status since the conference is at their home station, and is not eligible for per diem allowance.)

B. Employee is in travel status and the hotel they are staying at offers a continental breakfast. Employee does not have to deduct the partial day per diem amount for the continental breakfast (see Section 6. C. of the Board of Examiners Travel Policy). The employee can voluntarily choose to deduct the partial day per diem amount for the continental breakfast, if they utilized that service, but it is not required.

C. Employee is in travel status and attends a conference out of town and lunch is provided as part of the conference registration fee (registration fee was paid by the employer) then the employee can only be reimbursed the per diem amounts for any meals not provided (see Section 6. C. of the Board of Examiners Travel Policy).

D. Employee is in travel status and attends an agency sponsored meeting or training and lunch is provided, then the employee can only be reimbursed for any meals not provided (see Section 6. C. of the Board of Examiners Travel Policy).