

Dear Senators MARTIN, Souza, Jordan, and
Representatives WOOD, Wagoner, 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 - Proposed Rule (Docket No. 16-0310-2002);

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits - Proposed Rule (Docket No. 16-0310-2003).

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 12/03/2020. If a meeting is called, the subcommittee must hold the meeting within forty-two (42) days of receipt of the rules' analysis from Legislative Services. The final date to hold a meeting on the enclosed rules is 12/31/2020.

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.



Eric Milstead
Director

Legislative Services Office

Idaho State Legislature

Serving Idaho's Citizen Legislature

MEMORANDUM

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

FROM: Principal Legislative Drafting Attorney - Elizabeth Bowen

DATE: November 16, 2020

SUBJECT: Department of Health and Welfare

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits - Proposed Rule (Docket No. 16-0310-2002)

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits - Proposed Rule (Docket No. 16-0310-2003)

Summary and Stated Reasons for the Rule

Docket No. 16-0310-2002: This proposed rule implements an electronic visit verification (EVV) system to verify that in-home Medicaid services have been received by participants, as required by federal law.

Docket No. 16-0310-2003: This temporary rule increases the census requirement in behavioral care units from 20% to 30% for new providers in order to align with requirements in HB 351 (2020).

Negotiated Rulemaking / Fiscal Impact

Docket No. 16-0310-2002: Negotiated rulemaking was conducted. The anticipated negative fiscal impact on the state general fund is \$545,700, as approved in SB 1418 (2020).

Docket No. 16-0310-2003: N/a

Statutory Authority

This rulemaking appears to be consistent with the Department's statutory authority.

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. 16-0310-2002

NOTICE OF RULEMAKING – PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 56-202(b) and the 21st Century Cures Act – Public Law 114–255, Section 12006.

PUBLIC HEARING SCHEDULES: Public hearings concerning this rulemaking will be held as follows. ONE (1) is for Electronic Visit Verification – Personal Care Services and TWO (2) is for Behavioral Care Units:

PUBLIC HEARINGS

**For Electronic Visit Verification (EVV) --
Wednesday, October 14, 2020, 3:00 p.m. - 5:00 p.m. MDT**

WebEx INFORMATION

WebEx Phone:

+1-415-655-0003 US Toll

+1-720-650-7664 United States Toll

Meeting Number (Access Code): 133 127 0087

Meeting password: medicaidhearing (63342243 from phones and video systems)

WebEx Link:

<https://idhw.webex.com/idhw/j.php?MTID=m552a7147cb81abe347c3ac20a559c64c>

**For Behavioral Care Units --
Friday, October 16, 2020, 1:00 p.m. - 2:00 p.m. MDT**

WebEx INFORMATION

WebEx Phone:

+1-415-655-0003 US Toll

+1-720-650-7664 United States Toll

Meeting Number (Access Code): 133 091 2789

Meeting password: 9wpq64v5xm9 (99776485 from phones and video systems)

WebEx Link:

<https://idhw.webex.com/idhw/j.php?MTID=mcdf4fd75ab5d64ae832315a5595029ac>

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

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

ELECTRONIC VISIT VERIFICATION (EVV) - PERSONAL CARE SERVICES (PCS) and Aged and Disabled (A&D) Waiver Services -- All Sections EXCEPT for 267 and 268 -- This rulemaking is being done by the Department to secure state authority allowing implementation of an Electronic Visit Verification (EVV) system to comply with Section 12006 of the 21st Century Cures Act (Public Law 114–255) while helping minimize provider administrative burden. The Cures Act mandates states to implement an Electronic Visit Verification (EVV) system for all Personal Care Services (PCS) and Aged and Disabled (A&D) Waiver Services that require an in-home visit by a provider.

EVV Implementation aims to protect participants by verifying services are received using an electronic verification method (phone, GPS, etc.), and also aims to reduce instances of fraud, waste, and abuse by providers who bill for these services. Medicaid is in the process of implementing an Open Model structure for providers, allowing providers freedom to choose the EVV provider that best fits with each agency's budget and needs as long as it is certified as compatible with the Data Aggregator DXC Technology (Medicaid's existing Medicaid Management Information System vendor) will launch to process EVV claims. DXC will also include provider training and certification to help the implementation process. Rulemaking will be as minimal as possible, to ensure CMS compliance with the Act, while procedural guidance will be provided via Idaho Provider Handbook and DXC training materials.

The Department is also simplifying existing procedural requirements in rule related to Home Health services that correspond to EVV implementation.

BEHAVIORAL CARE UNITS (BCU) -- ONLY Sections 267 and 268 -- The Department, providers, and the Idaho Health Care Association have agreed to increase the current Behavioral Care Unit (BCU) census requirement from 20% to 30% for new BCU providers. This increase will help the Department maintain support for BCU providers consistent with state needs and aligns this chapter with HB351 (2020) requirements for nursing facilities. The changes contained in this rulemaking are the first stage of those required to comply with the aforementioned legislation. These changes were requested by stakeholders to be put into rule as soon as possible. Other changes are planned for 2021 to complete the alignment of this chapter with the requirements of this new statute.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: N/A for EVV-PCS and BCU.

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

EVV - PCS and A&D -- S1418 (2020) approved costs that include a one-time system implementation expense of \$545,700 from the SGF for SFY2020. This cost is shared with expenses shown with the companion docket for 16.03.09 Medicaid Basic Plan Benefits for EVV Home Health services. To minimize fiscal impact to SGF, the Department chose to pursue the minimum system implementation by amending the contract with our current MMIS contractor (DXC Technologies) to add an MMIS Aggregator for EVV and provide training and validation for providers that must comply with EVV requirements. Providers are allowed the choice of the EVV Solution that meets their agency's budget and process needs, if it is verified as compatible by the MMIS subcontractor in charge of the EVV work. A rate increase was approved, and this was for PCS and related A&D Waiver Services totaling \$1,589,000 of the combined budget allocation. These rate increases went into effect on July 1, 2020. Ongoing support and maintenance related to EVV systems include a monthly fee, that is incorporated in the annually approved MMIS Contract and is not expected to add to an additional line item for the future.

BCU -- Budgets for nursing facilities will remain the same. There is no anticipated fiscal impact to state or general funds as a result of this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because negotiated rulemaking was not feasible. However, for both **EVV - PCS** and **BCU** - extensive informal negotiated rulemaking was conducted with stakeholders in 2019 and 2020.

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: N/A

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the proposed rule, for **EVV - PCS** contact Jennifer Pinkerton (208) 287-1171; for **BCU** contact Angela Toomey at (208) 364-1817.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2020.

Dated this 14th day of August, 2020.

Tamara Prisock
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5564
Fax: (208) 334-6558
dhwrules@dhw.idaho.gov

THE FOLLOWING IS THE PROPOSED TEXT FOR DOCKET NO. 16-0310-2002
(Only Those Sections With Amendments Are Shown.)

041. SPECIALIZED REIMBURSEMENT: ELECTRONIC VISIT VERIFICATION (EVV).

01. Services Subject to EVV Requirement. Effective July 1, 2021, providers of the following services are required to submit claims using a compliant EVV system as mandated by Section 12006 of the 21st Century Cures Act for services provided in a participant’s residence: ()

a. Private Duty Nursing Services as described in Sections 200 through 210 of these rules: ()

b. Personal Care Services (PCS) as described in Sections 300 through 309 of these rules: ()

c. The following Aged and Disabled Waiver Services as described in Sections 320 through 329 of these rules: ()

i. Attendant Care: ()

ii. Homemaker; and ()

iii. Respite. ()

02. EVV Definitions. ()

a. Aggregator. System that collects provider EVV information from multiple software platforms and standardizes the information in MMIS for EVV data validation. ()

b. Claims Adjudication. The process of determining Medicaid financial responsibility for claims submitted to MMIS. ()

c. Electronic Visit Verification (EVV). EVV is software or device(s) that electronically captures information verifying services delivered in a participant’s home. ()

03. Claims Subject to EVV Requirements. To submit eligible claims for services with EVV requirements, providers must: ()

a. Maintain an EVV system chosen by their agency and certified as compliant with the MMIS aggregator, as determined by the Department and/or the MMIS Contractor; ()

- b.** Document and retain participant consent for use of location and identity verification methods; ()
- c.** Develop and maintain policies and procedures outlining agency implementation and use of EVV technology, including strategies for safeguarding of participant information and privacy; and ()
- d.** Submit EVV data that captures these six (6) system-validated data elements for services delivered in the Participant's home: ()
- i.** Date of service; ()
 - ii.** Time the service begins and ends; ()
 - iii.** Individual providing the service; ()
 - iv.** Participant receiving the service; ()
 - v.** Type of service performed; and ()
 - vi.** Location of service delivery. ()
- e.** Provider claims for services requiring EVV will include the corresponding EVV data elements listed above. Provider EVV data will be submitted to the state's aggregator prior to billing claims. These claims are subject to a quality review in accordance with Subsection 210.10 of IDAPA 16.03.09, "Medicaid Basic Plan Benefits." ()

0412. -- 049. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

202. PRIVATE DUTY NURSING: ELIGIBILITY.

To be eligible for *Private Duty Nursing* (PDN), the nursing needs must be of such a nature that the Idaho Nursing Practice Act, Rules, Regulations, or policy require the service to be provided by an Idaho Licensed Registered Nurse (RN), or by an Idaho Licensed Practical Nurse (LPN), and require more individual and continuous care than is available from Home Health nursing services. PDN service will be authorized by the Department prior to delivery of service. (3-19-07)()

203. PRIVATE DUTY NURSING: FACTORS ASSESSED FOR ELIGIBILITY AND REDETERMINATION.

Factors assessed for eligibility/redetermination include: (3-19-07)

- 01. Age for Eligibility.** The individual is under the age of twenty-one (21) years. (3-19-07)
- 02. Maintained in Personal Residence.** That the child is *being* maintained in their personal residence and receives safe and effective services through PDN services. (3-19-07)()
- 03. Medical Justification.** The child receiving PDN services has medical justification and physician's orders. (3-19-07)
- 04. Written Plan of Care.** That there is an updated written plan of care signed by the attending physician, the parent or legal guardian, PDN, RN supervisor, and a representative from the Department. (3-19-07)
- 05. Attending Physician.** That the attending physician has determined the number of PDN hours needed to ensure the health and safety of the child in their home. (3-19-07)

06. Redetermination. Redetermination will be at least annually. The purpose of an annual redetermination for PDN is to: (3-19-07)

a. Determine if the child continues to meet the PDN criteria in Subsection 203.01 through 203.05 of these rules; and (3-19-07)

b. Assure that services and care are medically necessary and appropriate. (3-19-07)

204. PRIVATE DUTY NURSING: COVERAGE AND LIMITATIONS.

PDN services are functions that cannot be delegated to an Unlicensed Assistive Personnel (UAP) as defined by Idaho Code and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (3-19-07)

01. Ordered by a Physician. PDN Services must be ordered by a physician and include: (3-19-07)

a. A medical status that is so complex or unstable, as determined by the attending physician, that licensed or professional nursing assessment is needed to determine the need for changes in medications or other interventions; or (3-19-07)

b. An assessment by a licensed registered nurse of a child's health status for unstable chronic conditions that includes an evaluation of the child's responses to interventions or medications. (3-19-07)

02. Plan of Care. PDN Services ~~must include~~ require a Plan of Care that: ~~(3-20-20)~~()

a. Is developed by a multi-disciplinary team to include, at a minimum, the parent or legal guardian, the primary PDN, RN, or RN Supervisor, and a representative from the Department; (3-19-07)

b. Includes all aspects of the medical, licensed, and personal care services medically necessary to be performed, including the amount, type, and frequency of such service; (3-19-07)

c. Is approved and signed by the attending physician, parent or legal guardian, and primary PDN, RN, or RN supervisor, and a representative from the Department; and (3-19-07)

d. Is revised and updated as child's needs change or upon significant change of condition, but at least annually, and is submitted to the Department for review and prior authorization of service. (3-19-07)

03. Status Updates. Status updates must be completed every ninety (90) days from the start of services. The Status Update is intended to document any change in the child's health status. Annual plan reviews will replace the fourth quarter Status Update. The Status Update must be signed by both the parent or legal guardian and the primary RN supervisor completing the form. (3-19-07)

04. Limitations. PDN Services may be provided only in the child's personal residence or when normal life activities take the child outside of this setting. However, if service is requested only to attend school or other activities outside of the home, but does not need such services in the home, private duty nursing will not be authorized. The following are specifically excluded as personal residences: (3-19-07)

a. Licensed Nursing Facilities (NF); (3-19-07)

b. Licensed Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID); (3-19-07)

c. Residential Assisted Living Facilities; (3-20-20)

d. Licensed hospitals; and (3-19-07)

e. Public or private school. (3-19-07)

205. – 208. (RESERVED)

209. PRIVATE DUTY NURSING: PROVIDER QUALIFICATIONS AND DUTIES.

01. Primary RN Responsibility For PDN Redetermination. Primary RN responsibility for PDN redetermination is to submit a current plan of care to the Department at least annually or as the child's needs change. Failure to submit an updated plan of care to the Department prior to the end date of the most recent authorization will cause payments to cease until completed information is received and evaluated and authorization given for further PDN services. The plan of care must include all requested material outlined in Subsection 204.02 of these rules.

(3-19-07)

02. Physician Responsibilities. Physician responsibilities include:

(3-19-07)

a. Medical Information. Provide the Department the necessary medical information in order to establish the child's medical eligibility for services based on an EPSDT screen.

(3-19-07)

b. Order Services. Order all services to be delivered by the private duty nurse.

(3-19-07)

c. Sign Medical Plan of Care. Review, sign, and date child's Medical Plan of Care and orders at least annually or as condition changes.

(3-19-07)

d. Community Resources. Determine if the combination of PDN Services along with other community resources are sufficient to ensure the health or safety of the child. If it is determined that the resources are not sufficient to ensure the health and safety of the child, notify the family and the Department and facilitate the admission of the child to the appropriate medical facility.

(3-19-07)

03. Private Duty Nurse Responsibilities. RN supervisor or an RN providing PDN services responsibilities include:

(3-19-07)

a. Notify the physician immediately of any significant changes in the child's medical condition or response to the service delivery;

(3-19-07)

b. Notify the Department within forty-eight (48) hours or on the first business day following a weekend or holiday of any significant changes in the child's condition or if the child is hospitalized at any time;

(3-19-07)

c. Evaluate changes of condition;

(3-19-07)

d. Provide services in accordance with the nursing care plan; and

(3-19-07)

e. Must ensure copies of records are maintained in the child's home including:

(3-20-20)

i. The date;

(3-19-07)

ii. Time of start and end of service delivery each day;

(3-19-07)

iii. Comments on child's response to services delivered;

(3-19-07)

iv. Nursing assessment of child's status and any changes in that status per each working shift;

(3-19-07)

v. Services provided during each working shift; and

(3-19-07)

vi. The Medical Plan of Care signed by the physician, primary RN, the parent or legal guardian and a representative from the Department.

(3-19-07)

04. LPN Providers. ~~In the case of~~ LPN providers, document that oversight of services by an RN is in accordance with the Idaho Nursing Practice Act and IDAPA 23.01.01, "Rules of the Board of Nursing." RN

Supervisor visits must occur at least once every thirty (30) days when services are provided by an LPN.

(3-19-07)()

05. Ensure Health and Safety of Children. PDN providers must notify the physician if the combination of ~~Private Duty Nursing~~ PDN Services along with other community resources are not sufficient to ensure the health or safety of the child.

(3-19-07)()

210. PRIVATE DUTY NURSING SERVICES: PROVIDER REIMBURSEMENT.

Provider claims for PDN Services require EVV compliance as described in Section 041 of these rules in order to be eligible for payment.

()

~~210~~1. - 214. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

267. NURSING FACILITY: TREATMENT OF NEWLY LICENSED FACILITIES WITH BEHAVIORAL CARE UNITS.

01. Criteria to Qualify as a New BCU On or After September 1, 2017. Facilities licensed on or after September 1, 2017, must meet the qualifications for a BCU described in Subsections 266.02, 266.03, and 266.05 through 266.15 of these rules. BCU facilities existing prior to this date that receive a new license due to a change in ownership will not be subject to the provisions of this rule.

(3-28-18)

02. Reimbursement for Years One (1) Through Three (3). Beginning with the first day of the first month following approval of the BCU license and when the provider can demonstrate that BCU days from a minimum of sixty (60) calendar days, regardless of payer source, divided by total census days for that same sixty-day (60) period, equals or exceeds a minimum of ~~twenty~~ thirty percent (~~20~~30%), the provider's rate will change to reflect BCU services. The provider will be reimbursed at the median rate for BCU facilities of that type, either freestanding or hospital-based, for the remaining period within the first three (3) full years of operation. If there are no facilities of the same type (for example, no other hospital-based BCUs), the provider will receive the median rate for their type, but the direct cost portion of the rate will be revised to the median rate of existing BCUs. The rate change to reflect BCU services will not be retroactive to rate quarters paid prior to meeting the ~~twenty~~ thirty percent (~~20~~30%) BCU occupancy requirement.

(3-28-18)()

a. A nursing facility must apply for BCU eligibility on an annual basis in accordance with Subsection 266.07 of these rules. If the provider did not meet the BCU qualifications described in Section 266 of these rules, with the exception of Subsections 266.01 and 266.04, for a full cost report year corresponding to the initial application year, the twenty percent (20%) BCU day requirement will apply only to days beginning with the first day of BCU eligibility to the end of the year.

(3-28-18)

b. During the period of limitation, the facility's rate will be modified annually on July 1st to reflect the current median rate for skilled care facilities of that type. After the first three (3) complete years of operations, the facility will have its rate established at the next July 1st with the existing facilities in accordance with Subsections 266.03 and 266.05 of these rules.

(3-28-18)

c. During the period of limitation, providers must demonstrate annually that BCU days were equal to or exceeded twenty percent (20%), as described in Subsection 267.02 of this rule. Providers must provide a report to the Department with a calculation of BCU days for each month during the period being reviewed. If the twelve-month (12) average falls below twenty percent (20%), then the BCU reimbursement will revert back to the median rate per Section 260 of these rules. Once the Department has established the provider has met the requirements of Subsection 267.01 of this rule they will be eligible for a new rate outlined in Subsection 267.02.b. of this rule.

(3-28-18)

268. NURSING FACILITY: EXISTING PROVIDER ELECTS TO ADD BEHAVIORAL CARE UNIT (BCU).

An existing nursing facility provider that elects to add a BCU on or after September 1, 2017, may be deemed eligible after meeting the following requirements: (3-28-18)

01. Meet Criteria for BCU. The nursing facility provider must meet the criteria for a BCU described in Section 266 of these rules. (4-4-13)

02. BCU Eligible Days. The provider must demonstrate that BCU days from a minimum of sixty (60) calendar days, regardless of payer source, divided by total census days for that same sixty (60) day period, equals or exceeds a minimum of ~~twenty~~ thirty percent (~~20~~30%). (~~3-28-18~~)()

03. BCU Payments. Once the provider has met the requirements of Subsections 268.01 and 268.02 of this rule, beginning with the first day of the first quarter following approval of the BCU license, the provider's rate will change to reflect BCU services. At no time will the rate be adjusted mid-quarter. The rate will be calculated as follows. (3-28-18)

a. The indirect costs, costs exempt from limitations, and property cost will be reimbursed in the same manner as all other nursing facilities in accordance with reimbursement provisions contained in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (3-28-18)

b. The direct cost portion of the rate will be reimbursed as a prospective rate not subject to a change from an interim rate to a final rate. The direct cost portion of the rate will be calculated by determining the median direct cost portion for BCU facilities of that type (freestanding or hospital-based) effective on July 1 of the rate year. If there are no facilities of the same type (for example no other hospital-based BCUs), the direct cost portion of the rate will be set at the median rate of existing BCUs. The direct cost portion of the rate will be updated on July 1 of each rate year until the provider has a qualifying twelve-month (12) cost report, as described in Subsection 268.03.d. of this rule. (3-28-18)

c. The provider's total calculated rate will be subject to customary charge limitations and any other rate reductions implemented for other providers. (3-28-18)

d. Once the provider has a twelve-month (12) cost report that contains a full year of BCU costs, their rate will be calculated in the same manner as other providers in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (3-28-18)

e. A nursing facility must apply for BCU eligibility on an annual basis in accordance with Section 266 of these rules. If the provider was not a BCU for a full cost report year, the twenty percent (20%) BCU day requirement will apply only to days beginning with the first day of BCU eligibility to the end of the year. (3-28-18)

(BREAK IN CONTINUITY OF SECTIONS)

301. PERSONAL CARE SERVICES: DEFINITIONS.

01. Children's PCS Assessment. A set of standardized criteria adopted by the Department to assess functional and cognitive abilities of children to determine eligibility for children's ~~personal care services~~ PCS. (~~3-29-10~~)()

02. Natural Supports. Personal associations and relationships that enhance the quality and security of life for people, such as family, friends, neighbors, volunteers, church, or others. (3-29-10)

03. Personal Care Services (PCS). A range of medically-oriented care services related to a participant's physical or functional requirements. These services are provided in the participant's home or personal residence, but do not include housekeeping or skilled nursing care. (3-29-10)

04. PCS Family Alternate Care Home. The private home of an individual licensed by the Department to provide ~~personal care services~~ PCS to one (1) or two (2) children, who are unable to reside in their own home and

require assistance with medically-oriented tasks related to the child's physical or functional needs. ~~(3-29-10)~~()

(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 IDAPA 16.03.22, "Residential Assisted Living Facilities." The requirements for the NSA for participants in Certified Family Homes 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. (3-19-07)

a. The plan of care for participants who live in their own homes or in a PCS Family Alternate Care Home is based on: (3-29-10)

- i.** The physician's or authorized provider's information if applicable; (4-2-08)
- ii.** The results of the UAI for adults, the children's PCS assessment and, if applicable, the QIDP's assessment and observations of the participant; and (3-29-10)
- iii.** Information obtained from the participant. (3-19-07)

b. The plan of care must include all aspects of medical and non-medical care that the provider needs to perform, including the amount, type and frequency of necessary services. (3-19-07)

c. The plan of care must be revised and updated based upon treatment results or a change(s) in the participant's needs, or both, but at least annually. (3-19-07)

d. The plan of care or NSA must meet the person-centered planning requirements described in Sections 316 and 317 of these rules. (7-1-16)

02. Service Supervision. The delivery of PCS may be overseen by a licensed registered nurse (RN) or Qualified Intellectual Disabilities Professional (QIDP). The BLTC will identify the need for supervision. (3-20-20)

a. Oversight must include all of the following: (3-19-07)

- i.** Assistance in the development of the written plan of care; (3-19-07)
- ii.** Review of the treatment given by the personal assistant through a review of the participant's PCS record as maintained by the provider; (3-19-07)
- iii.** Reevaluation of the plan of care as necessary; and (3-19-07)
- iv.** Immediate notification of the guardian, emergency contact, or family members of any significant changes in the participant's physical condition or response to the services delivered. (3-19-07)

b. All participants who are developmentally disabled, other than those with only a physical disability as determined by the BLTC, may receive oversight by a QIDP as defined in 42 CFR 483.430. Oversight must include: (3-20-20)

- 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; (3-19-07)
- ii.** Review of the care or training programs given by the personal assistant through a review of the

participant's PCS record as maintained by the provider and through on-site interviews with the participant; (3-19-07)

iii. Reevaluation of the plan of care as necessary, but at least annually; and (3-19-07)

iv. An on-site visit to the participant to evaluate any change of condition when requested by the personal assistant, the Personal Assistance Agency, the nurse supervisor, the service coordinator or the participant. (3-19-07)

03. Prior Authorization Requirements. All PCS services must be prior authorized by the Department. Authorizations will be based on the information from: (3-29-10)

a. The children's PCS assessment or Uniform Assessment Instrument (UAI) for adults; (3-29-10)

b. The individual service plan developed by the Personal Assistance Agency; and (3-29-10)

c. Any other medical information that supports the medical need. (3-29-10)

04. PCS Record Requirements for a Participant in Their Own Home. ~~The~~ PCS records must be maintained ~~on for~~ all participants ~~who~~ receive~~ing~~ PCS in their own homes or in a PCS Family Alternate Care Home. (3-20-20)()

a. Written Documentation Requirements. ~~The~~ PCS provider must maintain ~~written~~ documentation of every visit made to the participant's home and must record the following minimum information: (3-19-07)()

i. Date and time of visit; (3-19-07)

ii. Length of visit; (3-19-07)

iii. Services provided during the visit; and (3-19-07)

iv. Documentation of any changes noted in the participant's condition or any deviations from the plan of care. (3-19-07)

b. Participant's Signature. The participant or legal guardian must ~~sign the record of service delivery verifying that the~~ services were delivered using the provider's EVV system. ~~The BLTC may waive this requirement if it determines the participant is not able to verify the service delivery.~~ (3-20-20)()

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. (7-1-16)

d. Copy Requirement. A copy of the information required in Subsection 304.04 of these rules must be maintained and available in a format accessible to the participant's ~~home unless the BLTC authorizes the information to be kept elsewhere~~. Failure to maintain this information may result in recovery of funds paid for undocumented services. (3-20-20)()

e. ~~Telephone Tracking~~ Electronic Visit Verification (EVV) System. ~~Agencies may employ a software system that allows personal assistants to register their start and stop times and a list of services by placing a telephone call to the agency system from the participant's home. This system~~ EVV systems as described in Section 041 of these rules will not take the place of documentation requirements of Subsection 304.04 of these rules but may be used to generate documentation retained in the participant's home. (3-19-07)()

05. PCS Record Requirements for a Participant in a Residential Assisted Living Facility or Certified Family Home. The PCS records must be maintained on all participants who receive PCS in a Residential Assisted Living Facility (RALF) or Certified Family Home (CFH). (7-1-16)()

a. Participant in a ~~Residential Assisted Living Facility~~ RALF. The additional PCS record requirements

for participants in ~~Residential Assisted Living Facility~~ **RALE** are described in IDAPA 16.03.22, “Residential Assisted Living Facilities.” (7-1-16)()

b. Participant in a ~~Certified Family Home~~ **CFH**. The additional PCS record requirements for participants in ~~Certified Family Homes~~ **CFHs** are described in IDAPA 16.03.19, “Certified Family Homes.” (7-1-16)()

c. Participant’s Signature. The participant or legal guardian must sign the NSA agreeing to the delivery of services as specified. (7-1-16)

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. (7-1-16)

06. Provider Responsibility for Notification. The Personal Assistance Agency is responsible to notify the BLTC and physician or authorized provider when any significant changes in the participant's condition are noted during service delivery. This notification must be documented in the Personal Assistance Agency record. (3-20-20)

(BREAK IN CONTINUITY OF SECTIONS)

307. PERSONAL CARE SERVICES: PROVIDER REIMBURSEMENT.

01. Reimbursement Rate. Personal assistance providers will be paid a uniform reimbursement rate for service as established by the Department. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (4-4-13)

02. Calculated Fee. The fee calculated for personal care provider reimbursement includes a basic rate for services and mileage. No separate charges for mileage will be paid by the Department for non-medical transportation, unless approved by the Department or its contractor under a Home and Community-Based Services (HCBS) waiver, or provider transportation to and from the participant's home. Fees will be calculated as provided in Subsections 307.03 through 307.08 of this rule. (4-4-13)

03. Weighted Average Hourly Rate Methodology. Annually Medicaid will conduct a poll of all Idaho nursing facilities and ICFs/ID, and establish the weighted average hourly rates (WAHR) for nursing facility industry employees in comparable positions (i.e. RN, ~~QMRP~~, certified and non-certified nurse's aides) in Idaho to be used in calculating the reimbursement rate to be effective on July 1st of that year. (4-4-13)()

04. Payment for Personal Assistance Agency. Payment for personal assistance agency services will be paid according to rates established by the Department. (4-4-13)

a. The Department will establish Personal Assistance Agency rates for personal assistance services based on the WAHR.

Personal Assistance Agencies	WAHR x supplemental component	=	\$ amount/hour
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(4-4-13)

b. The Department will calculate a supplemental component using costs reported for travel, administration, training, and all payroll taxes and fringe benefits. The survey data is the cost information collected during the prior State Fiscal Year. (4-4-13)

c. The Department will survey one hundred percent (100%) of ~~personal care service~~ **PCS** providers. Cost surveys are unaudited, but a provider that refuses or fails to respond to the periodic state surveys may be disenrolled as a Medicaid provider. The Department will derive reimbursement rates using direct care staff costs,

employment related expenditures, program related costs, and indirect general and administrative costs in the reimbursement methodology, when these costs are incurred by a provider. (4-4-13)()

05. Payment Levels for Adults in Residential Assisted Living Facilities a RALF or Certified Family Homes CFH. Adult participants living in Residential Assisted Living Facilities (RALFs) or Certified Family Homes (CFHs) will receive personal care services PCS at a rate based on their care level. Each level will convert to a specific number of hours of personal care services PCS. (3-19-07)()

a. Reimbursement Level I -- One point twenty-five (1.25) hours of personal care services PCS per day or eight point seventy-five (8.75) hours per week. (3-19-07)()

b. Reimbursement Level II -- One point five (1.5) hours of personal care services PCS per day or ten point five (10.5) hours per week. (3-19-07)()

c. Reimbursement Level III -- Two point twenty-five (2.25) hours of personal care services PCS per day or fifteen point seventy-five (15.75) hours per week. (3-19-07)()

d. Reimbursement Level IV - One point seventy-nine (1.79) hours of personal care services PCS per day or twelve point five (12.5) hours per week. This level will be assigned based on a documented diagnosis of mental illness, intellectual disability, or Alzheimer's disease. If an individual is assessed as Level III with a diagnosis of mental illness, intellectual disability, or Alzheimer's disease the provider reimbursement rate will be the higher amount as described in Subsection 307.05.c. of these rules. (3-19-07)()

06. Attending Physician Reimbursement Level. The attending physician or authorized provider will be are reimbursed for services provided using current payment levels and methodologies for other services provided to eligible participants. (3-19-07)()

07. Supervisory RN and OMRP QIDP Reimbursement Level. The supervisory RN and OMRP QIDP will be are reimbursed at a per visit amount established by the Department for supervisory visits. Participant evaluations and Care Plan Development will be reimbursed at a rate established by the Department, following authorization by the Department or its contractor. (4-4-13)()

a. The number of supervisory visits by the RN or OMRP QIDP to be conducted per calendar quarter will be approved as part of the PCS care plan by the Department or its contractor. (4-4-13)()

b. Additional evaluations or emergency visits in excess of those contained in the approved care plan will be authorized when needed by the Department or its contractor. (4-4-13)

08. Payment for PCS Family Alternate Care Home. The Department will establish PCS Family Alternate Care Home rates for personal assistance services based on the WAHR. Based on the survey conducted, the Department will calculate a supplemental component using costs reported for administration, and training. The survey data is the cost information collected during the prior State Fiscal Year.

PCS Family Alternate Care Home	Children's PCS Assessment Weekly Hours x (WAHR x supplemental component)	=	\$ amount/week
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(4-4-13)

09. EVV Compliance. Provider claims for PCS require EVV compliance as described in Section 041 of these rules in order to be eligible for payment. ()

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

01. Responsibility for Quality. Personal Assistance Agencies, Residential Assisted Living Facilities (RALFs), and Certified Family Homes (CFHs) furnishing PCS are responsible for assuring that they provide quality services in compliance with applicable rules. (7-1-16)()

02. Review Results. Results of quality assurance reviews conducted by the Department must be transmitted to the provider within forty-five (45) days after the review is completed. (3-19-07)

03. Quality Improvement Plan. The provider must respond within forty-five (45) days after the results are received. If problems are identified, the provider must implement a quality improvement plan and report the results to the Department upon request. (3-19-07)

04. HCBS Compliance. Personal Assistance Agencies are responsible for ensuring they meet the setting requirements described in Section 313 of these rules. ~~Residential Assisted Living Facilities RALFs~~, and ~~Certified Family Homes CFHs~~ are responsible for ensuring that they meet the setting requirements described in Sections 313 and 314 of these rules. All providers furnishing PCS are responsible for ensuring they meet the person-centered planning requirements described in 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 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. (7-1-16)()

(BREAK IN CONTINUITY OF SECTIONS)

324. AGED AND DISABLED WAIVER SERVICES: TARGET GROUP.

Persons who would be Medicaid eligible if residing in a nursing facility, require the level of care provided in a nursing facility, are over the age of eighteen (18), demonstrate significant disability on the ~~Uniform Assessment Instrument (UAI)~~, and have deficits that affect their ability to function independently. (3-19-07)()

325. HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER: PARTICIPANT LIMITATIONS.

The number of Medicaid participants to receive waiver services under the ~~Home and Community-Based Services (HCBS)~~ waiver for the aged and disabled will be limited to the projected number of users identified in the Department's approved waiver. If necessary, participants 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 of each new waiver year. The earliest effective date of waiver service delivery for these participants will be October 1st of each new waiver year. (3-19-07)()

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

01. Adult Day Health. Adult day health is a supervised, structured service generally furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week. It is provided outside the home of the participant in a non-institutional, community-based setting, and it encompasses health services, social services, recreation, supervision for safety, and assistance with activities of daily living needed to ensure the optimal functioning of the participant. Adult day health services provided under this waiver will not include room and board payments. (4-4-13)

02. Adult Residential Care Services. Adult residential care services consist of a range of services provided in a homelike, non-institutional setting that include ~~residential care or assisted living facilities RALFs~~ and ~~certified family homes CFHs~~. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. (4-4-13)()

a. Adult residential care services consist of a range of services provided in a congregate setting licensed under IDAPA 16.03.22, "Residential Assisted Living Facilities," that include: (4-4-13)

- i. Medication assistance, to the extent permitted under State law; (4-4-13)
- ii. Assistance with activities of daily living; (3-19-07)
- iii. Meals, including special diets; (3-19-07)

- iv. Housekeeping; (3-19-07)
 - v. Laundry; (3-19-07)
 - vi. Transportation; (3-19-07)
 - vii. Opportunities for socialization; (3-19-07)
 - viii. Recreation; and (3-19-07)
 - ix. Assistance with personal finances. (3-19-07)
 - x. Administrative oversight must be provided for all services provided or available in this setting. (3-19-07)
 - xi. A ~~written~~ **documented** individual service plan must be negotiated between the participant or their legal representative, and a facility representative. (~~3-19-07~~)()
- b.** Adult residential care services also consist of a range of services provided in a setting licensed under IDAPA 16.03.19, "Certified Family Homes," that include: (4-4-13)
- i. Medication assistance, to the extent permitted under State law; (4-4-13)
 - ii. Assistance with activities of daily living; (4-4-13)
 - iii. Meals, including special diets; (4-4-13)
 - iv. Housekeeping; (4-4-13)
 - v. Laundry; (4-4-13)
 - vi. Transportation; (4-4-13)
 - vii. Recreation; and (4-4-13)
 - viii. Assistance with personal finances. (4-4-13)
 - ix. Administrative oversight must be provided for all services provided or available in this setting. (4-4-13)
 - x. A ~~written~~ **documented** individual service plan must be negotiated between the participant or their legal representative, and a facility representative. (~~4-4-13~~)()
- 03. Specialized Medical Equipment and Supplies.** (4-4-13)
- a.** Specialized medical equipment and supplies include: (4-4-13)
- i. Devices, controls, or appliances that enable a participant to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live; and (4-4-13)
 - ii. Items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. (4-4-13)
- b.** Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid State plan and exclude those items that are not of direct medical or remedial benefit to

the participant. (4-4-13)

04. Non-Medical Transportation. Non-medical transportation enables a waiver participant to gain access to waiver and other community services and resources. (4-4-13)

a. Non-medical transportation is offered in addition to medical transportation required in IDAPA 16.03.09, “Medicaid Basic Plan Benefits,” and will not replace it. (4-4-13)

b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge, or public transit providers will be utilized. (3-19-07)

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 cueing to prompt the participant to perform a task. (4-4-13)

06. Chore Services. Chore services include the following services when necessary to maintain the functional use of the home, or to provide a clean, sanitary, and safe environment: (4-4-13)

a. Intermittent assistance may include the following. (4-4-13)

i. Yard maintenance; (3-19-07)

ii. Minor home repair; (3-19-07)

iii. Heavy housework; (3-19-07)

iv. Sidewalk maintenance; and (3-19-07)

v. Trash removal to assist the participant to remain in the home. (4-4-13)

b. Chore activities may include the following: (3-19-07)

i. Washing windows; (3-19-07)

ii. Moving heavy furniture; (3-19-07)

iii. Shoveling snow to provide safe access inside and outside the home; (3-19-07)

iv. Chopping wood when wood is the participant's primary source of heat; and (3-19-07)

v. Tacking down loose rugs and flooring. (3-19-07)

c. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community volunteer, agency, or third-party payer is willing to provide them or is responsible for their provision. (4-4-13)

d. In the case of rental property, the landlord’s responsibility under the lease agreement will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (4-4-13)

07. Companion Services. Companion services include non-medical care, supervision, and socialization provided to a functionally impaired adult. Companion services are in-home services to ensure the safety

and well-being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergency situations, or other conditions that would require a person 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. 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. (4-4-13)

08. Consultation. Consultation services are services to a participant or family member. Services 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. (4-4-13)

09. Home Delivered Meals. Home delivered meals are 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: (4-4-13)

- a. Rents or owns a home; (4-4-13)
- b. Is alone for significant parts of the day; (4-4-13)
- c. Has no caregiver for extended periods of time; and (4-4-13)
- d. Is unable to prepare a meal without assistance. (4-4-13)

10. Homemaker Services. Homemaker services 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. (4-4-13)

11. Environmental Accessibility Adaptations. Environmental accessibility adaptations include minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization or have a risk to health, welfare, or safety. Such adaptations may include: (4-4-13)

a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but must exclude those adaptations or improvements to the home that are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. (4-4-13)

b. Unless otherwise authorized by the Department, permanent environmental modifications are limited to a home that is the participant's principal residence, and is owned by the participant or the participant's non-paid family. (4-4-13)

c. Portable or non-stationary modifications may be made when such modifications can follow the participant to their next place of residence or be returned to the Department. (4-4-13)

12. Personal Emergency Response System (PERS). PERS is an electronic device that enables a waiver participant to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. This service is limited to participants who: (4-4-13)

- a. Rent or own a home, or live with unpaid caregivers; (4-4-13)
- b. Are alone for significant parts of the day; (3-19-07)

- c. Have no caregiver for extended periods of time; and (4-4-13)
- d. Would otherwise require extensive, routine supervision. (3-19-07)

13. Respite Care. Respite care includes short-term breaks from care giving responsibilities to non-paid caregivers. The caregiver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other services that are duplicative in nature. Respite care services provided under this waiver do not include room and board payments. Respite care services may be provided in the participant's residence, a ~~certified family home~~ **CFH**, a developmental disabilities agency, a ~~residential care or assisted living facility~~ **RALE**, or an adult day health facility. (4-4-13)()

14. Skilled Nursing. Skilled nursing includes intermittent or continuous oversight, training, or skilled care that is within the scope of the Nurse Practice Act. Such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a licensed registered nurse, licensed to practice in Idaho. These services are not appropriate if they are less cost effective than a Home Health visit. (4-4-13)

15. Habilitation. Habilitation services assist the participant to reside as independently as possible in the community, or maintain family unity. (4-4-13)

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. The services and supports that may be furnished consist of the following: (4-4-13)

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; (3-30-07)

ii. Money management consists of training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (3-30-07)

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, appliances, as well as following home safety, first aid, and emergency procedures; (3-30-07)

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; (3-30-07)

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 (3-30-07)

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. (3-30-07)

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 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. (4-4-13)

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. (4-4-13)

16. Supported Employment. Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work. (3-30-07)

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. (4-4-13)

b. Federal Financial Participation (FFP) cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize the employer's participation in a supported employment program, payments that are passed through to beneficiaries of a supported employment program, or payments for vocational training that is not directly related to a waiver participant's supported employment program. (4-4-13)

17. Transition Services. Transition services include goods and services that enable a participant residing in a nursing facility, hospital, IMD, or ICF/ID 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) Medicaid-reimbursed days. (4-11-19)

- a.** Qualified Institutions include the following: (4-11-19)
 - i.** Skilled, or Intermediate Care Facilities; (4-11-19)
 - ii.** Nursing Facility; (4-11-19)
 - iii.** Licensed Intermediate Care Facility for the Persons with Intellectual Disabilities (ICF/ID); (4-11-19)
 - iv.** Hospitals; and (4-11-19)
 - v.** Institutions for Mental Diseases (IMD). (4-11-19)
- b.** Transition services may include the following goods and services: (4-11-19)
 - i.** Security deposits that are required to obtain a lease on an apartment or home; (4-11-19)
 - ii.** Cost of essential household furnishings, including furniture, window coverings, food preparation items, and bed/bath linens; and (4-11-19)
 - iii.** Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (4-11-19)
 - iv.** Services necessary for the individual's health and safety such as pest eradication and one-time

- cleaning prior to occupancy; (4-11-19)
- v. Moving expenses; and (4-11-19)
 - vi. Activities to assess need, arrange for and procure transition services. (4-11-19)
- 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. (4-11-19)
- 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 person is unable to meet such expense or when the support cannot be obtained from other sources. (4-11-19)

(BREAK IN CONTINUITY OF SECTIONS)

328. AGED AND DISABLED WAIVER SERVICES: PROCEDURAL REQUIREMENTS.

01. Role of the Department. The Department or its contractor will provide for the administration of the UAI, and the development of the initial individual service plan. This will be done either by Department staff or a contractor. The Department or its contractor will review and approve all individual service plans, and will authorize Medicaid payment by type, scope, and amount. (4-4-13)

a. Services that are not in the individual service plan approved by the Department or its contractor are not eligible for Medicaid payment. (4-4-13)

b. Services in excess of those in the approved individual service plan are not eligible for Medicaid payment. (3-19-07)

c. The earliest date that services may be approved by the Department or its contractor for Medicaid payment is the date that the participant's individual service plan is signed by the participant or their designee. (4-4-13)

02. Pre-Authorization Requirements. All waiver services must be pre-authorized by the Department. Authorization will be based on the information from: (3-19-07)

a. The UAI; (3-19-07)

b. The individual service plan developed by the Department or its contractor; and (3-19-07)

c. Any other medical information that verifies the need for nursing facility services in the absence of the waiver services. (3-19-07)

03. UAI Administration. The UAI will be administered, and the initial individual service plan developed, by the Department or its contractor. (4-4-13)

04. Individual Service Plan. All waiver services must be authorized by the Department or its contractor in the Region where the participant will be residing and services provided based on a ~~written~~ **documented** individual service plan. ~~(4-4-13)~~ **()**

a. The initial individual service plan is developed by the Department or its contractor, based on the UAI, in conjunction with: (4-4-13)

i. The waiver participant (with efforts made by the Department or its contractor to maximize the participant's involvement in the planning process by providing them with information and education regarding their rights); (4-4-13)

- ii. The guardian, when appropriate; (3-30-07)
- iii. The supervising nurse or case manager, when appropriate; and (3-19-07)
- iv. Others identified by the waiver participant. (3-19-07)
- b.** The individual service plan must include the following: (3-19-07)
 - i. The specific type, amount, frequency, and duration of Medicaid reimbursed waiver services to be provided; (3-30-07)
 - ii. Supports and service needs that are to be met by the participant's family, friends, neighbors, volunteers, church, and other community services; (3-30-07)
 - iii. The providers of waiver services when known; (3-30-07)
 - iv. Documentation that the participant has been given a choice between waiver services and institutional placement; and (3-19-07)
 - v. The signature of the participant or their legal representative, agreeing to the plan. (3-19-07)
- c.** The individual service plan must be revised and updated at least annually, based upon treatment results or a change in the participant's needs. (3-19-07)
- d.** All services reimbursed under the Aged and Disabled Waiver must be authorized by the Department or its contractor prior to the payment of services. (4-4-13)
- e.** The individual service plan, which includes all waiver services, is monitored by the Personal Assistance Agency, participant, family, and the Department or its contractor. (4-4-13)
- 05. Service Delivered Following a ~~Written~~ Documented Plan of Care.** All services that are provided must be based on a ~~written~~ documented plan of care. (~~3-30-07~~)()
- a.** The plan of care is developed by the plan of care team that includes: (3-30-07)
 - i. The waiver participant with efforts made to maximize their participation on the team by providing them with information and education regarding their rights; (3-30-07)
 - ii. The guardian when appropriate; (3-30-07)
 - iii. Service provider identified by the participant or guardian; and (3-30-07)
 - iv. May include others identified by the waiver participant. (3-30-07)
- b.** The plan of care must be based on an assessment process approved by the Department. (3-30-07)
- c.** The plan of care must include the following: (3-30-07)
 - i. The specific types, amounts, frequency and duration of Medicaid reimbursed waiver services to be provided; (3-30-07)
 - ii. Supports and service needs that are to be met by the participant's family, friends and other community services; (3-30-07)
 - iii. The providers of waiver services; (3-30-07)

- iv. Goals to be addressed within the plan year; (3-30-07)
- v. Activities to promote progress, maintain functional skills, or delay or prevent regression; and (3-30-07)
- vi. The signature of the participant or their legal representative. (3-30-07)
- 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. (7-1-16)
- d. The plan must be revised and updated by the plan of care team based upon treatment results or a change in the participant's needs. A new plan must be developed and approved annually. (3-30-07)
- e. The Department's Nurse Reviewer monitors the plan of care and all waiver services. (7-1-16)
- f. The plan of care may be adjusted during the year with an addendum to the plan. These adjustments must be based on changes in a participant's need or demonstrated outcomes. Additional assessments or information may be clinically necessary. Adjustment of the plan of care is subject to prior authorization by the Department. (3-30-07)
- 06. Individual Service Plan and ~~Written~~ Plan of Care.** The development and documentation of the individual service plan and plan of care must meet the person-centered planning requirements described in Sections 316 and 317 of these rules. ~~(7-1-16)~~()
- 07. Provider Records.** Records will be maintained on each waiver participant. (3-19-07)
- a. Each service provider must document each visit made or service provided to the participant, and will record at a minimum the following information: (3-19-07)
- i. Date and time of visit; (3-19-07)
- ii. Services provided during the visit; (3-19-07)
- iii. Provider observation of the participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and (3-19-07)
- iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the Department or its contractor determines that the participant is unable to do so, the service delivery will be verified by the participant as evidenced by their signature on the service record. (4-4-13)
- b. The provider is required to keep the original service delivery record. A copy of the service delivery record will be maintained ~~in~~ and available in a format accessible to the participant ~~in their living arrangement unless authorized to be kept elsewhere by the Department.~~ Failure to maintain documentation according to these rules will result in the recoupment of funds paid for undocumented services. ~~(4-4-13)~~()
- c. The individual service plan initiated by the Department or its contractor must specify which waiver services are required by the participant. The plan will contain all elements required by Subsection 328.04.a. of these rules and a copy of the most current individual service plan will be maintained in the participant's home and will be available to all service providers and the Department. A copy of the current individual service plan and UAI will be available from the Department or its contractor to each individual service provider with a release of information signed by the participant or legal representative. (4-4-13)
- d. Record requirements for participants in ~~residential care or assisted living facilities~~ RALFs are described in IDAPA 16.03.22, "Residential Assisted Living Facilities." ~~(4-4-13)~~()
- e. Record requirements for participants in ~~certified family homes~~ CFHs are described in IDAPA 16.03.19, "Certified Family Homes." ~~(4-4-13)~~()

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. ()

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. (4-4-13)

09. Records Retention. Personal Assistance Agencies, and other providers are responsible to retain their records for five (5) years following the date of service. (3-19-07)

10. Requirements for an 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 Section 329 of these rules. (3-19-07)

329. AGED AND DISABLED WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES. Each provider must have a signed provider agreement with the Department for each of the services it provides. (3-19-07)

01. Employment Status. Unless otherwise specified by the Department, each individual service provider must be an employee of record or fact of an agency. The Department may enter into provider agreements with individuals in situations in which no agency exists, or no fiscal intermediary agency is willing to provide services. Such agreements will be reviewed annually to verify whether coverage by a personal assistance agency or fiscal intermediary agency is still not available. (5-8-09)

02. Fiscal Intermediary Services. An agency that has responsibility for the following: (5-8-09)

a. To directly assure compliance with legal requirements related to employment of waiver service providers; (3-19-07)

b. To offer supportive services to enable participants or their families *consumers* to perform the required employer tasks themselves; (~~3-19-07~~)()

c. To bill the Medicaid program for services approved and authorized by the Department; (3-19-07)

d. To collect any participant participation due; (3-19-07)

e. To pay personal assistants and other waiver service providers for service; (3-19-07)

f. To perform all necessary withholding as required by state and federal labor and tax laws, rules and regulations; (3-19-07)

g. To assure that personal assistants providing services meet the standards and qualifications under in this rule; (5-8-09)

h. To maintain liability insurance coverage; (5-8-09)

i. To conduct, at least annually, participant satisfaction or quality control reviews that are available to the Department and the general public; (5-8-09)

j. To obtain such criminal background checks and health screens on new and existing employees of record and fact as required. (5-8-09)

03. Provider Qualifications. All providers of homemaker services, respite care, adult day health,

transportation, chore services, companion services, attendant care, adult residential care, and home delivered meals must meet, either by formal training or demonstrated competency, the training requirements contained in the provider training matrix and the standards for direct care staff and allowable tasks or activities in the Department's Aged and Disabled waiver as approved by CMS. (4-4-13)

a. A waiver provider cannot be a relative of any participant to whom the provider is supplying services. (3-19-07)

b. For the purposes of Section 329 of these rules, a relative is defined as a spouse or parent of a minor child. (3-19-07)

c. Individuals who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

04. Quality Assurance. Providers of Aged and Disabled waiver services are responsible for ensuring that they provide quality services in compliance with applicable rules. (7-1-16)

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. (7-1-16)

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. (7-1-16)

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. (7-1-16)

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 Sections 311 through 318 of these rules, as applicable, and must comply with associated Department quality assurance activities. (7-1-16)

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. (4-4-13)

07. Skilled Nursing Service. Skilled nursing service providers must be licensed in Idaho as a licensed registered nurse or licensed practical nurse in good standing, or must be practicing on a federal reservation and be licensed in another state. Skilled nursing providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

08. Consultation Services. Consultation services must be provided through a Personal Assistance Agency by a person who has demonstrated skills in training participants/family members in hiring, firing, training, and supervising their own care providers. (4-4-13)

09. Adult Residential Care. Adult residential care providers will meet all applicable state laws and regulations. In addition, the provider must ensure that adequate staff are provided to meet the needs of the participants accepted for admission. Adult residential care providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.03.19, "Certified Family Homes," or IDAPA 16.03.22, "Residential Assisted Living Facilities." (4-4-13)

10. Home Delivered Meals. Providers of home delivered meals must be a public agency or private business, and must exercise supervision to ensure that: (4-4-13)

- a.** Each meal meets one-third (1/3) of the Recommended Daily Allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences; (4-4-13)
- b.** Meals are delivered in accordance with the service plan, in a sanitary manner, and at the correct temperature for the specific type of food; (4-4-13)
- c.** Documentation is maintained demonstrating that the meals served are made from the highest USDA grade for each specific food served; (4-4-13)
- d.** The agency or business is inspected and licensed as a food establishment under IDAPA 16.02.19, "Idaho Food Code"; (4-4-13)
- e.** A Registered Dietitian documents the review and approval of menus, menu cycles, and any changes or substitutions; and (4-4-13)
- f.** Either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule have been met. (4-4-13)
- 11. Personal Emergency Response Systems.** Personal emergency response system providers must demonstrate that the devices installed in a waiver participant's home meet Federal Communications Standards, or Underwriter's Laboratory Standards, or equivalent standards. (4-4-13)
- 12. Adult Day Health.** Providers of adult day health must meet the following requirements: (4-4-13)
- a.** Services provided in a facility must be provided in a facility that meets the building and health standards identified in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." (4-4-13)
- b.** Services provided in a home must be provided in a home that meets the standards of home certification identified in IDAPA 16.03.19, "Certified Family Homes." (4-4-13)
- c.** Services provided in a ~~residential adult living facility~~ **RALF** must be provided in a ~~residential adult living~~ facility that meets the standards identified in IDAPA 16.03.22, "Residential Assisted Living Facilities." (4-4-13)()
- d.** Adult day health providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)
- e.** Providers of adult day health must notify the Department on behalf of the participant, if the adult day health is provided in a ~~certified family home~~ **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. (4-4-13)()
- f.** Adult day health providers who provide direct care or services must be free from communicable disease. (4-4-13)
- g.** All providers of adult day health services must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)
- 13. Non-Medical Transportation Services.** Providers of non-medical transportation services must: (4-4-13)
- a.** Possess a valid driver's license; (4-4-13)
- b.** Possess valid vehicle insurance; and (4-4-13)

c. Meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)

14. Attendant Care. Attendant care providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." All providers of attendant care must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)

15. Homemaker Services. The homemaker must be an employee of record or fact of an agency. Homemaker service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." All providers of homemaker services must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)

16. Environmental Accessibility Adaptations. All services must be provided in accordance with applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. (4-4-13)

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: (4-4-13)

- a. Direct service staff must meet the following minimum qualifications: (3-30-07)
 - i. Be at least eighteen (18) years of age; (3-30-07)
 - ii. Be a high school graduate, or have a GED, or demonstrate the ability to provide services according to a plan of service; (4-4-13)
 - iii. Have current CPR and First Aid certifications; (3-30-07)
 - iv. Be free from communicable disease; (4-4-13)
 - v. Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. (3-30-07)
 - vi. Residential habilitation service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks;" (4-4-13)
 - vii. Have appropriate certification or licensure if required to perform tasks that require certification or licensure. Direct service staff must also have taken a traumatic brain injury training course approved by the Department. (3-30-07)

b. The provider agency is responsible for providing direct service staff with a traumatic brain injury training course approved by the Department, and training specific to the needs of the participant. (4-4-13)

c. Prior to delivering services to a participant, agency direct service staff must complete an orientation program. The orientation program must include the following subjects: (4-4-13)

- i. Purpose and philosophy of services; (3-30-07)

- ii. Service rules; (3-30-07)
- iii. Policies and procedures; (3-30-07)
- iv. Proper conduct in relating to waiver participants; (3-30-07)
- v. Handling of confidential and emergency situations that involve the waiver participant; (3-30-07)
- vi. Participant rights; (3-30-07)
- vii. Methods of supervising participants; (3-30-07)
- viii. Working with individuals with traumatic brain injuries; and (3-30-07)
- ix. Training specific to the needs of the participant. (3-30-07)
- d.** Additional training requirements must be completed within six (6) months of employment with the residential habilitation agency and include at a minimum: (3-29-12)
 - i. Instructional techniques: Methodologies for training in a systematic and effective manner; (3-30-07)
 - ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; (3-30-07)
 - iii. Feeding; (3-30-07)
 - iv. Communication; (3-30-07)
 - v. Mobility; (3-30-07)
 - vi. Activities of daily living; (3-30-07)
 - vii. Body mechanics and lifting techniques; (3-30-07)
 - viii. Housekeeping techniques; and (3-30-07)
 - ix. Maintenance of a clean, safe, and healthy environment. (3-30-07)
- e.** The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed. (4-4-13)

18. Day Habilitation. Providers of day habilitation services must have a minimum of two (2) years of experience working directly with persons with a traumatic brain injury, must provide documentation of standard licensing specific to their discipline, and must have taken a traumatic brain injury course approved by the Department. Day habilitation providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

- 19. Respite Care.** Providers of respite care services must meet the following minimum qualifications: (4-4-13)
- a.** Have received care giving instructions in the needs of the person who will be provided the service; (4-4-13)
 - b.** Demonstrate the ability to provide services according to a plan of service; (4-4-13)

- c. Be free of communicable disease; and (4-4-13)
- d. Respite care service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

20. Supported Employment. Supported employment services must be provided by an agency that supervises the direct service and is accredited by the Commission on Accreditation of Rehabilitation Facilities, other comparable standards, or meet State requirements to be a State-approved provider. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (3-20-20)

21. Chore Services. Providers of chore services must meet the following minimum qualifications: (4-4-13)

- a. Be skilled in the type of service to be provided; and (4-4-13)
- b. Demonstrate the ability to provide services according to a plan of service. (4-4-13)
- c. Chore service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)
- d. Meet, either by formal training or demonstrated competency, the training requirements in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)

22. Transition Services. Transition managers as described in Section 350.01 of these rules are responsible for administering transition services. (4-11-19)

330. AGED AND DISABLED WAIVER SERVICES: PROVIDER REIMBURSEMENT.

The criteria used in reimbursing providers for waiver services are listed in Subsections 330.01 through 330.03 of these rules. (3-19-07)

01. Fee for Services. Waiver service providers will be paid on a fee for service basis as established by the Department, or as agreed upon by the Department's contractor and the provider, depending on the type of service provided. Adult residential care will be paid on a per diem basis, based on the number of hours and types of assistance required by the participant as identified in the UAI. (4-4-13)

02. Provider Claims. Provider claims for payment will be submitted on claim forms provided or approved by the Department or its contractor. Billing instructions will be provided by the Department's payment system contractor. (4-4-13)

03. Calculation of Fees. The fees calculated for waiver services include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location when the participant is not being provided waiver or state plan transportation. (3-19-07)

04. EVV Compliance. Provider claims for the following Aged and Disabled Waiver Services require EVV compliance as described in Section 041 of these rules in order to be eligible for payment: ()

- a. Attendant Care: ()
- b. Homemaker; and ()
- c. Respite. ()

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.10 – MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-2003

NOTICE OF RULEMAKING – ADOPTION OF TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is October 1, 2020.

AUTHORITY: In compliance with Sections 67-5226, Idaho Code, notice is hereby given this agency has adopted a temporary rule. The action is authorized pursuant to Section 56-202(b), Idaho Code.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule:

The Department, providers, and the Idaho Health Care Association have agreed to increase the current Behavioral Care Unit (BCU) census requirement from 20% to 30% for new BCU providers. This increase will help the Department maintain support for BCU providers consistent with state needs and aligns this chapter with HB351 (2020) requirements for nursing facilities. The changes contained in this rulemaking are the first stage of those required to comply with the aforementioned legislation. These changes were requested by stakeholders to be put into rule as soon as possible. Other changes are planned for 2021 to complete the alignment of this chapter with the requirements of this new statute.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate to align this chapter of rules with the requirements of HB351 (2020).

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: N/A

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary rule, contact Angela Toomey at (208) 364-1817.

Dated this 14th day of August, 2020.

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

**THE FOLLOWING IS THE TEMPORARY RULE FOR DOCKET NO. 16-0310-2003
(Only Those Sections With Amendments Are Shown.)**

267. NURSING FACILITY: TREATMENT OF NEWLY LICENSED FACILITIES WITH BEHAVIORAL CARE UNITS.

01. Criteria to Qualify as a New BCU On or After September 1, 2017. Facilities licensed on or after September 1, 2017, must meet the qualifications for a BCU described in Subsections 266.02, 266.03, and 266.05 through 266.15 of these rules. BCU facilities existing prior to this date that receive a new license due to a change in ownership will not be subject to the provisions of this rule. (3-28-18)

02. Reimbursement for Years One (1) Through Three (3). Beginning with the first day of the first month following approval of the BCU license and when the provider can demonstrate that BCU days from a minimum of sixty (60) calendar days, regardless of payer source, divided by total census days for that same sixty-day (60) period, equals or exceeds a minimum of ~~twenty~~ **thirty** percent (~~230%~~), the provider's rate will change to reflect BCU services. The provider will be reimbursed at the median rate for BCU facilities of that type, either freestanding or hospital-based, for the remaining period within the first three (3) full years of operation. If there are no facilities of the same type (for example, no other hospital-based BCUs), the provider will receive the median rate for their type, but the direct cost portion of the rate will be revised to the median rate of existing BCUs. The rate change to reflect BCU services will not be retroactive to rate quarters paid prior to meeting the ~~twenty~~ **thirty** percent (~~230%~~) BCU occupancy requirement. (~~3-28-18~~)(10-1-20)T

a. A nursing facility must apply for BCU eligibility on an annual basis in accordance with Subsection 266.07 of these rules. If the provider did not meet the BCU qualifications described in Section 266 of these rules, with the exception of Subsections 266.01 and 266.04, for a full cost report year corresponding to the initial application year, the twenty percent (20%) BCU day requirement will apply only to days beginning with the first day of BCU eligibility to the end of the year. (3-28-18)

b. During the period of limitation, the facility's rate will be modified annually on July 1st to reflect the current median rate for skilled care facilities of that type. After the first three (3) complete years of operations, the facility will have its rate established at the next July 1st with the existing facilities in accordance with Subsections 266.03 and 266.05 of these rules. (3-28-18)

c. During the period of limitation, providers must demonstrate annually that BCU days were equal to or exceeded twenty percent (20%), as described in Subsection 267.02 of this rule. Providers must provide a report to the Department with a calculation of BCU days for each month during the period being reviewed. If the twelve-month (12) average falls below twenty percent (20%), then the BCU reimbursement will revert back to the median rate per Section 260 of these rules. Once the Department has established the provider has met the requirements of Subsection 267.01 of this rule they will be eligible for a new rate outlined in Subsection 267.02.b. of this rule. (3-28-18)

268. NURSING FACILITY: EXISTING PROVIDER ELECTS TO ADD BEHAVIORAL CARE UNIT (BCU).

An existing nursing facility provider that elects to add a BCU on or after September 1, 2017, may be deemed eligible after meeting the following requirements: (3-28-18)

01. Meet Criteria for BCU. The nursing facility provider must meet the criteria for a BCU described in Section 266 of these rules. (4-4-13)

02. BCU Eligible Days. The provider must demonstrate that BCU days from a minimum of sixty (60) calendar days, regardless of payer source, divided by total census days for that same sixty (60) day period, equals or exceeds a minimum of ~~twenty~~ **thirty** percent (~~230%~~). (~~3-28-18~~)(10-1-20)T

03. BCU Payments. Once the provider has met the requirements of Subsections 268.01 and 268.02 of this rule, beginning with the first day of the first quarter following approval of the BCU license, the provider's rate will change to reflect BCU services. At no time will the rate be adjusted mid-quarter. The rate will be calculated as follows. (3-28-18)

a. The indirect costs, costs exempt from limitations, and property cost will be reimbursed in the same

manner as all other nursing facilities in accordance with reimbursement provisions contained in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (3-28-18)

b. The direct cost portion of the rate will be reimbursed as a prospective rate not subject to a change from an interim rate to a final rate. The direct cost portion of the rate will be calculated by determining the median direct cost portion for BCU facilities of that type (freestanding or hospital-based) effective on July 1 of the rate year. If there are no facilities of the same type (for example no other hospital-based BCUs), the direct cost portion of the rate will be set at the median rate of existing BCUs. The direct cost portion of the rate will be updated on July 1 of each rate year until the provider has a qualifying twelve-month (12) cost report, as described in Subsection 268.03.d. of this rule. (3-28-18)

c. The provider's total calculated rate will be subject to customary charge limitations and any other rate reductions implemented for other providers. (3-28-18)

d. Once the provider has a twelve-month (12) cost report that contains a full year of BCU costs, their rate will be calculated in the same manner as other providers in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (3-28-18)

e. A nursing facility must apply for BCU eligibility on an annual basis in accordance with Section 266 of these rules. If the provider was not a BCU for a full cost report year, the twenty percent (20%) BCU day requirement will apply only to days beginning with the first day of BCU eligibility to the end of the year. (3-28-18)