Legislative Services Office
Idaho State Legislature

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Eric Milstead
Director

MEMORANDUM

TO: Senators MARTIN, Souza, Jordan and,
Representatives WOOD, Wagoner, Chew

FROM: Elizabeth Bowen - Principal Legislative Drafting Attorney

DATE: April 02, 2020

SUBJECT: Temporary Rule

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits - Adoption of Temporary Rule - Docket No. 16-0310-2001

We are forwarding this temporary rule to you for your information only. No analysis was done by LSO. This rule is posted on our web site. If you have any questions, please call Elizabeth Bowen at the Legislative Services Office at (208) 334-4845. Thank you.

Attachment: Temporary Rule

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.10 – MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-2001

NOTICE OF RULEMAKING – ADOPTION OF TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is March 13, 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:

This temporary rulemaking is being done in anticipation on increased demands for Medicaid services due to the COVID-19 pandemic. These rule changes will allow Medicaid flexibility to ensure eligible participants receive necessary services throughout the emergency.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(a), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the purpose of protecting public health, safety, or welfare.

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 Michael Case at (208) 364-1878.

Dated this 26th day of March, 2020.

Tamara Prisock
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THE FOLLOWING IS THE TEMPORARY RULE FOR DOCKET NO. 16-0310-2001
(Only Those Sections With Amendments Are Shown.)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Criminal History Check. Agencies must verify that individuals working in the area listed in Subsection 009.03 of these rules whom are employed or whom they contract have complied with the provisions in IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." Except, through the duration of the declared COVID-19 public health emergency, if the individuals working in the area listed in this rule are unable to complete a criminal background check in accordance with the timeframes set forth in IDAPA 16.05.06, then agencies may allow newly hired direct care staff to begin rendering services prior to completion of the criminal background check in accordance with the requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. ~~(3-19-07)~~(3-13-20)T

02. Additional Criminal Convictions. Once an individual has received a criminal history clearance, any additional criminal convictions must be reported by the agency to the Department when the agency learns of the conviction. (3-19-07)

03. Providers Subject to Criminal History and Background Check Requirements. The following providers are required to have a criminal history and background check: (3-19-07)

a. Adult Day Health Providers. The criminal history and background check requirements applicable to providers of adult day health as provided in Sections 329 and 705 of these rules. (4-4-13)

b. Adult Residential Care Providers. The criminal history and background check requirements applicable to adult residential care providers as provided in Section 329 of these rules. (4-2-08)

c. Attendant Care Providers. The criminal history and background check requirements applicable to attendant care providers as provided in Section 329 of these rules. (4-2-08)

d. Behavior Consultation or Crisis Management Providers. The criminal history and background check requirements applicable to behavior consultation or crisis management providers as provided in Section 705 of these rules. (4-4-13)

e. Certified Family Home Providers and All Adults in the Home. The criminal history and background check requirements applicable to certified family homes are found in Sections 305, 329 and 705 of these rules, and as provided in IDAPA 16.03.19, "Rules Governing Certified Family Homes." (4-2-08)

f. Chore Services Providers. The criminal history and background check requirements applicable to chore services providers as provided in Sections 329 and 705 of these rules. (4-2-08)

g. Companion Services Providers. The criminal history and background check requirements applicable to companion services providers as provided in Section 329 of these rules. (4-2-08)

h. Day Habilitation Providers. The criminal history and background check requirements applicable to day habilitation providers as provided in Section 329 of these rules. (4-4-13)

i. Developmental Disabilities Agencies (DDA). The criminal history and background check for DDA and staff as provided in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," Section 009. (7-1-11)

j. Homemaker Services Providers. The criminal history and background check requirements applicable to homemaker services providers as provided in Section 329 of these rules. (4-2-08)

k. Personal Assistance Agencies Acting As Fiscal Intermediaries. The criminal history and background check requirements applicable to the staff of personal assistance agencies acting as fiscal intermediaries as provided in Subsection 329.02 of these rules. (3-19-07)

l. Personal Care Providers. The criminal history and background check requirements applicable to personal care providers as provided in Subsection 305.06 of these rules. (3-19-07)

m. Residential Habilitation Providers. The criminal history and background check requirements applicable to residential habilitation providers as provided in Sections 329 and 705 of these rules, and IDAPA 16.04.17 "Rules Governing Residential Habilitation Agencies," Sections 202 and 301. (4-2-08)

n. Respite Care Providers. The criminal history and background check requirements applicable to respite care providers as provided in Sections 329, 665, and 705 of these rules. (7-1-11)

o. Service Coordinators and Paraprofessionals. The criminal history and background check requirements applicable to service coordinators and paraprofessionals working for an agency as provided in Section 729 of these rules. (3-19-07)

p. Skilled Nursing Providers. The criminal history and background check requirements applicable to skilled nursing providers as provided in Sections 329 and 705 of these rules. (4-4-13)

q. Supported Employment Providers. The criminal history and background check requirements applicable to supported employment providers as provided in Sections 329 and 705 of these rules. (4-2-08)

r. Therapeutic Consultant. The criminal history and background check requirements applicable to therapeutic consultation providers as provided in Section 685 of these rules. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

200. PRIVATE DUTY NURSING SERVICES.

01. Description of Private Duty Nursing Services. Private Duty Nursing (PDN) services are nursing services provided by a licensed registered nurse or licensed practical nurse to a non-institutionalized child under the age of twenty-one (21) requiring care for conditions of such medical severity or complexity that skilled nursing care is necessary. Sections 200 through 209 of these rules cover requirements for private duty nursing services. ~~*(3-19-07)*~~(3-13-20)T

02. Temporary Changes to Private Duty Nursing Rules During Declared State of Emergency Related to Novel Coronavirus Disease (COVID-19). In response to Idaho's declaration on 3/13/20 of a state of emergency related to COVID-19, the Department reserves the right to temporarily alter requirements and processes related to PDN services in order to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS-approved 1135 waiver through the duration of the emergency state. (3-13-20)T

(BREAK IN CONTINUITY OF SECTIONS)

300. PERSONAL CARE SERVICES (PCS).

01. Description of Personal Care Services (PCS). Under Sections 39-5601 through 39-5607, Idaho Code, it is the intent of the Department to provide personal care services (PCS) to eligible participants in their own homes or personal residences to prevent unnecessary institutional placement, to provide for the greatest degree of independence possible, to enhance quality of life, to encourage individual choice, and to maintain community integration. ~~*(3-19-07)*~~(3-13-20)T

02. Temporary Changes to PCS Rules During Declared State of Emergency Related to Novel Coronavirus Disease (COVID-19). In response to Idaho's declaration on 3/13/20 of a state of emergency related to COVID-19, the Department reserves the right to temporarily alter requirements and processes related to PCS

services, currently and through the duration of the emergency state, in order to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS approved 1135 waiver. In the event additional changes are required in the future, guidance will be posted on the Medicaid Information Releases webpage. Changes already in affect at the time of this rulemaking supersede existing rule and include: (3-13-20)T

a. Criminal History Background Checks. (Amends Subsections: 009.03.b., 009.03.k., 009.03.l., and 305.06) Newly hired direct care staff may begin rendering services prior to a completed criminal history background check as long as all of the conditions in Medicaid Information Release MA20-15 are met. (3-13-20)T

b. Direct Care Staff Training Requirements. (Amends Subsection: 305.02) Newly hired direct care staff may begin rendering services prior to the requirements associated with the provider's agency type or service array according to guidance in the Medicaid Information Release MA20-15. (3-13-20)T

c. General Compliance and Oversight Activities. (Amends Sections: 304 and 308) Service providers may, at their discretion, implement the following changes to routine compliance and oversight activities according to guidance in the Medicaid Information Release MA20-15. Allowable changes include: (3-13-20)T

i. Suspending supervisory on-sight visits. (3-13-20)T

ii. Suspending face-to-face service plan development. (3-13-20)T

iii. Utilizing telehealth to provide services. Medicaid Information Release MA20-07 provides further guidance for providers able to use telehealth. (3-13-20)T

iv. Allowing alternative formats for signature requirements (such as electronic signatures). (3-13-20)T

v. Suspending the Department's on-site agency reviews. (3-13-20)T

d. Postponement of Annual Redeterminations. (Amends Subsection: 302.04) The Bureau of Long Term Care (BLTC) may postpone annual redeterminations at the discretion of the Department in order to prioritize workloads related to assessments for new waiver applicants and participants with significant changes. (3-13-20)T

(BREAK IN CONTINUITY OF SECTIONS)

302. PERSONAL CARE SERVICES: ELIGIBILITY.

01. Financial Eligibility. The participant must be financially eligible for medical assistance under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," or 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." (3-19-07)

02. Other Eligibility Requirements. Bureau of Long Term Care (BLTC) will prior authorize payment for the amount and duration of all services when all of the following conditions are met: (3-20-20)

a. The BLTC finds that the participant is capable of being maintained safely and effectively in their own home or personal residence using PCS. (3-20-20)

b. The participant is an adult for whom a Uniform Assessment Instrument (UAI) has been completed, or a child for whom a children's PCS assessment has been completed; (3-29-10)

c. The BLTC reviews the documentation for medical necessity; and (3-20-20)

d. The participant has a plan of care that meets the person-centered planning requirements described in Sections 316 and 317 of these rules. (7-1-16)

03. State Plan Option. A participant who receives medical assistance is eligible for PCS under the State Medicaid Plan option if the Department finds they require PCS due to a medical condition that impairs their physical, mental function, or independence. (3-19-07)

04. Annual Eligibility Redetermination. The participant's eligibility for PCS must be redetermined at least annually under Subsections 302.01. through 302.03 of these rules. Throughout the duration of the COVID-19 state of emergency, the Bureau of Long Term Care (BLTC) may postpone annual redeterminations at the discretion of the Department in order to prioritize workloads related to assessments for new waiver applicants and participants with significant changes. ~~*(3-19-07)*~~(3-13-20)T

a. The annual financial eligibility redetermination must be conducted under IDAPA 16.03.01, “Eligibility for Health Care Assistance for Families and Children,” or 16.03.05, “Eligibility for Aid to the Aged, Blind, and Disabled (AABD).” BLTC will make the medical eligibility redetermination. The redetermination can be completed more often than once each year at the request of the participant, the Self-Reliance Specialist, the Personal Assistance Agency, the personal assistant, the supervising RN, the QIDP, or the physician. (3-20-20)

b. The medical redetermination assesses the following factors: (3-19-07)

i. The participant's continued need for PCS; (3-19-07)

ii. Discharge from PCS; and (3-19-07)

iii. Referral of the participant from PCS to a nursing facility. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

304. PERSONAL CARE SERVICES: PROCEDURAL REQUIREMENTS.

01. Service Delivery Based on Plan of Care or NSA. All PCS services are provided based on a written plan of care or a negotiated service agreement (NSA). The requirements for the NSA for participants in Residential 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 all participants who receive PCS in their own homes or in a PCS Family Alternate Care Home. (3-20-20)

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

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

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

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

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

b. Participant's Signature. The participant must sign the record of service delivery verifying that the services were delivered. The 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 in 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 System. Agencies may employ a software system that allows personal assistants to register their start and stop times and a list of services by placing a telephone call to the agency system from the participant's home. This system will not take the place of documentation requirements of Subsection 304.04 of these rules. (3-19-07)

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 or Certified Family Home. (7-1-16)

a. Participant in a Residential Assisted Living Facility. The additional PCS record requirements for participants in Residential Assisted Living Facilities are described in IDAPA 16.03.22, "Residential Assisted Living Facilities." (7-1-16)

b. Participant in a Certified Family Home. The additional PCS record requirements for participants in Certified Family Homes 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)

07. COVID-19. The sections of this rule may be subject to amendment by the BLTC for the duration of the COVID-19 state of emergency. Please consult Medicaid Information Release MA20-15 for additional guidance. (3-13-20)T

(BREAK IN CONTINUITY OF SECTIONS)

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

01. Responsibility for Quality. Personal Assistance Agencies, Residential Assisted Living Facilities, and Certified Family Homes 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, and Certified Family Homes 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)

05. COVID-19. The sections of this rule may be subject to amendment by the BLTC for the duration of the COVID-19 state of emergency. Please consult Medicaid Information Release MA20-15 for additional guidance. (3-13-20)T

(BREAK IN CONTINUITY OF SECTIONS)

314. RESIDENTIAL PROVIDER-OWNED OR CONTROLLED SETTING QUALITIES.
In addition to the setting requirements described in Section 313 of these rules, provider-owned or controlled settings, including Residential Assisted Living Facilities and Certified Family Homes that provide services to HCBS participants, must also meet the following conditions: (7-1-16)

01. Written Agreement. A lease, residency agreement, admission agreement, or other form of written agreement will be in place for each HCBS participant at the time of occupancy. The lease or residency agreement must provide protections that address eviction processes and appeals comparable to those provided under Idaho landlord tenant law. (7-1-16)

02. Privacy. Participants have the right to privacy within their residence. Each participant must have privacy in their sleeping or living unit to include the following: (7-1-16)

a. The right to entrance doors that are lockable by the individual, with only appropriate staff having keys to doors. (7-1-16)

b. Participants sharing units have a choice of roommates in that setting. (7-1-16)

03. Décor. Participants have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement. (7-1-16)

04. Schedules and Activities. Participants have the freedom and support to control their own schedules and activities. (7-1-16)

05. Access To Food. Participants have access to food at any time. (7-1-16)

06. Visitors. Participants are able to have visitors of their choosing at any time in accordance with the applicable requirements under IDAPA 16.03.19, "Certified Family Homes," and IDAPA 16.03.22, "Residential Assisted Living Facilities." Except, through the duration of the declared COVID-19 public health emergency, CFH providers may restrict visitation to minimize the spread of the COVID-19 infection. ~~(7-1-16)~~(3-13-20)T

07. Accessibility. The setting is physically accessible to the participant. (7-1-16)

(BREAK IN CONTINUITY OF SECTIONS)

317. HOME AND COMMUNITY-BASED PERSON-CENTERED SERVICE PLAN REQUIREMENTS.

All person-centered service plans must reflect the following components: (7-1-16)

01. Services And Supports. Clinical services and supports that are important for the participant's behavioral, functional, and medical needs as identified through an assessment. (7-1-16)

02. Service Delivery Preferences. Indication of what is important to the participant with regard to the service provider and preferences for the delivery of such services and supports. (7-1-16)

03. Setting Selection. HCBS settings selected by the participant or the participant's decision-making authority are chosen from among a variety of setting options, as required in Section 313 of these rules. The person-centered service plan must identify and document the alternative home and community setting options that were considered by the participant, or the participant's decision-making authority. (7-1-16)

04. Participant Strengths and Preferences. (7-1-16)

05. Individually Identified Goals and Desired Outcomes. (7-1-16)

06. Paid and Unpaid Services and Supports. Paid and unpaid services and supports that will assist the participant to achieve identified goals, and the providers of those services and supports, including natural supports. (7-1-16)

07. Risk Factors. Risk factors to the participant as well as people around the participant and measures in place to minimize them, including individualized back-up plans and strategies when needed. (7-1-16)

08. Understandable Language. Be understandable to the participant receiving services and supports, and the individuals important in supporting them. At a minimum, the written plan must be understandable, and written in plain language in a manner that is accessible to participants with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b). (7-1-16)

09. Plan Monitor. Identify the name of the individual or entity responsible for monitoring the plan. (7-1-16)

10. Plan Signatures. Be finalized and agreed to, by the participant, or the participant's decision-making authority, in writing, indicating informed consent. The plan must also be signed by all individuals and providers responsible for its implementation indicating they will deliver services according to the authorized plan of service and consistent with home and community-based requirements. (7-1-16)

a. Children's DD service providers responsible for implementation of the plan include the providers of those services defined in Sections 663 and 683 of these rules. (7-1-16)

b. Adult DD service providers responsible for implementation of the plan include those required to develop a provider implementation plan as defined in Sections 513 and 654 of these rules. (7-1-16)

c. Consumer-directed service providers responsible for implementation of the plan include the participant, Support Broker, and Fiscal Employment Agency as identified in IDAPA 16.03.13, "Consumer-Directed Services." (7-1-16)

d. Personal Care and Aged and Disabled Waiver service providers responsible for the implementation of the plan include the providers of those services defined in Sections 303 and 326 of these rules. Alternate format signatures may be used; refer to Medicaid Information Release MA20-15 for guidance. ~~(7-1-16)~~(3-13-20)T

11. Plan Distribution. Be distributed to the participant and the participant's decision-making authority, if applicable, and other people involved in the implementation of the plan. At a minimum, the following providers will receive a copy of the plan: (7-1-16)

a. Children's DD providers of services defined in Sections 663 and 683 of these rules as identified on the plan of service developed by the family-centered planning team. (7-1-16)

b. Adult DD service providers required to develop a provider implementation plan as defined in Sections 513 and 654 of these rules. Additionally, the participant will determine during the person-centered planning process whether the service plan, in whole or in part, will be distributed to any other developmental disability service provider. (7-1-16)

c. Consumer-Directed service providers as defined in IDAPA 16.03.13, "Consumer-Directed Services," Section 110. Additionally, the participant, or the participant's decision-making authority will determine during the person-centered planning process whether the service plan, in whole or in part, will be distributed to any other community support worker or vendors. (7-1-16)

d. Personal Care and Aged and Disabled Waiver service providers furnishing those services defined in Sections 303 and 326 of these rules. (7-1-16)

12. Residential Requirements. For participants living in residential provider owned or controlled settings as described in Section 314 of these rules, the following additional requirements apply: (7-1-16)

a. Options described in Subsection 317.03 of this rule must include a residential setting option that allows for private units. Selection of residential settings will be based on the participant's needs, preferences, and resources available for room and board. (7-1-16)

b. Any exception to residential provider owned or controlled setting qualities as described in Section 314 of these rules must be documented in the person-centered plan as described in Section 315 of these rules. (7-1-16)

(BREAK IN CONTINUITY OF SECTIONS)

320. AGED AND DISABLED WAIVER SERVICES.

01. Description of Aged and Disabled Services. Idaho's elderly and physically disabled citizens should be able to maintain self-sufficiency, individuality, independence, dignity, choice, and privacy in a cost-effective home-like setting. When possible, services should be available in the consumer's own home and community regardless of their age, income, or ability and should encourage the involvement of natural supports, such as family, friends, neighbors, volunteers, church, and others. ~~*(3-19-07)*~~(3-13-20)T

02. Temporary Changes to Aged and Disabled Rules During Declared State of Emergency Related to Novel Coronavirus Disease (COVID-19). In response to Idaho's declaration on 3/13/20 of a state of emergency related to COVID-19, the Department reserves the right to temporarily alter requirements and processes related to Aged and Disabled waiver services, currently and through the duration of the emergency state, in order to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS-approved 1135 waiver or HCBS Attachment K amendment to the existing Aged and Disabled waiver. In the event additional changes are required in the future, guidance will be posted on the https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx webpage. Changes already in affect at the time of this rulemaking supersede existing rule and include: (3-13-20)T

a. Criminal History Background Checks. (Amends Subsections: 009.03.b., 009.03.k., 009.03.l., 329.03.c., 329.07, 329.09, 329.12.d., 329.14, 329.15, 329.17.a.vi., 329.18, 329.19.d., 329.20, 329.21.c.) Newly hired direct care staff may begin rendering services prior to a completed criminal history background check as long as all of the conditions in https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA2015.pdf are met. (3-13-20)T

b. Direct Care Staff Training Requirements. (Amends Subsections: 329.03, 329.10.f., 329.12.g., 329.13.c., 329.14, 329.15, 329.17.a. through d., 329.21.d.) Newly hired direct care staff may begin rendering services prior to the requirements associated with the provider's agency type or service array according to guidance in the https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA2015.pdf. (3-13-20)T

c. General Compliance and Oversight Activities. (Amends Sections: 328 and 329) Service providers may, at their discretion, implement the following changes to routine compliance and oversight activities according to guidance in the https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA2015.pdf. Allowable changes include: (3-13-20)T

i. Suspending supervisory on-sight visits. (3-13-20)T

ii. Suspending face-to-face service plan development. (3-13-20)T

iii. Utilizing telehealth to provide services. https://healthandwelfare.idaho.gov/LinkClick.aspx?fileticket=xMwhG1MtoaI%3d&tabid=264&portalid=0&mid=18434 provides further guidance for providers able to use telehealth. (3-13-20)T

iv. Allowing alternative formats for signature requirements (such as electronic signatures). (3-13-20)T

v. Suspending the Department's on-site agency reviews. (3-13-20)T

d. Postponement of Annual Redeterminations. (Amends Subsection: 323.03) The Bureau of Long Term Care (BLTC) may postpone annual redeterminations at the discretion of the Department in order to prioritize workloads related to assessments for new waiver applicants and participants with significant changes. (3-13-20)T

(BREAK IN CONTINUITY OF SECTIONS)

328. AGED AND DISABLED WAIVER SERVICES: PROCEDURAL REQUIREMENTS.

01. Role of the Department. The Department or its contractor will provide for the administration of the UAI, and the development of the initial individual service plan. This will be done either by Department staff or a contractor. The Department or its contractor will review and approve all individual service plans, and will authorize Medicaid payment by type, scope, and amount. (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 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 Plan of Care. All services that are provided must be based on a written plan of care. (3-30-07)

a. The plan of care is developed by the plan of care team 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 written 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 the participant's living arrangement unless authorized to be kept elsewhere by the Department. Failure to maintain documentation according to these rules will result in the recoupment of funds paid for undocumented services. (4-4-13)

c. The individual service plan initiated by the Department or its contractor must specify which waiver services are required by the participant. The plan will contain all elements required by Subsection 328.04.a. of these rules and a copy of the most current individual service plan will be maintained in the participant's home and will be available to all service providers and the Department. A copy of the current individual service plan and UAI will be

available from the Department or its contractor to each individual service provider with a release of information signed by the participant or legal representative. (4-4-13)

d. Record requirements for participants in residential care or assisted living facilities are described in IDAPA 16.03.22, "Residential Assisted Living Facilities." (4-4-13)

e. Record requirements for participants in certified family homes are described in IDAPA 16.03.19, "Certified Family Homes." (4-4-13)

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)

11. COVID-19. The sections of this rule may be subject to amendment by the BLTC for the duration of the COVID-19 state of emergency. Please consult Medicaid Information Release MA20-15 for additional guidance. (3-13-20)T

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23. COVID-19. The sections of this rule may be subject to amendment by the BLTC for the duration of the COVID-19 state of emergency. Please consult Medicaid Information Release MA20-15 for additional guidance. (3-13-20)T

(BREAK IN CONTINUITY OF SECTIONS)

350. TRANSITION MANAGEMENT.

Transition management provides relocation assistance and intensive service coordination activities to assist nursing facility, hospital, IMD and ICF/ID residents to transition to community settings of their choice. Transition managers provide oversight and coordination activities for participants during a transitional period up to twelve (12) months following a return to the community. This provider type will function as a liaison between the participant, institutional or facility discharge staff, other individuals as designated by the participant and the Department to support a successful and sustainable transition to the community. A participant is eligible to receive transition management when planning to discharge from a qualifying institution after residing within that institution for a minimum of forty-five (45) Medicaid-reimbursed days. (4-11-19)

01. Provider Qualifications. Transition managers must: (4-11-19)

a. Satisfactorily complete a criminal history and background check in accordance with IDAPA

16.05.06, "Criminal History and Background Checks"; (4-11-19)

b. Have documented successful completion of the Department approved Transition Manager training prior to providing any transition management and transition services; (4-11-19)

c. Have a Bachelor's Degree in a human services field from a nationally accredited university or college; or three (3) years' supervised work experience with the population being served; and (4-11-19)

d. Be employed with a provider type approved by the Department. (4-11-19)

02. Service Description. Transition management includes the following activities: (4-11-19)

a. A comprehensive assessment of health, social, and housing needs; (4-11-19)

b. Development of housing options with each participant, including assistance with housing choices, applications, waitlist follow-up, roommate selection, and introductory visits; (4-11-19)

c. Assistance with tasks necessary to accomplish a move from the institutional setting; (4-11-19)

d. Securing Transition Services in accordance with Subsection 326.17 or Subsection 703.15 of these rules in order to make arrangements necessary to move, including: (4-11-19)

i. Obtaining durable medical equipment, assistive technology, and medical supplies, if needed; (4-11-19)

ii. Arranging for home modifications, if needed; (4-11-19)

iii. Applying for public assistance, if needed; (4-11-19)

iv. Arranging household preparations including scheduling moving and/or cleaning services, utility set-up, purchasing furniture, and household supplies, if needed; (4-11-19)

e. Coordinating with others involved in plan development for the participant to ensure successful transition and establishment in a community setting; (4-11-19)

f. Providing post-transition support, including assistance with problem solving, dependency and isolation concerns, consumer-directed services and supports, Medicaid Enhanced Plan Benefits when applicable, and community inclusion. (4-11-19)

03. Service Limitations. Transition management is limited to seventy-two (72) hours per participant per qualifying transition. (4-11-19)

04. Temporary Changes to Transition Management Rules During Declared State of Emergency Related to Novel Coronavirus Disease (COVID-19). In response to Idaho's declaration on 3/13/20 of a state of emergency related to COVID-19, the Department reserves the right to temporarily alter requirements and processes related to Transition Management services, currently and through the duration of the emergency state, in order to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS approved 1135 waiver. In the event additional changes are required in the future, guidance will be posted on the Medicaid Information Releases webpage. Changes already in affect at the time of this rulemaking supersede existing rule and include: (3-13-20)T

a. Criminal History Background Checks. (Amends Subsection: 350.01.a.) Newly hired direct care staff may begin rendering services prior to a completed criminal history background check as long as all of the conditions in Medicaid Information Release MA20-15 are met. (3-13-20)T

b. General Compliance and Oversight Activities. (Amends Subsection: 350.02) Service providers may, at their discretion, implement the following changes to routine compliance and oversight activities according to

guidance in the Medicaid Information Release MA20-15. Allowable changes include: (3-13-20)T

i. Suspending face-to-face service plan development. (3-13-20)T

ii. Utilizing telehealth to provide services. Medicaid Information Release MA20-07 provides further guidance for providers able to use telehealth. (3-13-20)T

iii. Allowing alternative formats for signature requirements (such as electronic signatures). (3-13-20)T

(BREAK IN CONTINUITY OF SECTIONS)

513. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PLAN OF SERVICE.

In collaboration with the participant, the Department will assure that the participant has one (1) plan of service. This plan of service is based on the individualized participant budget referred to in Section 514 of these rules and must identify all services and supports. Participants may develop their own plan or designate a paid or non-paid plan developer. In developing the plan of service, the plan developer and the participant must identify services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. Authorized services must be delivered by providers who are selected by the participant. (3-29-12)

01. Qualifications of a Paid Plan Developer. Neither a provider of direct service to the participant nor the assessor may be chosen to be the paid plan developer. Family members and all others who wish to be paid for plan development must be employed as a service coordinator as defined in Sections 729 through 732 of these rules. (3-19-07)

02. Plan Development. All participants must direct the development of their service plan through a person-centered planning process. Individuals invited to participate in the person-centered planning process will be identified by the participant and may include family members, guardian, or individuals who are significant to the participant. In developing the plan of service, the plan developer and participant must identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals and outcomes. (7-1-16)

a. The plan of service must be submitted within forty-five (45) days prior to the expiration of the existing plan of service unless delayed because of participant unavailability due to extenuating circumstances. If the plan is not submitted within this time period, authorization for provider payments may be terminated. (7-1-16)

b. The plan development process must meet the person-centered planning requirements described in Section 316 of these rules. (7-1-16)

c. The participant may facilitate their own person-centered planning meeting, or designate a paid or non-paid plan developer to facilitate the meeting. Individuals responsible for facilitating the person-centered planning meeting cannot be providers of direct services to the participant. (7-1-16)

03. Prior Authorization Outside of These Rules. The plan developer must ensure that all services that require prior authorization outside of these rules are submitted to the appropriate unit of the Department. These services include: (3-19-07)

a. Durable Medical Equipment (DME); (3-19-07)

b. Transportation; and (3-19-07)

c. Physical therapy, occupational therapy, and speech-language pathology services. (7-1-13)

04. No Duplication of Services. The plan developer will ensure that there is no duplication of services. Duplicate services will not be authorized. (3-29-12)

05. Plan Monitoring. The participant, service coordinator or plan monitor must monitor the plan. The plan developer is the plan monitor unless there is a service coordinator, in which case the service coordinator assumes the roles of both service coordinator and plan monitor. The planning team must identify the frequency of monitoring, which must be at least every ninety (90) days. Plan monitoring must include the following: (3-19-07)

a. Review of the plan of service in a face-to-face contact with the participant to identify the current status of programs and changes if needed. The face-to-face encounter may occur via synchronous interaction telehealth, as defined in Title 54, Chapter 57, Idaho Code; ~~(3-19-07)~~(3-13-20)T

b. Contact with service providers to identify barriers to service provision; (3-19-07)

c. Discuss with participant satisfaction regarding quality and quantity of services; and (3-19-07)

d. Review of provider status reviews. (3-29-12)

e. The provider will immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as well as injuries of unknown origin to the agency administrator, the Department, the adult protection authority, and any other entity identified under Section 39-5303, Idaho Code, or federal law. (3-29-12)

06. Provider Status Reviews. Service providers, with exceptions identified in Subsection 513.09 of these rules, must report the participant's progress toward goals to the plan monitor on the provider status review when the plan has been in effect for six (6) months and at the annual person-centered planning meeting. The semi-annual and annual reviews must include: (7-1-16)

a. The status of supports and services to identify progress; (3-19-07)

b. Maintenance; or (3-19-07)

c. Delay or prevention of regression. (3-19-07)

07. Content of the Plan of Service. The plan of service must identify the type of service to be delivered, goals to be addressed within the plan year, frequency of supports and services, and identified service providers. The plan of service must include activities to promote progress, maintain functional skills, or delay or prevent regression. (3-19-07)

a. The written plan of service must meet the person-centered planning requirements described in Section 317 of these rules. (7-1-16)

b. The written plan of service must be finalized and agreed to according to procedural requirements described in Section 704 of these rules. (7-1-16)

c. The Department will distribute a copy of the plan of service to adult DD service providers defined in Section 317 of these rules. Additionally, the plan developer will be responsible to distribute a copy of the plan of service, in whole or part, to any other developmental disability service provider identified by the participant during the person-centered planning process. (7-1-16)

08. Informed Consent. Unless the participant has a guardian who retains full decision-making authority, the participant must make decisions regarding the type and amount of services required. Prior to plan development, the plan developer must document that they have provided information and support to the participant to maximize their ability to make informed choices regarding the services and supports they receive and from whom. During plan development and amendment, planning team members must each indicate whether they believe the plan meets the needs of the participant, and represents the participant's choice. If there is a conflict that cannot be resolved among person-centered planning members or if a member does not believe the plan meets the participant's needs or represents the participant's choice, the plan or amendment may be referred to the Bureau of Developmental Disability Services to negotiate a resolution with members of the planning team. (7-1-16)

09. Provider Implementation Plan. Each provider of Medicaid services must develop an implementation plan that complies with home and community-based setting requirements and identifies specific objectives that relate to goals finalized and agreed to in the participant's authorized plan of service. These objectives must demonstrate how the provider will assist the participant to meet the participant's goals, desired outcomes, and needs identified in the plan of service. (7-1-16)

a. Exceptions. An implementation plan is not required for waiver providers of: (3-19-07)

i. Specialized medical equipment; (3-19-07)

ii. Home delivered meals; (3-19-07)

iii. Environmental accessibility adaptations; (7-1-16)

iv. Non-medical transportation; (3-19-07)

v. Personal emergency response systems (PERS); (3-19-07)

vi. Respite care; and (3-19-07)

vii. Chore services. (3-19-07)

b. Time for Completion. Implementation plans must be completed within fourteen (14) days of receipt of the authorized plan of service or the service start date, whichever is later. (7-1-16)

i. If the authorized plan of service is received after the service start date, service providers must support billing by documenting service provision as agreed to by the participant and consistent with Section 704 of these rules. (7-1-16)

ii. Implementation plan revision must be based on changes to the needs of the participant. (7-1-16)

c. Documentation of Changes. Documentation of Implementation Plan changes will be included in the participant's record. This documentation must include, at a minimum, the reason for the change, documentation of coordination with other service providers (where applicable), the date the change was made, the signature of the person making the change complete with the date and title. (3-19-07)

10. Home and Community-Based Services Plan of Service Signature. Upon receipt of the authorized plan of service, HCBS providers responsible for the implementation of the plan as identified in Section 317 of these rules must sign the plan indicating they will deliver services according to the finalized and authorized plan of service, and consistent with home and community-based requirements. Each HCBS provider responsible for the implementation of the plan must maintain their signed plan in the participant's record. Documentation of signature must include the signature of the professional responsible for service provision complete with their title and the date signed. Provider signature will be completed each time an initial or annual plan of service is implemented. (7-1-16)

11. Addendum to the Plan of Service. (7-1-16)

a. A plan of service may be adjusted during the year with an addendum to the plan. These adjustments must be based on a change to a cost, addition of a service or increase to a service, or a change of provider. Additional assessments or information may be clinically necessary. Adjustment of the plan of service is subject to prior authorization by the Department. (7-1-16)

b. When a service plan has been adjusted, the Department will distribute a copy of the addendum to HCBS providers responsible for the implementation of the plan of service as identified in Section 317 of these rules. (7-1-16)

c. Upon receipt of the addendum, the HCBS provider must sign the addendum indicating they have

reviewed the plan adjustment and will deliver services accordingly. Documentation must include the signature of the professional responsible for service provision complete with their title and the date signed, and must be maintained in the participant's record. Provider signature will be completed each time an addendum is authorized. (7-1-16)

12. Annual Reauthorization of Services. A participant's plan of service must be reauthorized annually. The Department will review and authorize the new plan of service prior to the expiration of the current plan. (3-19-07)

a. Plan Developer Responsibilities for Annual Reauthorization. A new plan of service must be provided to the Department by the plan developer at least forty-five (45) days prior to the expiration date of the current plan. Prior to this, the plan developer must: (3-19-07)

i. Notify the providers who appear on the plan of service of the annual review date. (3-19-07)

ii. Obtain a copy of the current annual provider status review from each provider for use by the person-centered planning team. Each provider status review must meet the requirements in Subsection 513.06 of these rules. (7-1-16)

iii. Convene the person-centered planning team to develop a new plan of service; inviting individuals to participate that have been identified by the participant. (7-1-16)

b. Evaluation and Prior Authorization of the Plan of Service. The plan of service will be evaluated and prior authorized in accordance with the requirements in Sections 507 and 513 of these rules. (3-19-07)

c. Adjustments to the Annual Budget and Services. The annual budget and services may be adjusted by the Department based on demonstrated outcomes, progress toward goals and objectives, and benefit of services. (3-29-12)

d. Annual Status Reviews Requirement. If the provider's annual status reviews are not submitted with the annual plan, services will not be authorized at the time of the annual reauthorization. These services may be added to the plan of service only by means of an addendum to the plan in accordance with Subsection 513.10 of these rules. (7-1-16)

e. Reapplication After a Lapse in Service. For participants who are re-applying for service after a lapse in service, the assessor will evaluate whether assessments are current and accurately describe the status of the participant. (3-19-07)

f. Annual Assessment Results. An annual assessment will be completed in accordance with Section 512 of these rules. (3-19-07)

13. Complaints and Administrative Appeals. (3-29-12)

a. Participant complaints about the assessment process, eligibility determination, plan development, quality of service, and other relevant concerns may be referred to the Division of Medicaid. (3-29-12)

b. A participant who disagrees with a Department decision regarding program eligibility and authorization of services under these rules may file an appeal. Administrative appeals are governed by provisions of IDAPA 16.05.03, “Contested Case Proceedings and Declaratory Rulings.” (3-29-12)

(BREAK IN CONTINUITY OF SECTIONS)

522. CHILDREN’S DD HCBS STATE PLAN OPTION: ELIGIBILITY DETERMINATION.
Final determination of a participant's eligibility will be made by the Department. (3-20-20)

01. Initial Eligibility Assessment Developmental Disability Determination. The Department, or its

contractor, will determine if a child meets established criteria for a developmental disability by completing the following: (3-20-20)

a. Documentation of a participant's developmental disability diagnosis, demonstrated by: (3-20-20)

i. A medical assessment that contains medical information that accurately reflects the current status of the participant or establishes categorical eligibility in accordance with Section 66-402(5)(a), Idaho Code; or (3-20-20)

ii. The results of psychometric testing, if eligibility for developmental disabilities services is based on intellectual disability and there is no prior testing, or prior testing is inconclusive or invalid. Initial eligibility determinations also require documentation of diagnosis for a participant whose eligibility is based on developmental disabilities other than intellectual disability. (3-20-20)

b. An assessment of functional skills that reflects the participant's current functioning. The Department, or its contractor, will administer a functional assessment for use in initial eligibility determination of developmental disability eligibility. Annually, a new functional assessment may be required if the assessor determines that additional documentation is necessary to determine the participant's level of care criteria and must be completed sixty (60) calendar days before the expiration of the current plan of service. (3-20-20)

c. Medical, social, and developmental assessment (MSDA) summary. (3-20-20)

02. Determination for Children's DD HCBS State Plan Option. The Department, or its contractor, will determine if a child meets the established criteria necessary to receive children's DD HCBS state plan option services by verifying: (3-20-20)

a. The participant is birth through seventeen (17) years of age; and (3-20-20)

b. The participant has a developmental disability as defined under Sections 500, 501, and 503 these rules and Section 66-402, Idaho Code, and has a demonstrated need for Children's DD HCBS state plan option services; and (3-20-20)

c. The participant qualifies for Medicaid under an eligibility group who meets the needs-based criteria of the 1915(i) benefit for children with developmental disabilities and falls within the income requirements as specified in Attachment 2.2-A of the Idaho State Plan under Title XIX. (3-20-20)

03. Individualized Budget Methodology.
The following four (4) categories are used when determining individualized budgets for children with developmental disabilities. (3-20-20)

a. Children's DD - Level I. Children meeting developmental disabilities criteria. (3-20-20)

b. Children's DD - Level II. (3-20-20)

i. Children who qualify based on functional limitations when their composite full-scale standard score of less than fifty (50); or (3-20-20)

ii. Children who have an overall standard score up to fifty-three (53) when combined with a maladaptive behavior score of greater than one (1) to less than two (2) standard deviations from the mean. (3-20-20)

c. Children's DD - Level III. (3-20-20)

i. Children who qualify based on functional limitations when their composite full-scale standard score is less than fifty (50); and (3-20-20)

ii. Have an autism spectrum disorder diagnosis. (3-20-20)

d. Children's DD - Level IV. Children who qualify based on maladaptive behaviors when their maladaptive behavior score is two (2) standard deviations or greater from the mean. (3-20-20)

04. Participant Notification of Budget Amount. The Department, or its contractor, will notify each participant of his set budget amount as part of the eligibility determination process. The notification will include how the participant may appeal the set budget amount. (3-20-20)

05. ~~***Annual***~~ **Re-Evaluation**. Individualized budgets will be re-evaluated ~~*annually*~~. At the request of the participant, the Department, or its contractor, will also re-evaluate the set budget amount when there are documented changes that may support placement in a different budget category as outlined in Subsection 522.03 of this rule. ~~*(3-20-20)*~~(3-13-20)T

523. CHILDREN'S DD HCBS STATE PLAN OPTION: COVERAGE AND LIMITATIONS.

All children's DD HCBS must be identified on a plan of service developed by the family-centered planning team. The following services must be prior authorized and are reimbursable when provided in accordance with these rules. (3-20-20)

01. Respite. Respite provides supervision to the participant on an intermittent or short-term basis because of the need for relief of the primary unpaid caregiver or in response to a family emergency or crisis. Respite may be provided by a DDA or by an independent respite provider. An independent respite provider may be a relative of the participant. Payment for respite does not include room and board. Respite may be provided in the participant's home, the private home of the independent respite provider, a DDA, or in the community. The following limitations apply: (3-20-20)

a. Respite must not be provided on a continuous, long-term basis as a daily service that would enable an unpaid caregiver to work. (3-20-20)

b. Respite must only be offered to participants living with an unpaid caregiver who requires relief. (3-20-20)

c. Respite cannot exceed fourteen (14) consecutive days. (3-20-20)

d. Respite must not be provided at the same time other Medicaid services are being provided with the exception of when an unpaid caregiver is receiving family education. (3-20-20)

e. The respite provider must not use restraints on participants, other than physical restraints in the case of an emergency. Physical restraints may be used in an emergency to prevent injury to the participant or others and must be documented in the participant's record. (3-20-20)

f. When respite is provided as group respite, the following applies: (3-20-20)

i. When group respite is center-based, there must be a minimum of one (1) qualified staff providing direct services to every two (2) to six (6) participants. As the number and severity of the participants with functional impairments or behavioral needs increase, the participant ratio must be adjusted accordingly. (3-20-20)

ii. When group respite is community-based, there must be a minimum of one (1) qualified staff providing direct services to every two (2) ~~*or three*~~ to six (~~*3*~~6) participants. As the number and severity of the participants with functional impairments or behavioral needs increase, the participant ratio in the group must be adjusted ~~*from three (3) to two (2)*~~ accordingly. ~~*(3-20-20)*~~(3-13-20)T

g. Respite cannot be provided as center-based by an independent respite provider. An independent respite provider may only provide group respite when the following are met: (3-20-20)

i. The independent respite provider is a relative; and ~~*(3-20-20)*~~(3-13-20)T

~~*ii. The independent respite provider is delivering respite to no more than three (3) eligible siblings; and*~~ ~~*(3-20-20)*~~

ii~~i~~. The service is delivered in the home of the participants or the independent respite provider. (3-20-20)

02. Community-Based Supports. Community-based supports provides assistance to a participant by facilitating the participant's independence and integration into the community. This service provides an opportunity for participants to explore their interests, practice skills learned in other therapeutic environments, and learn through interactions in typical community activities. Integration into the community enables participants to expand their skills related to activities of daily living and reinforces skills to achieve or maintain mobility, sensory-motor, communication, socialization, personal care, relationship building, and participation in leisure and community activities. Community-based supports must: (3-20-20)

a. Not supplant services provided in school or therapy, or supplant the role of the primary caregiver; (3-20-20)

b. Ensure the participant is involved in age-appropriate activities in environments typical peers access according to the ability of the participant; and (3-20-20)

c. Have a minimum of one (1) qualified staff providing direct services ~~*to two (2) or three (3)*~~ for up to six (6) participants when provided as group community-based supports. As the number and severity of the participants with functional impairments or behavioral needs increase, the staff participant ratio must be adjusted accordingly. ~~*(3-20-20)*~~(3-13-20)T

03. Family Education. Family education is professional assistance to family members, or others, who participate in caring for the eligible participant to help them better meet the needs of the participant by providing an orientation to developmental disabilities and to educate families on generalized strategies for behavioral modification and intervention techniques specific to the participant's diagnosis. It offers education that is specific to the needs of the family and participant as identified on the plan of service. (3-20-20)

a. Family education providers must maintain documentation of the training in the participant's record including the provision of activities outlined in the plan of service. (3-20-20)

~~***b.*** *Family education may be provided in a group setting not to exceed five (5) participants' families.* *(3-20-20)*~~

04. Family-Directed Community Supports (FDCS). Families of participants eligible for the children's DD HCBS state plan option may choose to direct their individualized budget rather than receive the traditional services described in Subsections 523.01 through 523.04 of this rule when the participant lives at home with their parent or legal guardian. All services provided under FDCS option must be delivered on a one-to-one basis, must be identified on a plan of service developed by the family-centered planning team, and must be prior authorized. Additional requirements for this option are outlined in Sections 520 through 522, Subsections 523.05-06 524.01-03, 524.07-10, and 525.01, and Section 528, of these rules, and IDAPA 16.03.13, "Consumer-Directed Services." (3-20-20)

05. Limitations. (3-20-20)

a. Children's DD HCBS state plan option services are limited by the participant's individualized budget amount. (3-20-20)

b. Services offered in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," may not be authorized under these rules. (3-20-20)

c. Duplication of services cannot be provided. Services are considered duplicate when: (3-20-20)

i. An adaptive equipment and support service address the same goal; (3-20-20)

ii. Multiple adaptive equipment items address the same goal; (3-20-20)

iii. Goals are not separate and unique to each service provided; or (3-20-20)

iv. When more than one (1) service is provided at the same time, unless otherwise authorized. (3-20-20)

d. For the children's DD HCBS state plan option listed in Subsections 523.01, 523.02, and 523.03 of this rule, the following are excluded for Medicaid payment: (3-20-20)

i. Vocational services; (3-20-20)

ii. Educational services; and (3-20-20)

iii. Recreational services. (3-20-20)

06. HCBS Compliance. Providers of children's DD HCBS are responsible for ensuring that they meet the setting quality requirements described in Section 313 of these rules, as applicable, and must comply with associated Department quality assurance activities. The Department may take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with any term or provision of the provider agreement, or any applicable state or federal regulation. (3-20-20)

524. CHILDREN'S DD HCBS STATE PLAN OPTION: PLAN OF SERVICE PROCESS.
In collaboration with the participant, the Department must ensure that the participant has one (1) plan of service. This plan of service is developed within the individualized participant budget referred to in Section 522 of these rules and must identify all services. The plan of service must identify services and supports if available outside of Medicaid-funded services that can help the participant meet desired goals. Paid plan development must be provided by the Department, or its contractor, in accordance with Section 316 of these rules. (3-20-20)

01. History and Physical. Prior to the development of the plan of service, the plan developer must obtain a current history and physical completed by a practitioner of the healing arts. ~~*This is required at least annually or more frequently as determined by the practitioner.*~~ For participants in Healthy Connections, the Healthy Connections physician may conduct the history and physical and refer the participant for other evaluations. ~~*(3-20-20)*~~(3-13-20)T

02. Plan of Service Development. The plan of service must be developed with the child participant, the participant's decision-making authority, and facilitated by the Department, or its designee. If the participant is unable to attend the family-centered planning meeting, the plan of service must contain documentation to justify the participant's absence. With the decision-making authority's consent, the family-centered planning team may include other family members or participants who are significant to the participant. (3-20-20)

03. Requirements for Collaboration. Providers of children's DD HCBS must coordinate with the family-centered planning team as specified on the plan of service. (3-20-20)

04. Plan Monitoring. The family-centered planning team must identify the frequency of monitoring, which must be at least every six (6) months and document the plan monitor's name along with the monitoring frequency on the plan. The plan developer is considered the plan monitor and must meet face-to-face with the participant and the participant's decision-making authority ~~*at least annually*~~. Plan monitoring includes reviewing the plan of service with the participant and the participant's decision-making authority to identify the current status of services, any barriers to services, and any necessary changes to the plan of service. ~~*(3-20-20)*~~(3-13-20)T

05. Provider Status Reviews. The service providers identified in Section 526 of these rules must report the participant's progress toward goals to the plan monitor. The provider must complete a six (6) month and annual provider status review. ~~*The six (6) month status review must be submitted thirty (30) days prior to the six (6) month date listed on the plan of service. The annual provider status review must be submitted to the plan monitor forty-five (45) calendar days prior to the expiration of the existing plan of service.*~~ ~~*(3-20-20)*~~(3-13-20)T

06. Addendum to the Plan of Service. A plan of service may be adjusted during the year with an

addendum to the plan and these adjustments must be based on changes in a participant's need and requested by the parent or legal guardian. Adjustment of the plan of service requires the decision-making authority's signature and prior authorization by the Department. The Department will distribute the addendum to the providers involved in the addendum's implementation. Upon receipt by the provider, the addendum must be reviewed, signed, and returned to the Department, with a copy maintained in the participant's record. (3-20-20)

07. **~~_Annual_~~ Reauthorization of Services**. A participant's plan of service must be reauthorized ~~_annually_~~. The Department must review and authorize the new plan of service ~~_prior to the expiration of the current plan_~~. ~~_(3-20-20)_~~(3-13-20)T

08. **~~_Annual_~~ Eligibility Determination Results**. A~~_n annual_~~ determination must be completed in accordance with Section 522 of these rules. ~~_(3-20-20)_~~(3-13-20)T

09. **Adjustments to the Annual Budget and Services**. The annual budget may be adjusted when there are documented changes that may support placement in a different budget category as identified in Section 522 of these rules. Services may be adjusted at any time during the plan year. (3-20-20)

10. **Reapplication After a Lapse in Service**. For participants who are re-applying for service, the assessor must evaluate whether assessments are current and accurately describe the status of the participant. (3-20-20)

525. CHILDREN'S DD HCBS STATE PLAN OPTION: PROCEDURAL REQUIREMENTS.

01. **Requirements for Prior Authorization**. Prior authorization is to ensure the provision of the right care, in the right place, at the right price, and with the right outcomes in order to enhance health and safety, and to promote participants' rights, self-determination, and independence. Prior authorization is intended to help ensure the provision of necessary and appropriate services and supports. Services are reimbursable if they are identified on the authorized plan of service and are consistent with rules for HCBS as described in Sections 310 through 313 and 316 and 317 of these rules, and for the specific services included on the plan. Delivery of each service identified on the plan of service cannot be initiated until the plan has been signed by the parent or participant's decision-making authority, the provider responsible for service provision, and has been authorized by the Department. (3-20-20)

02. **Requirements for Supervision**. All children's DD HCBS provided by a DDA or independent provider must be supervised. The supervisor must meet the intervention specialist or professional qualifications as outlined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 575, "Children's Habilitation Intervention Services." The observation and review of the direct services must be performed by all staff ~~_on at least a monthly basis, or more often as necessary,_~~ to ensure staff demonstrate the necessary skills to correctly provide the services as defined in this rule set. ~~_(3-20-20)_~~(3-13-20)T

03. **Requirements for Quality Assurance**. Providers of DD HCBS state plan option must demonstrate high quality of services through an internal quality assurance review process. (3-20-20)

04. **General Requirements for Program Documentation**. The provider must maintain records for each participant served. Program documentation must be maintained by the independent provider or DDA in accordance with IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse, and Misconduct," Section 101. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. For each participant, the following program documentation is required: (3-20-20)

a. Date and time of visit; (3-20-20)

b. Support services provided during the visit; (3-20-20)

c. A summary of session or services provided; (3-20-20)

d. Length of visit, including time in and time out; (3-20-20)

e. Location of service; and (3-20-20)

f. Signature of the individual providing the service and date signed. (3-20-20)

05. Community-Based Supports Documentation. In addition to the general requirements listed in Subsection 525.04 of this rule, the supervisor must complete at a minimum, six (6) month and annual provider status reviews for community-based support services provided. These provider status reviews must be completed more frequently when required on the plan of service and must: (3-20-20)

a. Be submitted to the plan monitor; and (3-20-20)

b. Be submitted on Department-approved forms. (3-20-20)

06. Family Education Documentation. In addition to the general requirements listed in Subsection 525.04 of this rule, the DDA or independent provider must survey the parent or legal guardian's satisfaction of the service immediately following a family education session. (3-20-20)

526. CHILDREN'S DD HCBS STATE PLAN OPTION: PROVIDER QUALIFICATIONS AND DUTIES.
All providers of children's DD HCBS state plan option must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (3-20-20)

01. Respite. Respite may be provided by an agency that is certified as a DDA or by an independent respite provider. An independent respite provider is an individual who has entered into a provider agreement with the Department. Providers of respite must meet the following minimum qualifications: (3-20-20)

a. Be at least sixteen (16) years of age when employed by a DDA; or (3-20-20)

b. Be at least eighteen (18) years of age and be a high school graduate, or have a GED, to act as an independent respite provider; and (3-20-20)

c. Have received instructions in the needs of the participant who will be provided the service; (3-20-20)

d. Demonstrate the ability to provide services according to a plan of service; (3-20-20)

e. Satisfactorily complete a criminal history background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks,"; and ~~(3-20-20)~~(3-13-20)T

f. When employed by a DDA, be certified in CPR and first aid in accordance with the general training requirements under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." Independent respite providers must be certified in CPR and first aid prior to delivering services and must maintain current certification thereafter. (3-20-20)

02. Community-Based Support. Community-based supports may be provided by a DDA or an independent provider. An independent provider is an individual who has entered into a provider agreement with the Department. Providers of community-based supports must meet the following minimum qualifications: (3-20-20)

a. Be at least eighteen (18) years of age; (3-20-20)

b. Have received instructions in the needs of the participant who will be provided the service; (3-20-20)

c. Demonstrate the ability to provide services according to a plan of service; (3-20-20)

d. Have six (6) months supervised experience working with children with developmental disabilities. This can be achieved in the following ways: (3-20-20)

i. Have previous work experience gained through paid employment, university practicum experience,

or internship; or (3-20-20)

ii. Have on-the-job supervised experience gained through employment with increased supervision. Experience is gained by completing at least six (6) hours of job shadowing prior to the delivery of direct support services~~, and a minimum of weekly face-to-face supervision with the supervisor for a period of six (6) months while delivering services~~. ~~(3-20-20)~~(3-13-20)T

iii. For individuals providing community-based supports to children birth to age three (3), the six (6) months of documented experience must be with infants, toddlers, or children birth to age three (3) years of age with developmental delays or disabilities. (3-20-20)

e. Complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide community-based supports. (3-20-20)

f. Satisfactorily complete a criminal history background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks,"; and ~~(3-20-20)~~(3-13-20)T

g. When employed by a DDA, be certified in CPR and first aid in accordance with the general training requirements under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." Independent providers must be certified in CPR and first aid prior to delivering services and must maintain current certification thereafter. (3-20-20)

03. Family Education. Family Education can be provided by an agency certified as a DDA or an individual who holds an independent habilitation intervention provider agreement with the Department and meets the intervention specialist or professional qualifications as outlined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits". (3-20-20)

(BREAK IN CONTINUITY OF SECTIONS)

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

Home and community-based services are provided through the HCBS State Plan option as allowed in Section 1915(i) of the Social Security Act for adults with developmental disabilities who do not meet the ICF/ID level of care. HCBS state plan option services must comply with Sections 310 through 319, and Sections 645 through 657 of these rules. Through the duration of the COVID-19 public health emergency, the Department reserves the right to temporarily alter requirements and processes related to the Adult Developmental Disabilities HCBS State Plan Option program to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS approved 1135 waiver or a state plan amendment to the existing Adult Developmental Disabilities HCBS State Plan Option benefit. In the event additional changes are required in the future, guidance will be posted on the Medicaid Information Releases webpage. ~~(4-11-19)~~(3-13-20)T

(BREAK IN CONTINUITY OF SECTIONS)

651. DEVELOPMENTAL THERAPY: COVERAGE REQUIREMENTS AND LIMITATIONS.

Developmental therapy must be recommended by a physician or other practitioner of the healing arts. (7-1-13)

01. Requirements to Deliver Developmental Therapy. Developmental therapy may be delivered in a developmental disabilities agency center-based program, the community, or the home of the participant. ~~*Participants living in a certified family home must not receive home-based developmental therapy in a certified family home.*~~ Developmental therapy includes individual developmental therapy and group developmental therapy. Developmental therapy must be delivered by Developmental Specialists or paraprofessionals qualified in accordance with these rules, based on an assessment completed prior to the delivery of developmental therapy. ~~(7-1-13)~~(3-13-20)T

a. Areas of Service. These services must be directed toward the rehabilitation or habilitation of physical or developmental disabilities in the areas of self-care, receptive and expressive language, learning, mobility,

self-direction, capacity for independent living, or economic self-sufficiency. (7-1-13)

b. Age-Appropriate. Developmental therapy includes instruction in daily living skills the participant has not gained at the normal developmental stages in their life, or is not likely to develop without training or therapy. Developmental therapy must be age-appropriate. (7-1-11)

c. Tutorial Activities and Educational Tasks are Excluded. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the participant's disability. (7-1-11)

d. Settings for Developmental Therapy. Developmental Therapy may be provided in home and community-based settings as described in Section 312 of these rules. Developmental therapy, in both individual and group formats, must be available in both community-based and home-based settings, and be based on participant needs, interests, or choices. (7-1-16)

e. Staff-to-Participant Ratio. When group developmental therapy is center-based, there must be a minimum of one (1) qualified staff, who may be a paraprofessional or a Developmental Specialist, providing direct services for every twelve (12) participants. The community-based services must occur in integrated, inclusive settings and with no more than three (3) participants per qualified staff at each session. Additional staff must be added, as necessary, to meet the needs of each individual served. (7-1-13)

02. Excluded Services. The following services are excluded for Medicaid payments: (7-1-11)

a. Vocational services; (7-1-11)

b. Educational services; and (7-1-11)

c. Recreational services. (7-1-11)

03. Limitations on Developmental Therapy. Developmental therapy may not exceed the limitations as ~~*specified below.*~~ follows: ~~*(7-1-13)*~~

~~***a.*** *Developmental therapy must not exceed twenty-two (22) hours per week.* *(7-1-13)*~~

~~***b.*** *Developmental therapy provided in combination with Community Supported Employment services under Subsection 703.04 of these rules, must not exceed forty (40) hours per week.* *(7-1-13)*~~

~~***c.*** *When a participant receives adult day health as provided in Subsection 703.12 of these rules, the combination of adult day, health and developmental therapy must not exceed thirty (30) hours per week.* *(7-1-13)*~~

~~***d.***~~ ~~*O*~~only one (1) type of therapy will be reimbursed during a single time period by the Medicaid program. Developmental therapy will not be reimbursed during periods when the participant is being transported to and from the agency. ~~*(7-1-13)*~~(3-13-20)T

(BREAK IN CONTINUITY OF SECTIONS)

655. DEVELOPMENTAL THERAPY: PROVIDER QUALIFICATIONS AND DUTIES.

01. Developmental Specialist for Adults. To be qualified as a Developmental Specialist for adults, a person must have a minimum of two hundred forty (240) hours of professionally-supervised experience with individuals who have developmental disabilities and either: (7-1-11)

a. Possess a bachelor's or master's degree in special education, early childhood special education, speech and language pathology, applied behavioral analysis, psychology, physical therapy, occupational therapy, social work, or therapeutic recreation; or (7-1-11)

b. Possess a bachelor's or master's degree in an area not listed above in Subsection 657.05.a. of this rule and have: (7-1-11)

i. Completed a competency course jointly approved by the Department and the Idaho Association of Developmental Disabilities Agencies that relates to the job requirements of a Developmental Specialist; and (7-1-11)

ii. Passed a competency examination approved by the Department. (7-1-11)

c. Any person employed as a Developmental Specialist in Idaho prior to May 30, 1997, unless previously disallowed by the Department, will be allowed to continue providing services as a Developmental Specialist as long as there is not a gap of more than three (3) years of employment as a Developmental Specialist. (7-1-11)

d. Through the duration of the COVID-19 public health emergency, Development Specialists for adults may begin rendering services prior to completing the training requirements provided that they complete the training requirements within thirty (30) days of first rendering services, advise the participant or legal guardian that the individual has not yet completed the applicable trainings, and comply with any other requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. (3-13-20)T

02. Developmental Therapy Paraprofessionals. Paraprofessionals, such as aides or therapy technicians, may be used by an agency to provide developmental therapy if they are under the supervision of a Developmental Specialist. A developmental therapy paraprofessional must be at least seventeen (17) years of age. (7-1-13)

03. Requirements for Collaboration with Other Providers. When participants are receiving rehabilitative or habilitative services from other providers, each DDA must coordinate each participant's DDA program with these providers to maximize skill acquisition and generalization of skills across environments, and to avoid duplication of services. The DDA must maintain documentation of this collaboration. This documentation includes other plans of services such as the Individual Education Plan (IEP), Personal Care Services (PCS) plan, Residential Habilitation plan, and the outpatient behavioral health service plan. The participant's file must also reflect how these plans have been integrated into the DDA's plan of service for each participant. (3-20-14)

(BREAK IN CONTINUITY OF SECTIONS)

658. COVID-19 PUBLIC HEALTH EMERGENCY RESIDENTIAL HABILITATION.

Through the duration of the COVID-19 public health emergency, the Department will pay for residential habilitation services, as described in Subsection 703.01 of these rules, provided by facilities that have entered into a provider agreement with the Department and are certified as developmental disabilities agencies by the Department. Prior to receiving residential habilitation services from a DDA, an individual must be determined by the Department, or its contractor, to have a developmental disability under Sections 500 through 506 of these rules and Section 66-402, Idaho Code, be eighteen (18) years of age or older, and live in the community. DDA's providing residential habilitation services must comply with any additional requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. (3-13-20)T

65~~8~~9. -- 659. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

700. ADULTS WITH DEVELOPMENTAL DISABILITIES WAIVER SERVICES.

Under 42 CFR Section 440.180, it is the intention of the Department to provide waiver services to eligible adult

participants to prevent unnecessary institutional placement, provide for the greatest degree of independence possible, enhance the quality of life, encourage individual choice, and achieve and maintain community integration. For an adult participant to be eligible, the Department must find that the participant requires services due to a developmental disability that impairs their mental or physical function or independence, is capable of being maintained safely and effectively in a non-institutional setting, and would, in the absence of such services, need to reside in an ICF/ID. Through the duration of the COVID-19 public health emergency, the Department reserves the right to temporarily alter requirements and processes related to the Adult DD waiver program to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS approved 1135 waiver or HCBS Attachment K amendment to the existing Adult Developmental Disability waiver. In the event additional changes are required in the future, guidance will be posted on the Medicaid Information Releases webpage. ~~(7-1-11)~~(3-13-20)T

(BREAK IN CONTINUITY OF SECTIONS)

703. ADULT DD WAIVER SERVICES: COVERAGE AND LIMITATIONS.

01. Residential Habilitation. Residential habilitation services consist of an integrated array of individually tailored services and supports furnished to eligible participants. These services and supports are designed to assist the participants to reside successfully in their own homes, with their families, or in certified family homes. The services and supports that may be furnished consist of the following: (4-4-13)

a. Habilitation services aimed at assisting the individual to acquire, retain, or improve their ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (3-19-07)

i. Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (3-19-07)

ii. Money management including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (3-19-07)

iii. Daily living skills including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self-administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency procedures; (3-19-07)

iv. Socialization including training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to 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 non-therapeutic activities that are merely diversional or recreational in nature); (3-19-07)

v. Mobility, including training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; (3-19-07)

vi. Behavior shaping and management includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services that consist of reinforcing physical, occupational, speech and other therapeutic programs. (3-19-07)

b. Personal Assistance Services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on their own behalf. (3-19-07)

c. Skills training to teach waiver participants, family members, alternative family caregiver(s), or a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self-direction, money management, socialization, mobility and other therapeutic programs. (3-19-07)

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

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

i. Yard maintenance; (4-4-13)

ii. Minor home repair; (4-4-13)

iii. Heavy housework; (4-4-13)

iv. Sidewalk maintenance; and (4-4-13)

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

b. Chore activities may include the following: (4-4-13)

i. Washing windows; (4-4-13)

ii. Moving heavy furniture; (4-4-13)

iii. Shoveling snow to provide safe access inside and outside the home; (4-4-13)

iv. Chopping wood when wood is the participant's primary source of heat; and (4-4-13)

v. Tacking down loose rugs and flooring. (4-4-13)

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

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

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

04. Supported Employment. Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work. (4-4-13)

a. Supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act

(IDEA). Documentation must be maintained in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973 as amended, or the IDEA. (4-4-13)

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

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

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

b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge or public transit providers will be utilized. (4-4-13)

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

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

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

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

07. Specialized Medical Equipment and Supplies. (4-4-13)

a. Specialized medical equipment and supplies include: (4-4-13)

i. Devices, controls, or appliances that enable a participant to increase 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)

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

a. Rent or own a home, or live with unpaid caregivers; (4-4-13)

b. Are alone for significant parts of the day; (4-4-13)

c. Have no caregiver for extended periods of time; and (4-4-13)

d. Would otherwise require extensive, routine supervision. (4-4-13)

09. Home Delivered Meals. Home delivered meals are meals that are delivered to a participant's home to promote adequate participant nutrition. One (1) to two (2) meals per day may be provided to a participant who: (4-4-13)

a. Rents or owns a home; (4-4-13)

b. Is alone for significant parts of the day; (4-4-13)

c. Has no caregiver for extended periods of time; and (4-4-13)

d. Is unable to prepare a meal without assistance. (4-4-13)

10. Skilled Nursing. Skilled nursing includes intermittent or continuous oversight, training, or skilled care that is within the scope of the Nurse Practice Act. Such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a licensed registered nurse licensed to practice in Idaho. (4-4-13)

11. Behavior Consultation/Crisis Management. Behavior Consultation/Crisis Management services that provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also provide emergency back-up involving the direct support of the participant in crisis. (3-19-07)

12. Adult Day Health. Adult day health is a supervised, structured service generally furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week. It is provided outside the home of the participant in a non-institutional, community-based setting, and it encompasses health services, social services, recreation, supervision for safety, and assistance with activities of daily living needed to ensure the optimal functioning of the participant. Adult day health services provided under this waiver will not include room and board payments. ~~*Adult day health cannot exceed thirty (30) hours per week, either alone or in combination with developmental therapy and occupational therapy.*~~ ~~*(4-4-13)*~~(3-13-20)T

13. Self-Directed Community Supports. Participants eligible for the DD Waiver may choose to self-direct their individualized budget rather than receive the traditional waiver services described in this section of rule. The requirements for this option are outlined in IDAPA 16.03.13, "Consumer-Directed Services." (3-19-07)

14. Place of Service Delivery. Waiver services may be provided in home and community settings as described in Section 312 of these rules. Approved places of services include the participant's personal residence, a certified family home, day habilitation/supported employment program, or community. The following living situations are specifically excluded as a place of service for waiver services: (7-1-16)

a. Licensed skilled, or intermediate care facilities, certified nursing facility (NF) or hospital; and (3-19-07)

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

c. Residential Assisted Living Facility. (3-19-07)

d. Additional limitations to specific services are listed under that service definition. (3-19-07)

15. 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)

705. ADULT DD WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
All providers of waiver services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (3-19-07)

01. Residential Habilitation -- Supported Living. When residential habilitation services are provided by an agency, the agency must be certified by the Department as a Residential Habilitation Agency under IDAPA 16.04.17, "Residential Habilitation Agencies," and must supervise the direct services provided. Individuals who provide residential habilitation services in the home of the participant (supported living) must be employed by a Residential Habilitation Agency. Providers of residential habilitation services must meet the following requirements:

(4-4-13)

a. Direct service staff must meet the following minimum qualifications: (3-19-07)

i. Be at least eighteen (18) years of age; (3-19-07)

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; (3-19-07)

iv. Be free from communicable disease; (4-4-13)

v. Each staff person assisting with participant medications has successfully completed the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. (4-4-13)

vi. Residential habilitation service providers who provide direct care or services satisfactorily completed a criminal background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." ~~(4-2-08)~~(3-13-20)T

vii. Have appropriate certification or licensure if required to perform tasks that require certification or licensure. (3-19-07)

b. All skill training for agency direct service staff must be provided by a Qualified Intellectual Disabilities Professional (QIDP) who has demonstrated experience in writing skill training programs. (3-29-12)

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: (3-29-12)

i. Purpose and philosophy of services; (3-19-07)

ii. Service rules; (3-19-07)

iii. Policies and procedures; (3-19-07)

iv. Proper conduct in relating to waiver participants; (3-19-07)

v. Handling of confidential and emergency situations that involve the waiver participant; (3-19-07)

vi. Participant rights; (3-19-07)

vii. Methods of supervising participants; (3-19-07)

viii. Working with individuals with developmental disabilities; and (3-19-07)

ix. Training specific to the needs of the participant. (3-19-07)

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; (3-19-07)

ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; (3-19-07)

iii. Feeding; (3-19-07)

iv. Communication; (3-19-07)

v. Mobility; (3-19-07)

vi. Activities of daily living; (3-19-07)

vii. Body mechanics and lifting techniques; (3-19-07)

viii. Housekeeping techniques; and (3-19-07)

ix. Maintenance of a clean, safe, and healthy environment. (3-19-07)

e. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed. (3-19-07)

f. Through the duration of the COVID-19 public health emergency, agency direct service staff may begin rendering services prior to completing the training requirements, provided that they complete the training requirements within thirty (30) days of first rendering services, advise the participant or legal guardian that the individual has not yet completed the applicable trainings, and comply with any other requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. (3-13-20)T

02. Residential Habilitation -- Certified Family Home (CFH). (3-29-12)

a. An individual who provides direct residential habilitation services in their own home must be certified by the Department to operate a certified family home under IDAPA 16.03.19, "Certified Family Homes," and must receive residential habilitation program coordination services provided through the Department, or its contractor, for the residential habilitation services they provide. (3-29-12)

b. CFH providers providing residential habilitation services as a DD Waiver provider must meet the following minimum qualifications: (3-29-12)

i. Be at least eighteen (18) years of age; (3-29-12)

ii. Be a high school graduate, have a GED, or demonstrate the ability to provide services according to a plan of service; (3-29-12)

iii. Have current CPR and First Aid certifications; (3-29-12)

iv. Be free from communicable disease; (4-4-13)

v. Each CFH provider of residential habilitation services assisting with participant medications has successfully completed the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing, or other Department-approved training. (3-29-12)

vi. CFH providers of residential habilitation services who provide direct care and services have satisfactorily completed a criminal history check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks;" and ~~(3-29-12)~~(3-13-20)T

vii. Have appropriate certification or licensure if required to perform tasks that require certification or licensure. (3-29-12)

c. All skill training for CFH providers who are providing residential habilitation services must be provided through the Department or its contractor by qualified intellectual disabilities professional (QIDP) who has demonstrated experience in writing skill training programs. (3-29-12)

d. Prior to delivering residential habilitation services to a participant, the CFH provider must complete an orientation training in the following areas as provided by either the Department, or its contractor or both, and include the following areas: (3-29-12)

i. Purpose and philosophy of services; (3-29-12)

ii. Service rules; (3-29-12)

iii. Policies and procedures; (3-29-12)

iv. Proper conduct in relating to waiver participants; (3-29-12)

v. Handling of confidential and emergency situation that involve the waiver participant; (3-29-12)

vi. Participant rights; (3-29-12)

vii. Methods of supervising participants; (3-29-12)

viii. Working with individuals with developmental disabilities; and (3-29-12)

ix. Training specific to the needs of the participant. (3-29-12)

e. Additional training requirements for CFH providers providing residential habilitation waiver services must be completed by the CFH provider within six (6) months of certification date and include a minimum of the following: (3-29-12)

i. Instructional Techniques: Methodologies for training in a systematic and effective manner; (3-29-12)

ii. Managing behaviors: techniques and strategies for teaching adaptive behaviors; (3-29-12)

iii. Feeding; (3-29-12)

iv. Communication; (3-29-12)

v. Mobility; (3-29-12)

vi. Activities of daily living; (3-29-12)

vii. Body mechanics and lifting techniques; (3-29-12)

viii. Housekeeping techniques; and (3-29-12)

ix. Maintenance of a clean, safe, and healthy environment. (3-29-12)

f. The Department or its contractor will be responsible for providing on-going training to the CFH provider of residential habilitation specific to the needs of the participant as needed. (3-29-12)

g. Through the duration of the COVID-19 public health emergency, CFH providers may begin rendering services prior to completing the training requirements, provided that they complete the training requirements within thirty (30) days of first rendering services, advise the participant or legal guardian that the individual has not yet completed the applicable trainings, and comply with any other requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. (3-13-20)T

03. **Chore Services**. Providers of chore services must meet the following minimum qualifications: (3-19-07)

a. Be skilled in the type of service to be provided; and (3-19-07)

b. Demonstrate the ability to provide services according to a plan of service. (3-19-07)

c. Chore service providers who provide direct care and services have satisfactorily completed a criminal history and background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." ~~*(4-2-08)*~~(3-13-20)T

04. 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; (3-19-07)

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 have satisfactorily completed a criminal history and background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." ~~*(4-2-08)*~~(3-13-20)T

05. Supported Employment. Supported employment services must be provided by an agency that supervises the direct service and is accredited by the Commission on Accreditation of Rehabilitation Facilities or other comparable standards, or meets State requirements to be a State-approved provider. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." ~~*(4-4-13)*~~(3-13-20)T

06. Non-Medical Transportation. Providers of non-medical transportation services must: (4-4-13)

a. Possess a valid driver's license; and (3-19-07)

b. Possess valid vehicle insurance. (3-19-07)

07. 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)

08. 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)

09. Personal Emergency Response System. 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)

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

11. Skilled Nursing. 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 Section 009 of these rules and IDAPA 16.05.06, “Criminal History and Background Checks.” ~~(4-4-13)~~(3-13-20)T

12. Behavior Consultation or Crisis Management. Behavior Consultation or Crisis Management Providers must meet the following: (3-19-07)

a. Work under the direct supervision of a licensed psychologist or Ph.D. in Special Education, with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and (4-4-13)

b. Have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education or a closely related course of study; or (3-19-07)

c. Be a licensed pharmacist; or (3-19-07)

d. Be a Qualified Intellectual Disabilities Professional (QIDP). (3-19-07)

e. Emergency back-up providers must meet the minimum residential habilitation provider qualifications described under IDAPA 16.04.17, “Residential Habilitation Agencies.” (3-19-07)

f. Behavior consultation or crisis management providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with Section 009 of these rules and IDAPA 16.05.06, “Criminal History and Background Checks.” ~~(4-2-08)~~(3-13-20)T

13. 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. Adult day health providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with Section 009 of these rules and IDAPA 16.05.06, “Criminal History and Background Checks”; ~~(4-4-13)~~(3-13-20)T

d. Providers of adult day health must notify the Department on behalf of the participant, if the adult day health is provided in a certified family home other than the participant’s primary residence. The adult day health provider must provide care and supervision appropriate to the participant’s needs as identified on the plan. (4-4-13)

e. Adult day health providers who provide direct care or services must be free from communicable disease. (4-4-13)

14. Service Supervision. The plan of service that includes all waiver services is monitored by the plan monitor or targeted service coordinator. (3-19-07)

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

(BREAK IN CONTINUITY OF SECTIONS)

727. SERVICE COORDINATION: COVERAGE AND LIMITATIONS.
Service coordination consists of services provided to assist individuals in gaining access to needed services. Service coordination includes the following activities described in Subsections 727.01 through 727.10 of this rule. (3-20-14)

01. Plan Assessment and Periodic Reassessment. Activities that are required to determine the participant's needs by development of a plan assessment and periodic reassessment as described in Section 730 of these rules. These activities include: (5-8-09)

a. Taking a participant's history; (5-8-09)

b. Identifying the participant's needs and completing related documentation; and (5-8-09)

c. Gathering information from other sources such as family members, medical providers, social workers, and educators, to form a complete assessment of the participant. (5-8-09)

02. Development of the Plan. Development and revision of a specific plan, described in Section 731 of these rules that includes information collected through the assessment and specifies goals and actions needed by the participant. The plan must be updated at least annually (or extended through the duration of the declared COVID-19 public health emergency) and as needed to meet the needs of the participant. ~~*(3-20-14)*~~(3-13-20)T

03. Referral and Related Activities. Activities that help link the participant with service providers that are capable of providing needed services to address identified needs and achieve goals specified in the service coordination plan. (3-20-14)

04. Monitoring and Follow-Up Activities. Monitoring and follow-up contacts that are necessary to ensure the plan is implemented and adequately addresses the participant's needs. These activities may be with the participant, family members, providers, or other entities or individuals and conducted as frequently as necessary. These activities must include at least one face-to-face contact with the participant at least every ninety (90) days (the face-to-face encounter may occur via synchronous interaction telehealth, as defined in Title 54, Chapter 57, Idaho Code), to determine whether the following conditions are met: ~~*(5-8-09)*~~(3-13-20)T

a. Services are being provided according to the participant's plan; (5-8-09)

b. Services in the plan are adequate; and (5-8-09)

c. Whether there are changes in the needs or status of the participant, and if so, making necessary adjustments in the plan and service arrangements with providers. (5-8-09)

05. Crisis Assistance. Crisis assistance is service coordination used to assist a participant to access community resources in order to resolve a crisis. Crisis service coordination does not include crisis counseling, transportation to emergency service providers, or direct skill-building services. The need for all crisis assistance hours must meet the definition of crisis in Section 721 of these rules. (5-8-09)

a. Crisis Assistance for Children's Service Coordination. Crisis hours are not available until four and a half (4.5) hours of service coordination have already been provided in the month. Crisis hours for children's service coordination must be authorized by the Department. (5-8-09)

b. Crisis Assistance for Adults With a Developmental Disability. Crisis hours are not available until four and a half (4.5) hours of service coordination have already been provided in the month. Crisis assistance for adults with a developmental disability must be authorized by the Department and is based on community crisis supports as found in Section 646 through 648 of these rules. (7-1-16)

c. Authorization for crisis assistance hours may be requested retroactively as a result of a crisis, defined in Section 721 of these rules, when a participant's service coordination benefits have been exhausted and no other means of support is available to the participant. In retroactive authorizations, the service coordinator must submit a request for crisis services to the Department within seventy-two (72) hours of providing the service. (5-8-09)

06. Contacts for Assistance. Service coordination may include contacts with non-eligible individuals only when the contact is directly related to identifying the needs and supports to help the participant access services. (5-8-09)

07. Exclusions. Service coordination does not include activities that are: (5-8-09)

a. An integral component of another covered Medicaid service; (5-8-09)

b. Integral to the administration of foster care programs; (5-8-09)

c. Integral to the administration of another non-medical program for which a participant may be eligible. This exclusion does not apply to case management provided as part of the individualized education program or individualized family service plan required by the Individuals with Disabilities Education Act. (5-8-09)

08. Limitations on the Provision of Direct Services. Providers of service coordination services may only provide both service coordination and direct services to the same Medicaid participant when the participant is receiving children's service coordination. The service coordination provider must document that the participant has made a free choice of service coordinators and direct service providers. (3-20-14)

09. Limitations on Service Coordination. Service coordination is limited to four and a half (4.5) hours per month. (3-20-14)

10. Limitations on Service Coordination Plan Assessment and Plan Development. Reimbursement for the annual assessment and plan development cannot exceed six (6) hours per year. (3-20-14)

728. SERVICE COORDINATION: PROCEDURAL REQUIREMENTS.

01. Prior Authorization for Service Coordination Services. Services must be prior authorized by the Department according to the direction provided in the Medicaid Provider Handbook available at www.idmedicaid.com. (3-20-14)

02. Service Coordination Plan Development. (5-8-09)

a. A written plan, described in Section 731 of these rules, must be developed and implemented within sixty (60) days after the participant chooses a service coordinator. (3-20-14)

b. The plan must be updated at least annually (or extended through the duration of the declared COVID-19 public health emergency) and amended as necessary. ~~(5-8-09)~~(3-13-20)T

c. The plan must address the service coordination needs of the participant as identified in the assessment described in Section 730 of these rules. (5-8-09)

d. The plan must be developed prior to ongoing service coordination being provided. (5-8-09)

03. Documentation of Service Coordination. Agencies must maintain records that contain documentation describing the services provided, review of the continued need for service coordination, and progress toward each service coordination goal. Documentation must be completed as required in Section 56-209(h), Idaho Code. All active records must be immediately available. Documentation must include all of the following: (3-19-07)

a. The name of the eligible participant. (5-8-09)

b. The name of the provider agency and the person providing the services. (5-8-09)

c. The date, time, duration, and place the service was provided. (5-8-09)

d. The nature, content, units of the service coordination received and whether goals specified in the plan have been achieved. (5-8-09)

e. Whether the participant declined any services in the plan. (5-8-09)

f. The need for and occurrences of coordination with any non-Medicaid case managers. (5-8-09)

g. The timeline for obtaining needed services. (5-8-09)

h. The timeline for re-evaluation of the plan. (5-8-09)

i. A copy of the assessment or prior authorization from the Department that documents eligibility for service coordination services, and a dated and signed plan. (5-8-09)

j. Agency records must contain documentation describing details of the service provided signed by the person who delivered the service. (5-8-09)

k. Documented review of participant's continued need for service coordination and progress toward each service coordination goal. A review must be completed at least every one hundred eighty (180) days after the plan development or update. Progress reviews must include the date of the review, and the signature of the service coordinator completing the review. (5-8-09)

l. Documentation of the participant's, family's, or legal guardian's satisfaction with service. (5-8-09)

m. A copy of the informed consent form signed by the participant, parent, or legal guardian that documents that the participant has been informed of the purposes of service coordination, their rights to refuse service coordination, and their right to choose their service coordinator and other service providers. (5-8-09)

n. A plan that is signed by the participant, parent, or legal guardian, and the service coordinator. The plan must reflect person-centered planning principles and document the participant's inclusion in the development of the plan. The service coordinator must also document that a copy of the plan was given to the participant or their legal representative. The plan must be updated and authorized when required, but at least annually. Children's service coordination plans cannot be effective before the date that the child's parent or legal guardian has signed the plan. (3-20-14)

04. Documentation Completed by a Paraprofessional. Each entry completed by a paraprofessional must be reviewed by the participant's service coordinator and include the date of review and the service coordinator's signature on the documentation. (5-8-09)

05. Participant Freedom of Choice. A participant must have freedom of choice when selecting from the service coordinators available to them. The service coordinator cannot restrict the participant's choice of other health care providers. (5-8-09)

06. Service Coordinator Contact and Availability. The frequency of contact, mode of contact, and person or entity to be contacted must be identified in the plan and must meet the needs of the participant. The contacts must verify the participant's well being and whether services are being provided according to the written plan. At least every ninety (90) days, service coordinators must have face-to-face contact with each participant. The face-to-face encounter may occur via synchronous interaction telehealth, as defined in Title 54, Chapter 57, Idaho Code. ~~(3-20-14)~~(3-13-20)T

a. When it is necessary for the children's service coordinator to conduct a face-to-face contact with a child participant without the parent or legal guardian present, the service coordinator must notify the parent or legal guardian prior to the face-to-face contact with the participant. Notification must be documented in the participant's

file. (5-8-09)

b. Service coordinators do not have to be available on a twenty-four (24) hour basis, but must include an individualized objective on the plan describing what the participant, families, and providers should do in an emergency situation. The individualized objective must include how the service coordinator will coordinate needed services after an emergency situation. (5-8-09)

07. Service Coordinator Responsibility Related to Conflict of Interest. Service coordinators have a primary responsibility to the participant whom they serve, to respect and promote the right of the participant to self-determination, and preserve the participant's freedom to choose services and providers. In order to assure that participant rights are being addressed, service coordinators must: (5-8-09)

a. Be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. (5-8-09)

b. Inform the participant parent, or legal guardian when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the participant's interests primary and protects the participant's interests to the greatest extent possible. (5-8-09)

08. Agency Responsibility Related to Conflict of Interest. To assure that participants are protected from restrictions to their self-determination rights because of conflict of interest, the agency must guard against conflict of interest, and inform all participants and guardians of the risk. Each agency must have a document in each participant's file that contains the following information: (5-8-09)

a. The definition of conflict of interest as defined in Section 721 of these rules; (5-8-09)

b. A signed statement by the agency representative verifying that the concept of conflict of interest was reviewed and explained to the participant parent, or legal guardian; and (5-8-09)

c. The participant's, parent's, or legal guardian's signature on the document. (5-8-09)

729. SERVICE COORDINATION: PROVIDER QUALIFICATIONS.
Service coordination services must be provided by an agency as defined in Section 721 of these rules. (5-8-09)

01. Provider Agreements. Service coordinators must be employees or contractors of an agency that has a valid provider agreement with the Department. (3-19-07)

02. Supervision. The agency must provide supervision to all service coordinators and paraprofessionals. The agency must clearly document: (5-8-09)

a. Each supervisor's ability to address concerns about the services provided by employees and contractors under their supervision, and (5-8-09)

b. That a paraprofessional is not a supervisor. (5-8-09)

03. Agency Supervisor Required Education and Experience. (5-8-09)

a. Master's Degree in a a human services field from a nationally accredited university or college, and have twelve (12) months supervised work experience with the population being served; or (5-8-09)

b. Bachelor's degree in a human services field from a nationally accredited university or college, and have twenty-four (24) months supervised work experience with the population being served. (5-8-09)

c. Be a licensed registered nurse (RN) and have twenty-four (24) months supervised work experience with the population being served. (5-8-09)

04. Service Coordinator Education and Experience. (5-8-09)

a. Minimum of a Bachelor's degree in human services field from a nationally accredited university or college and have twelve (12) months supervised work experience with the population being served; or (5-8-09)

b. Be a licensed registered nurse (RN) and have twelve (12) months work experience with the population being served. (5-8-09)

c. When an individual meets the education or licensing requirements in Subsections 729.04.a. or 729.04.b. of this rule, but does not have the required supervised work experience, the individual must be supervised by a qualified service coordinator while gaining the required work experience. (5-8-09)

05. Paraprofessional Education and Experience. Under the supervision of a qualified service coordinator, a paraprofessional may be used to assist in the implementation of the plan. Paraprofessionals must have the following qualifications: (5-8-09)

a. Be at least eighteen (18) years of age and have a minimum of a high school diploma or equivalency; (5-8-09)

b. Be able to read and write at an appropriate level to process the required paperwork and forms involved in the provision of the service; and (5-8-09)

c. Have twelve (12) months supervised work experience with the population being served. (5-8-09)

06. Limitations on Services Delivered by Paraprofessionals. Paraprofessionals must not conduct assessments, evaluations, person-centered planning meetings, ninety (90) day face-to-face contacts described in Section 728.06 of these rules, one hundred eighty (180) day progress reviews, plan development, or plan changes. Paraprofessionals cannot be identified as the service coordinator on the plan and they cannot supervise service coordinators or other paraprofessionals. (3-20-14)

07. Criminal History Check Requirements. Service coordination agencies must verify that each service coordinator and paraprofessional they employ or with whom they contract has complied with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." ~~(5-8-09)~~(3-13-20)T

08. Health, Safety and Fraud Reporting. Service coordinators are required to report any concerns about health and safety to the appropriate governing agency and to the Department. Service coordinators must also report fraud, including billing of services that were not provided, to the Department unit responsible for authorizing the service; and to the Surveillance and Utilization Review Unit (SUR) within the Department or its toll-free Medicaid fraud hotline. (3-19-07)

09. Individual Service Coordinator Case Loads. The total caseload of a service coordinator must assure quality service delivery and participant satisfaction. (5-8-09)