

HEALTH AND WELFARE COMMITTEE

ADMINISTRATIVE RULES REVIEW

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2014 Legislative Session

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IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.01.01 - EMERGENCY MEDICAL SERVICES (EMS) - ADVISORY COMMITTEE (EMSAC)

DOCKET NO. 16-0101-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice, the pending rule becomes final and effective on July 1, 2014, after review by the legislature, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-1011 through 56-1023, Idaho Code.

DESCRIPTIVE SUMMARY: There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 7, 2013, Idaho Administrative Bulletin, [Vol. 13-8, pages 118 and 119](#).

Over the past several years, meetings have been held to negotiate and discuss the rewrite and update of the Emergency Medical Services (EMS) chapters of rules. The changes made to this chapter align these rules with the new “EMS - Rule Definitions” chapter being implemented under Docket 16-0102-1301 in this Bulletin. A name change in the Department for the Bureau of Emergency Services and Preparedness has also been included in this docket.

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

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Chris Stoker at (208) 334-4000.

DATED this 21st day of November, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720

Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-1011 through 56-1023, Idaho Code.

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

Thursday, August 22, 2013 6:00 p.m. - 7:00 p.m.	Monday, August 26, 2013 3:30 p.m. - 4:30 p.m.	Wednesday, August 28, 2013 6:00 p.m. - 7:00 p.m.
Coeur d'Alene Public Library Community Room 702 E. Front Ave. Coeur d'Alene, ID 83814	EMS Bureau Conference Room 650 W. State St. B-25 Boise, ID 83702	Fire Station #2 Training Room 1539 N Hayes Pocatello, ID 83204

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

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

Over the past several years, meetings have been held to negotiate and discuss the rewrite and update of the Emergency Medical Services (EMS) chapters of rules. The changes being made to this chapter are needed to align these rules with the new "EMS - Rule Definitions" chapter being implemented under Docket 16-0102-1301 in this Bulletin. This change updates definitions necessary to meet the ever-changing terminology and technology used to protect the health and safety of the public in emergency situations. There is a name change in the Department for the Bureau of Emergency Services and Preparedness that has also been included in this docket.

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

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

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is

intended to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 3, 2013, [Vol. 13-4, page 13 and 14](#), and May 1, 2013, [Vol. 13-5, page 75 and 76](#), Idaho Administrative Bulletins, under Docket No. 16-0203-1301, for “Emergency Medical Services.” In addition to the negotiated townhall meetings held around the state, a task force committee, comprised of EMS professionals and interested stakeholder groups, met to develop the rule concepts.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Chris Stoker at (208) 334-4000.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 28, 2013.

DATED this 9th day of July, 2013.

[LSO Rules Analysis Memo](#)

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0101-1301

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE NUMBER -- INTERNET WEBSITE.

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the state of Idaho. (3-29-12)

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. (3-29-12)

03. Street Address. (3-29-12)

a. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. (3-29-12)

b. The [EMS Bureau of Emergency Medical Services and Preparedness](#) is located at 650 W. State Street, Suite B-17, Boise, Idaho 83702. (~~3-29-12~~)()

04. Telephone. (3-29-12)

a. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. (3-29-12)

b. The telephone number for the EMS Bureau of Emergency Medical Services and Preparedness is (208) 334-4000. The toll-free, phone number is 1-877-554-3367. ~~(3-29-12)~~()

05. Internet Websites. (3-29-12)

a. The Department's internet website is found at <http://www.healthandwelfare.idaho.gov>. (3-29-12)

b. The Bureau of Emergency Medical Services Bureau's and Preparedness internet website is found at <http://www.idahoems.org>. ~~(3-29-12)~~()

(BREAK IN CONTINUITY OF SECTIONS)

010. DEFINITIONS ~~AND ABBREVIATIONS.~~

For the purposes of this chapter, ~~of rules the following terms~~ the definitions in IDAPA 16.01.02, "Emergency Medical Services (EMS) -- Rule Definitions" apply. ~~(3-29-12)~~()

~~**01. Emergency Medical Services Advisory Committee (EMSAC).**~~ *The statewide advisory board of the EMS Bureau whose members are appointed by the Director of the Idaho Department of Health and Welfare to provide counsel to the Department on administering the EMS Act.* (3-29-12)

~~**02. Third Service.**~~ *An EMS agency that is neither fire nor law enforcement based.* (3-29-12)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.01.02 - EMERGENCY MEDICAL SERVICES (EMS) - RULE DEFINITIONS
DOCKET NO. 16-0102-1301 (NEW CHAPTER)
NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice, the pending rule becomes final and effective on July 1, 2014, after review by the legislature, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-1011 through 56-1023, Idaho Code.

DESCRIPTIVE SUMMARY: There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 7, 2013, Idaho Administrative Bulletin, [Vol. 13-8, pages 120 through 129](#).

Over the past several years, meetings have been held to negotiate and discuss the rewrite and update of the Emergency Medical Services (EMS) chapters of rules. This new chapter aligns definitions for all EMS rules to meet the ever-changing terminology and technology used to protect the health and safety of the public in emergency situations. This new chapter ensures that all EMS chapters use current and consistent terminology to avoid confusion and to ensure compliance with all the EMS rules.

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

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Chris Stoker at (208) 334-4000.

DATED this 21st day of November, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720

Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-1011 through 56-1023, Idaho Code.

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

Thursday, August 22, 2013 6:00 p.m. - 7:00 p.m.	Monday, August 26, 2013 3:30 p.m. - 4:30 p.m.	Wednesday, August 28, 2013 6:00 p.m. - 7:00 p.m.
Coeur d'Alene Public Library Community Room 702 E. Front Ave. Coeur d'Alene, ID 83814	EMS Bureau Conference Room 650 W. State St. B-25 Boise, ID 83702	Fire Station #2 Training Room 1539 N Hayes Pocatello, ID 83204

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

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

Over the past several years, meetings have been held to negotiate and discuss the rewrite and update of the Emergency Medical Services chapters of rules. This new chapter of rules is needed to align definitions for all EMS chapters of rule in order to meet the ever-changing terminology and technology used to protect the health and safety of the public in emergency situations. This new chapter will ensure that EMS chapters that are being implemented or updated will use the same definitions and keep other EMS chapters with current and consistent terminology to avoid confusion, and ensure compliance with licensing requirements.

This new chapter of rules provides the following:

1. Definitions for the EMS chapters of rules;
2. Authority, scope, and references to the EMS chapters to which these rules apply; and
3. Required sections to meet the requirements of the rules of the Office of the Administrative Rules Coordinator.

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

increased: N/A

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

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is intended to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 3, 2013, [Vol. 13-4, page 13 and 14](#), and May 1, 2013, [Vol. 13-5, page 75 and 76](#), Idaho Administrative Bulletins, under Docket No. 16-0203-1301, for “Emergency Medical Services.” In addition to the negotiated townhall meetings held around the state, a task force committee, comprised of EMS professionals and interested stakeholder groups, met to develop the rule concepts.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Chris Stoker at (208) 334-4000.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 28, 2013.

DATED this 1st day of July, 2013.

[LSO Rules Analysis Memo](#)

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0102-1301

**IDAPA 16
TITLE 01
CHAPTER 02**

16.01.02 - EMERGENCY MEDICAL SERVICES (EMS) - RULE DEFINITIONS

000. LEGAL AUTHORITY.

The Idaho Board of Health and Welfare is authorized under Section 56-1023, Idaho Code, to adopt rules and standards concerning the administration of the Idaho Emergency Medical Services Act, Sections 56-1011 through 56-1023, Idaho Code. The Director is authorized under Section 56-1003, Idaho Code, to supervise and administer an emergency medical services program. ()

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.01.02, “Emergency Medical Services (EMS) - Rule Definitions.” ()

02. Scope. These rules contain the definitions used throughout the Emergency Medical Services chapters of rules adopted by the Department. Those chapters include: ()

a. IDAPA 16.01.01, “Emergency Medical Services (EMS) - Advisory Committee (EMSAC)”;

b. IDAPA 16.01.03, “Emergency Medical Services (EMS) - Agency Licensing Requirements”;

c. IDAPA 16.01.07, “Emergency Medical Services (EMS) - Personnel Licensing Requirements”;

d. IDAPA 16.01.12, “Emergency Medical Services (EMS) - Complaints, Investigations and Disciplinary Actions”; and ()

e. IDAPA 16.02.03, “Emergency Medical Services.” ()

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, the Department may have written statements that pertain to the interpretation of this chapter. ()

003. ADMINISTRATIVE APPEALS.

Administrative appeals and contested cases are governed by the provisions of IDAPA 16.05.03, “Rules Governing Contested Case Proceedings and Declaratory Rulings.” ()

004. INCORPORATION BY REFERENCE.

There are no documents incorporated by reference in this chapter of rules. ()

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE NUMBER -- INTERNET WEBSITE.

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the state of Idaho. ()

02. Mailing Address. The mailing address for the business office is Idaho Department

of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. ()

03. Street Address. ()

a. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. ()

b. The Bureau of Emergency Medical Services and Preparedness is located at 650 W. State Street, Suite B-17, Boise, Idaho 83702. ()

04. Telephone. ()

a. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. ()

b. The telephone number for the Bureau of Emergency Medical Services and Preparedness is (208) 334-4000. The toll-free phone number is 1-877-554-3367. ()

05. Internet Websites. ()

a. The Department internet website is found at <http://www.healthandwelfare.idaho.gov>. ()

b. The Bureau of Emergency Medical Services and Preparedness internet website is found at <http://www.idahoems.org>. ()

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS ACT COMPLIANCE AND REQUESTS.

01. Confidentiality of Records. Any disclosure of confidential information used or disclosed in the course of the Department's business is subject to the restrictions in state or federal law, federal regulation, and IDAPA 16.05.01, "Use and Disclosure of Department Records." ()

02. Public Records Act. The Department will comply with Sections 9-337 through 9-350, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. ()

007. -- 009. (RESERVED)

010. DEFINITIONS AND ABBREVIATIONS A THROUGH B.

For the purposes of the Emergency Medical Services (EMS) chapters of rules, the following definitions apply: ()

01. Advanced Emergency Medical Technician (AEMT). An AEMT is a person who: ()

a. Has met the qualifications for licensure under Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.07, “Emergency Medical Services (EMS) - Personnel Licensing Requirements”; ()

b. Is licensed by the Department under Sections 56-1011 through 56-1023, Idaho Code; ()

c. Carries out the practice of emergency medical care within the scope of practice for AEMT determined by the Idaho Emergency Medical Services Physician Commission (EMSPC), under IDAPA 16.02.02, “Rules of the Idaho Emergency Medical Services (EMS) Physician Commission”; and ()

d. Practices under the supervision of a physician licensed in Idaho. ()

02. Advanced Life Support (ALS). The provision of medical care, medication administration and treatment with medical devices that correspond to the knowledge and skill objectives in the Paramedic curriculum currently approved by the State Health Officer and within the scope of practice defined in IDAPA 16.02.02, “Rules of the Idaho Emergency Medical Services (EMS) Physician Commission,” by persons licensed as Paramedics by the Department. ()

03. Advanced Practice Professional Nurse. A person who meets all the applicable requirements and is licensed to practice as an Advanced Practice Professional Nurse under Sections 54-1401 through 54-1418, Idaho Code. ()

04. Advertise. Communication of information to the public, institutions, or to any person concerned, by any oral, written, graphic means including handbills, newspapers, television, radio, telephone directories, billboards, or electronic communication methods. ()

05. Affiliation. The formal association that exists between an agency and those licensed personnel who appear on the agency’s roster, which includes active participation, collaboration, and involvement. Affiliation can be demonstrated by the credentialing of licensed personnel by the agency medical director. ()

06. Affiliating EMS Agency. The licensed EMS agency, or agencies, under which licensed personnel are authorized to provide patient care. ()

07. Air Ambulance. Any privately or publicly owned fixed wing aircraft or rotary wing aircraft used for, or intended to be used for, the transportation of persons experiencing physiological or psychological illness or injury who may need medical attention during transport. This may include dual or multipurpose vehicles which otherwise comply with Sections 56-1011 through 56-1023, Idaho Code, and specifications established in IDAPA 16.01.03, “Emergency Medical Services (EMS) - Agency Licensing Requirements.” ()

08. Air Medical Agency. An agency licensed by the Department that responds to requests for patient care and transportation from hospitals and EMS agencies using a fixed wing aircraft or rotary wing aircraft. ()

09. Air Medical I. A service type available to a licensed air medical EMS agency that meets the requirements in IDAPA 16.01.03, “Emergency Medical Services (EMS) - Agency Licensing Requirements.” ()

10. Air Medical II. A service type available to a licensed air medical EMS agency that meets the requirements in IDAPA 16.01.03, “Emergency Medical Services (EMS) - Agency Licensing Requirements.” ()

11. Air Medical Response. The deployment of an aircraft licensed as an air ambulance to an emergency scene intended for the purpose of patient treatment and transportation. ()

12. Ambulance. Any privately or publicly owned motor vehicle, or nautical vessel, used for, or intended to be used for, the transportation of sick or injured persons who may need medical attention during transport. This may include dual or multipurpose vehicles which otherwise comply with Sections 56-1011 through 56-1023, Idaho Code, and specifications established in IDAPA 16.01.03, “Emergency Medical Services (EMS) - Agency Licensing Requirements.” ()

13. Ambulance-Based Clinicians. Licensed Professional Nurses and Advanced Practice Professional Nurses who are currently licensed under Sections 54-1401 through 54-1418, Idaho Code, and Physician Assistants who are currently licensed under Sections 54-1801 through 54-1841, Idaho Code. ()

14. Ambulance Agency. An agency licensed by the Department under Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.03, “Emergency Medical Services (EMS) - Agency Licensing Requirements,” operated with the intent to provide personnel and equipment for medical treatment at an emergency scene, during transportation or during transfer of persons experiencing physiological or psychological illness or injury who may need medical attention during transport. ()

15. Applicant. Any organization that is requesting an agency license under Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.03, “Emergency Medical Services (EMS) - Agency Licensing Requirements,” including the following: ()

a. An organization seeking a new license; ()

b. An existing agency that intends to: ()

i. Change the level of licensed personnel it utilizes; ()

ii. Change its geographic coverage area (except by agency annexation); or ()

iii. Begin or discontinue providing patient transport services. ()

16. Assessment. The evaluation of a patient by EMS licensed personnel intending to provide treatment or transportation to that patient. ()

17. Basic Life Support (BLS). The provision of medical care, medication administration, and treatment with medical devices which correspond to the knowledge and skill objectives in the EMR or EMT curriculum currently approved by the State Health Officer and within scope of practice defined in IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission," by persons licensed as EMRs or EMTs by the Department. ()

18. Board. The Idaho Board of Health and Welfare. ()

011. DEFINITIONS AND ABBREVIATIONS C THROUGH E.

For the purposes of the Emergency Medical Services (EMS) chapters of rules, the following definitions apply: ()

01. Call Volume. The number of requests for service that an agency either anticipated or responded to during a designated period of time. ()

02. Candidate. Any individual who is requesting an EMS personnel license under Sections 56-1011 through 56-1023, Idaho Code, IDAPA 16.01.07, "Emergency Medical Services (EMS) - Personnel Licensing Requirements." ()

03. Certificate of Eligibility. Documentation that an individual is eligible for affiliation with an EMS agency, having satisfied all requirements for an EMS Personnel Licensure except for affiliation, but is not licensed to practice. ()

04. Certification. A credential issued to an individual by the Department for a specified period of time indicating that minimum standards have been met. ()

05. Certified EMS Instructor. An individual approved by the Department, who has met the requirements in IDAPA 16.02.03, "Emergency Medical Services," to provide EMS education and training. ()

06. Compensated Volunteer. An individual who performs a service without promise, expectation, or receipt of compensation other than payment of expenses, reasonable benefits or a nominal fee to perform such services. This individual cannot be a part-time or full-time employee of the same organization performing the same services as a volunteer and employee. ()

07. Credentialing. The local process by which licensed EMS personnel are authorized to provide medical care in the out-of-hospital, hospital, and medical clinic setting, including the determination of a local scope of practice. ()

08. Credentialed EMS Personnel. Individuals who are authorized to provide medical care by the EMS medical director, hospital supervising physician, or medical clinic supervising physician. ()

09. Critical Care. The treatment of a patient with continuous care, monitoring, medication, or procedures requiring knowledge or skills not contained within the Paramedic curriculum approved by the State Health Officer. Interventions provided by Paramedics are governed by the scope of practice defined in IDAPA 16.02.02, "Rules of the Idaho Emergency

Medical Services (EMS) Physician Commission.” ()

10. Critical Care Agency. An ambulance or air medical EMS agency that advertises and provides all of the skills and interventions defined as critical care in IDAPA 16.02.02, “Rules of the Idaho Emergency Medical Services (EMS) Physician Commission.” ()

11. Department. The Idaho Department of Health and Welfare. ()

12. Director. The Director of the Idaho Department of Health and Welfare or his designee. ()

13. Division. The Division of Public Health, Idaho Department of Health and Welfare. ()

14. Emergency. A medical condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the person’s health in serious jeopardy, or in causing serious impairments of bodily function or serious dysfunction of any bodily organ or part. ()

15. Emergency Medical Care. The care provided to a person suffering from a medical condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the person’s health in serious jeopardy, or in causing serious impairments of bodily function or serious dysfunction of any bodily organ or part. ()

16. Emergency Medical Responder (EMR). An EMR is a person who: ()

a. Has met the qualifications for licensure in Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.07, “Emergency Medical Services - Personnel Licensing Requirements”; ()

b. Is licensed by the Department under Sections 56-1011 through 56-1023, Idaho Code; ()

c. Carries out the practice of emergency medical care within the scope of practice for EMR determined by the Idaho Emergency Medical Services Physician Commission (EMSPC), under IDAPA 16.02.02, “Rules of the Idaho Emergency Medical Services (EMS) Physician Commission”; and ()

d. Practices under the supervision of a physician licensed in Idaho. ()

17. Emergency Medical Services (EMS). The system utilized in responding to a perceived individual need for immediate care in order to prevent loss of life, aggravation of physiological or psychological illness, or injury. ()

18. Emergency Medical Services Advisory Committee (EMSAC). The statewide advisory board of the Department as described in IDAPA 16.01.01, “Emergency Medical Services (EMS) - Advisory Committee (EMSAC).” EMSAC members are appointed by the Director of the Idaho Department of Health and Welfare to provide counsel to the Department on administering the EMS Act. ()

19. EMS Agency. Any organization licensed by the Department under Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.03, “Emergency Medical Services (EMS) - Agency Licensing Requirements,” that operates an air medical service, ambulance service, or non-transport service. ()

20. EMS Bureau. The Bureau of Emergency Medical Services (EMS) & Preparedness of the Idaho Department of Health and Welfare. ()

21. EMS Medical Director. A physician who supervises the medical activities of licensed personnel affiliated with an EMS agency. ()

22. EMS Physician Commission (EMSPC). The Idaho Emergency Medical Services Physician Commission created under Section 56-1013A, Idaho Code, also referred to as “the Commission.” ()

23. Emergency Medical Technician (EMT). An EMT is a person who: ()

a. Has met the qualifications for licensure in Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.07, “Emergency Medical Services - Personnel Licensing Requirements”; ()

b. Is licensed by the EMS Bureau under Sections 56-1011 through 56-1023, Idaho Code; ()

c. Carries out the practice of emergency medical care within the scope of practice for EMT determined by the Idaho Emergency Medical Services Physician Commission (EMSPC), under IDAPA 16.02.02, “Rules of the Idaho Emergency Medical Services (EMS) Physician Commission”; and ()

d. Practices under the supervision of a physician licensed in Idaho. ()

24. Emergency Scene. Any setting outside of a hospital, with the exception of the inter-facility transfer, in which the provision of EMS may take place. ()

012. DEFINITIONS AND ABBREVIATIONS F THROUGH N.

For the purposes of the Emergency Medical Services (EMS) chapters of rules, the following definitions apply: ()

01. Full-Time Paid Personnel. Personnel who perform a service with the promise, expectation, or receipt of compensation for performing such services. Full-time personnel differ from part-time personnel in that full-time personnel work a more regular schedule and typically work more than thirty-five (35) hours per week. ()

02. Glasgow Coma Score (GCS). A scale used to determine a patient's level of consciousness. It is a rating from three (3) to fifteen (15) of the patient's ability to open his eyes, respond verbally, and move normally. The GCS is used primarily during the examination of patients with trauma or stroke. ()

03. Ground Transport Time. The total elapsed time calculated from departure of the ambulance from the scene to arrival of the ambulance at the patient destination. ()

04. Hospital. A facility in Idaho licensed under Sections 39-1301 through 39-1314, Idaho Code, and defined in Section 39-1301(a)(1), Idaho Code. ()

05. Intermediate Life Support (ILS). The provision of medical care, medication administration, and treatment with medical devices which correspond to the knowledge and skill objectives in the AEMT curriculum currently approved by the State Health Officer and within the scope of practice defined in IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission," by persons licensed as AEMTs by the Department. ()

06. Investigation. Research of the facts concerning a complaint or issue of non-compliance which may include performing or obtaining interviews, inspections, document review, detailed subject history, phone calls, witness statements, other evidence, and collaboration with other jurisdictions of authority. ()

07. License. A document issued by the Department to an agency or individual authorizing specified activities and conditions as described under Sections 56-1011 through 56-1023, Idaho Code. ()

08. Licensed Personnel. Those individuals who are licensed by the Department as Emergency Medical Responders (EMR), Emergency Medical Technicians (EMT), Advanced Emergency Medical Technicians (AEMT), and Paramedics. ()

09. Licensed Professional Nurse. A person who meets all the applicable requirements and is licensed to practice as a Licensed Professional Nurse under Sections 54-1401 through 54-1418, Idaho Code. ()

10. Local Incident Management System. The local system of interagency communications, command, and control established to manage emergencies or demonstrate compliance with the National Incident Management System. ()

11. Medical Supervision Plan. The written document describing the provisions for medical supervision of licensed EMS personnel. ()

12. National Registry of Emergency Medical Technicians (NREMT). An independent, non-governmental, not for profit organization which prepares validated examinations for the state's use in evaluating candidates for licensure. ()

13. Non-transport Agency. An agency licensed by the Department, operated with the intent to provide personnel or equipment for medical stabilization at an emergency scene, but not

intended to be the service that will actually transport sick or injured persons. ()

14. Non-transport Vehicle. Any vehicle operated by an agency with the intent to provide personnel or equipment for medical stabilization at an emergency scene, but not intended as the vehicle that will actually transport sick or injured persons. ()

15. Nurse Practitioner. An Advanced Practice Professional Nurse, licensed in the category of Nurse Practitioner, as defined in IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." ()

013. DEFINITIONS AND ABBREVIATIONS O THROUGH Z.

For the purposes of the Emergency Medical Services (EMS) chapters of rules, the following definitions apply: ()

01. Out-of-Hospital. Any setting outside of a hospital, including inter-facility transfers, in which the provision of EMS may take place. ()

02. Paramedic. A paramedic is a person who: ()

a. Has met the qualifications for licensure in Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.07, "Emergency Medical Services - Personnel Licensing Requirements"; ()

b. Is licensed by the EMS Bureau under Sections 56-1011 through 56-1023, Idaho Code; ()

c. Carries out the practice of emergency medical care within the scope of practice for paramedic determined by the Idaho Emergency Medical Services Physician Commission (EMSPC), under IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission"; and ()

d. Practices under the supervision of a physician licensed in Idaho. ()

03. Part-Time Paid Personnel. Personnel who perform a service with the promise, expectation, or receipt of compensation for performing such services. Part-time personnel differ from the full-time personnel in that the part-time personnel typically work an irregular schedule and work less than thirty-five (35) hours per week. ()

04. Patient. A sick, injured, incapacitated, or helpless person who is under medical care or treatment. ()

05. Patient Assessment. The evaluation of a patient by EMS licensed personnel intending to provide treatment or transportation to that patient. ()

06. Patient Care. The performance of acts or procedures under emergency conditions in responding to a perceived individual need for immediate care in order to prevent loss of life, aggravation of physiological or psychological illness, or injury. ()

07. Patient Movement. The relatively short distance transportation of a patient from an off-highway emergency scene to a rendezvous with an ambulance or air ambulance. ()

08. Patient Transport. The transportation of a patient by ambulance or air ambulance from a rendezvous or emergency scene to a medical care facility. ()

09. Physician. A person who holds a current active license in accordance with Section 54-1803, Idaho Code, issued by the State Board of Medicine to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine in Idaho and is in good standing with no restrictions upon, or actions taken against, his license. ()

10. Physician Assistant. A person who meets all the applicable requirements and is licensed to practice as a licensed physician assistant under Title 54, Chapter 18, Idaho Code. ()

11. Planned Deployment. The deliberate, planned placement of EMS personnel outside of an affiliating agency's deployment model declared on the application under which the agency is currently licensed. ()

12. Prehospital. Any setting outside of a hospital, with the exception of transfers, in which the provision of EMS may take place. ()

13. Response Time. The total time elapsed from when the agency receives a call for service to when the agency arrives and is available at the scene. ()

14. Skills Proficiency. The process overseen by an EMS agency medical director to verify competency in psychomotor skills. ()

15. State Health Officer. The Administrator of the Division of Public Health. ()

16. Supervision. The medical direction by a licensed physician of activities provided by licensed personnel affiliated with a licensed ambulance, air medical, or non-transport service, including: ()

a. Establishing standing orders and protocols; ()

b. Reviewing performance of licensed personnel; ()

c. Providing instructions for patient care via radio or telephone; and ()

d. Other oversight. ()

17. Third Service. A public EMS agency that is neither law-enforcement nor fire-department based. ()

18. Transfer. The transportation of a patient from one (1) medical care facility to another. ()

19. Uncompensated Volunteer. An individual who performs a service without promise, expectation, or receipt of any compensation for the services rendered. An uncompensated volunteer cannot be a part-time or full-time employee of the same organization performing the same services as a volunteer and employee. ()

014. -- 999. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.01.03 - EMERGENCY MEDICAL SERVICES (EMS) -- AGENCY LICENSING REQUIREMENTS

DOCKET NO. 16-0103-1301 (NEW CHAPTER)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice, the pending rule becomes final and effective on July 1, 2014, after review by the legislature, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-1011 through 56-1023, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the August 7, 2013, Idaho Administrative Bulletin, [Vol. 13-8, pages 130 through 159](#). After review through hearings and comments received on the proposed agency licensing rules, the Department is removing the licensing operational declarations of “Rescue” and “Extrication” in the pending rule. Also, the term ‘physically’ is being removed from the inspection process to allow use of new technology as it becomes available.

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

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Chris Stoker at (208) 334-4000.

DATED this 21st day of November, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-1011 through 56-1023, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be held as follows:

Thursday, August 22, 2013 6:00 p.m. - 7:00 p.m.	Monday, August 26, 2013 3:30 p.m. - 4:30 p.m.	Wednesday, August 28, 2013 6:00 p.m. - 7:00 p.m.
Coeur d'Alene Public Library Community Room 702 E. Front Ave. Coeur d'Alene, ID 83814	EMS Bureau Conference Room 650 W. State St. B-25 Boise, ID 83702	Fire Station #2 Training Room 1539 N Hayes Pocatello, ID 83204

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

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

Over the past several years, meetings have been held to negotiate and discuss the rewrite and update of the Emergency Medical Services chapters of rules. This new chapter of rules is needed to ensure that EMS agencies meet minimum licensing, staffing, and equipment requirements. This chapter reflects current technology and deployment models being used by EMS agencies in Idaho and will ensure compliance with rules that protect the health and safety of the public in emergency situations.

This new chapter of rules provides the following:

1. Types of agency licensing models, licensing requirements, and air medical utilization requirements;
2. Personnel and equipment requirements for agency licensure;

3. Application processes and requirements for initial agency licensure and license renewal;
4. References to licensure requirements in other chapters, such as personnel, investigations, disciplinary actions; and
5. Required sections to meet the requirements of the rules of the Office of the Administrative Rules Coordinator.

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

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

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is intended to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 3, 2013, [Vol. 13-4, page 13 and 14](#), and May 1, 2013, [Vol. 13-5, page 75 and 76](#), Idaho Administrative Bulletins, under Docket No. 16-0203-1301, for “Emergency Medical Services.” In addition to the negotiated townhall meetings held around the state, a task force committee, comprised of EMS professionals and interested stakeholder groups, met to develop the rule concepts.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the “Minimum Equipment Standards for Licensed EMS Services”, edition 2014, version 1.0, is being incorporated by reference into these rules to give it the force and effect of law. The document is not being reprinted in this chapter of rules due to its length and format and because of the cost for republication.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Chris Stoker at (208) 334-4000.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 28, 2013.

DATED this 9th day of July, 2013.

[LSO Rules Analysis Memo](#)

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0103-1301

**IDAPA 16
TITLE 01
CHAPTER 03**

**16.01.03 - EMERGENCY MEDICAL SERVICES (EMS) - AGENCY LICENSING
REQUIREMENTS**

000. LEGAL AUTHORITY.

The Idaho Board of Health and Welfare is authorized under Section 56-1023, Idaho Code, to adopt rules and standards concerning the administration of the Idaho Emergency Medical Services Act, Sections 56-1011 through 56-1023, Idaho Code. The Director is authorized under Section 56-1003, Idaho Code, to supervise and administer an emergency medical service program. ()

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.01.03, “Emergency Medical Services (EMS) - Agency Licensing Requirements.” ()

02. Scope. These rules include the categories of EMS agencies, eligibility requirements and standards for the licensing of EMS agencies, utilization of air medical services, and the initial application and renewal process for EMS agencies licensed by the state. ()

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, the Department may have written statements that pertain to the interpretation of this chapter, or to the documentation of compliance with these rules. ()

003. ADMINISTRATIVE APPEALS.

Administrative appeals and contested cases are governed by the provisions of IDAPA 16.05.03, “Rules Governing Contested Case Proceedings and Declaratory Rulings.” ()

004. INCORPORATION BY REFERENCE.

The Board of Health and Welfare has adopted the “Minimum Equipment Standards for Licensed EMS Services,” edition 2014, version 1.0, as its standard for minimum equipment requirements for licensed EMS Agencies and incorporates it by reference. Copies of these standards may be obtained from the Department, as described in Section 005 of these rules, or online at: <http://www.idahoems.org>. ()

**005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS --
TELEPHONE NUMBER -- INTERNET WEBSITE.**

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the state of Idaho. ()

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. ()

03. Street Address. ()

a. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. ()

b. The Bureau of Emergency Medical Services and Preparedness is located at 650 W. State Street, Suite B-17, Boise, Idaho 83702. ()

04. Telephone. ()

a. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. ()

b. The telephone number for the Bureau of Emergency Medical Services and Preparedness is (208) 334-4000. The toll-free phone number is 1-877-554-3367. ()

05. Internet Websites. ()

a. The Department internet website is found at <http://www.healthandwelfare.idaho.gov>. ()

b. The Bureau of Emergency Medical Services and Preparedness internet website is found at <http://www.idahoems.org>. ()

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS ACT COMPLIANCE AND REQUESTS.

01. Confidentiality of Records. Any disclosure of confidential information used or disclosed in the course of the Department's business is subject to the restrictions in state or federal law and must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records." ()

02. Public Records Act. The Department will comply with Sections 9-337 through 9-350, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. ()

007. -- 009. (RESERVED)

010. DEFINITIONS.

For the purposes of this chapter, the definitions in IDAPA 16.01.02, "Emergency Medical Services (EMS) - Rule Definitions," apply. ()

011. -- 074. (RESERVED)

075. INVESTIGATION OF COMPLAINTS FOR EMS LICENSING VIOLATIONS.

Investigation of complaints and disciplinary actions for EMS agency licensing are provided under IDAPA 16.01.12, "Emergency Medical Services (EMS) - Complaints, Investigations, and Disciplinary Actions." ()

076. ADMINISTRATIVE LICENSE OR CERTIFICATION ACTION.

Any license or certification may be suspended, revoked, denied, or retained with conditions for noncompliance with any standard or rule. Administrative license or certification actions, including fines, imposed by the EMS Bureau for any action, conduct, or failure to act that is inconsistent with the professionalism, or standards, or both, are provided under Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.12, "Emergency Medical Services (EMS) - Complaints, Investigations, and Disciplinary Actions." ()

077. -- 099. (RESERVED)

**EMS Agency General Licensure Requirement
(SECTIONS 100-199)**

100. AGENCY LICENSE REQUIRED.

Any organization that advertises or provides ambulance, air medical, or non-transport emergency medical services in Idaho must be licensed as an EMS agency under the requirements in Sections 56-1011 through 56-1023, Idaho Code, and this chapter of rules. ()

101. EXEMPTION OF EMS AGENCY LICENSURE.

An organization, licensed without restriction to provide emergency medical services in another state and not restricted from operating in Idaho by the Department, may provide emergency medical services in Idaho within the limits of its license without an Idaho EMS license only when the organization meets one (1) of the following: ()

01. Interstate Compact with Idaho. The organization holds an EMS license in another state where an interstate compact specific to EMS agency licensure with Idaho is in effect. ()

02. Emergency, Natural, or Man-made Disaster. The organization is responding to an emergency, or a natural or man-made disaster, declared by federal, state, or local officials and the services of the organization are requested by an entity of local or state government in Idaho. ()

03. Transfer of Patient From Out-of-State Medical Facility. The organization is: ()

a. Transferring a patient from an out-of-state medical facility to a medical facility in Idaho. The organization may return the patient to the point of origin; or ()

b. Transferring a patient from an out-of-state medical facility through the state of Idaho. ()

04. Transport of Patient From Out-of-State Emergency Scene. The organization is: ()

a. Transporting a patient from an out-of-state emergency scene to a medical facility in Idaho; or ()

b. Transporting a patient to a rendezvous with another ambulance. ()

102. SERVICES PROVIDED BY A LICENSED EMS AGENCY.

An EMS agency can provide only those services that are within the agency's service type, clinical level, and operational declarations stated on the most recent license issued by the Department, except when the agency has a planned deployment agreement described in Section 603 of these rules. ()

103. ELIGIBILITY FOR EMS AGENCY LICENSURE.

An entity is eligible for EMS agency licensure upon demonstrated compliance with the requirements in Idaho statutes and administrative rules in effect at the time the Department receives the application. ()

104. -- 199. (RESERVED)

**EMS Agency Licensure Model
(SECTIONS 200-299)**

200. EMS AGENCY-- LICENSING MODEL.

01. Licensing an EMS Agency. An eligible EMS agency in Idaho is licensed using a descriptive model that bases the agency licensure on the declarations made in the most recent approved initial or renewal application. An EMS agency must provide only those EMS services described in the most recent application on which the agency was issued a license by the Department. ()

02. EMS Agency License Models. An EMS agency license is based on the agency's service types, clinical levels, license duration, and operational declarations. Geographic coverage areas and resources may differ between the service types, clinical levels, and operational declarations under which an agency is licensed. ()

03. EMS Agency Providing Both Air Medical and Ground-Based EMS Services. An EMS agency that provides both air medical and ground-based EMS services must be licensed accordingly and meet all the requirements of an air medical and either an ambulance or non-transport agency, depending on the ground EMS services provided. ()

04. Multiple Organization EMS Agency. An EMS agency may be comprised of multiple organizations licensed under a single responsible authority to which the governing

officials of each organization agree. The authority must establish a deployment strategy that declares in which areas and at what times within their geographical response area will be covered by each declared service type, clinical level, and operational declaration. ()

201. EMS AGENCY -- SERVICE TYPES.

An EMS agency may be licensed as one (1) or more service types. An agency that provides multiple service types must meet the minimum requirements for each service type provided. The following are the agency services types available for EMS agency licensure. ()

01. Ground Agency Service Types. ()

a. Non-transport. ()

b. Ambulance. ()

02. Air Medical Agency Service Types. ()

a. Air Medical I. ()

b. Air Medical II. ()

202. EMS AGENCY -- CLINICAL LEVELS.

An EMS agency is licensed at one (1) or more of the following clinical levels depending on the agency's highest level of licensed personnel and life support services advertised or offered. ()

01. Non-transport. ()

a. EMR/BLS; ()

b. EMT/BLS; ()

c. AEMT/ILS; or ()

d. Paramedic/ALS. ()

02. Ambulance. ()

a. EMT/BLS; ()

b. AEMT/ILS; ()

c. Paramedic/ALS; or ()

d. Paramedic/ALS Critical Care. ()

03. Air Medical I. ()

- a. Paramedic/ALS; or ()
- b. Paramedic/ALS Critical Care. ()
- 04. Air Medical II.** ()
- a. EMT/BLS; or ()
- b. AEMT/ILS. ()

203. EMS AGENCY -- LICENSE DURATION.

Each EMS agency must identify the license duration for each license type. License durations are: ()

01. Ongoing. The agency is licensed to provide EMS personnel and equipment for an ongoing period of time and plans to renew its license on an annual basis. ()

02. Limited. The agency is licensed to provide EMS personnel and equipment for the duration of a specific event or a specified period of time with no expectation of renewing the agency license. ()

204. GROUND EMS AGENCY -- OPERATIONAL DECLARATIONS.

An agency providing ground services is licensed with one (1) or more of the following operational declarations depending on the services that the agency advertises or offers. ()

01. Prehospital. The prehospital operational declaration is available to an agency with primary responsibility for responding to calls for EMS within their designated geographic coverage area. ()

02. Prehospital Support. The prehospital support operational declaration is available to an agency that provides support under agreement to a prehospital agency having primary responsibility for responding to calls for EMS within a designated geographic coverage area. ()

03. Community Health EMS. The community health EMS operational declaration is available to an agency with a prehospital operational declaration that provides personnel and equipment for medical assessment and treatment at a non-emergency scene or at the direction of a physician or independent practitioner. ()

04. Transfer. The transfer operational declaration is available to an ambulance agency that provides EMS personnel and equipment for the transportation of patients from one (1) medical care facility in their designated geographic coverage area to another. An agency with this operational declaration must declare which sending facilities it routinely responds to if requested. ()

05. Standby. The standby operational declaration is available to an agency that provides EMS personnel and equipment to be staged at prearranged events within their designated geographic coverage area. ()

06. Non-Public. The non-public operational declaration is available to an agency that provides EMS personnel and equipment intended to treat patients who are employed or contracted by the license holder. An agency with a non-public operational declaration is not intended to treat members of the general public. A non-public agency must maintain written plans for patient treatment and transportation. ()

205. AIR MEDICAL AGENCY -- OPERATIONAL DECLARATIONS.

An agency providing air medical services is licensed with one (1) or both of the following operational declarations depending on the services that the agency advertises or offers. Service levels, geographic coverage areas, and resources may differ between the operational declarations under which an agency is licensed. ()

01. Air Medical Transport. The air medical transport operational declaration is available to an air medical agency that provides transportation of patients by air ambulance from a rendezvous or emergency scene to a medical care facility within its designated geographic coverage area. ()

02. Air Medical Transfer. The air medical transfer operational declaration is available to an Air Medical I agency that provides transportation of patients by air ambulance from one (1) medical care facility in its designated geographic coverage area to another. An agency with this operational declaration must declare which sending facilities it routinely responds to if requested. ()

206. -- 209. (RESERVED)

210. AMBULANCE EMS AGENCY -- PATIENT TRANSPORT OR TRANSFER.

An agency that is licensed as an ambulance service is intended for patient transport or transfer. ()

01. Transport. An ambulance agency may provide transportation of patients from a rendezvous or emergency scene to a rendezvous or medical care facility when that agency is licensed with one (1) of the following operational declarations: ()

- a. Prehospital; ()
- b. Prehospital Support; *or* ()
- c. Standby. ()

02. Transfer. An ambulance agency that provides the operational declaration of transfer can provide transportation of patients from one (1) medical care facility within their designated geographic coverage area to another. ()

211. AIR MEDICAL EMS AGENCY -- PATIENT TRANSPORT OR TRANSFER.

An agency that is licensed with an air medical service type is intended for patient transport or transfer. ()

01. Transport. An air medical agency that provides the operational declaration of air medical transport may provide transportation of patients from a rendezvous or emergency scene to a medical care facility. ()

02. Transfer. An air medical agency that provides the operational declaration of air medical transfer can provide transportation of patients from one (1) medical care facility within their designated geographic coverage area to another. ()

212. NON-TRANSPORT EMS AGENCY -- PATIENT MOVEMENT.

A non-transport agency is an agency that is not intended for patient transport and cannot advertise ambulance services. A non-transport agency can move a patient by vehicle only when: ()

01. Accessibility of Emergency Scene. The responding ambulance or air ambulance agency cannot access the emergency scene. ()

02. Licensed Personnel Level. Patient care is provided by EMS personnel licensed at: ()

a. EMT level or higher; or ()

b. EMR level only when the patient care integration agreement under which the non-transport agency operates addresses and enable patient movement. The agency must ensure that its personnel are trained and credentialed in patient packaging and movement. ()

03. Rendezvous with Transport EMS Agency. Movement of the patient is to rendezvous with an ambulance or air ambulance agency during which the EMS personnel must be in active communication with the ambulance or air ambulance with which they will rendezvous. ()

04. Report Patient Movement. A non-transport agency must report all patient movement events to the Department within thirty (30) days of the event. ()

213. -- 299. (RESERVED)

**Personnel Requirements For EMS Agency Licensure
(SECTIONS 300-399)**

300. EMS AGENCY -- GENERAL PERSONNEL REQUIREMENTS.

Personnel must be licensed according to IDAPA 16.01.07, "Emergency Medical Services (EMS) - Personnel Licensing Requirements." ()

01. Personnel Requirements for EMS Agency Licensure. Each agency must ensure availability of affiliated personnel licensed and credentialed at or above the agency's highest clinical level for the entire anticipated call volume for each of the agency's operational declarations. ()

02. Personnel Requirements for an Agency Utilizing Emergency Medical

Dispatch. An agency dispatched by a public safety answering point (PSAP) that uses an emergency medical dispatch (EMD) process to determine the clinical needs of the patient must ensure availability of personnel licensed and credentialed at clinical levels appropriate to the anticipated call volume for each of the clinical levels the agency provides. ()

03. Personnel Requirements for Prehospital ALS. A licensed Paramedic must be present whenever prehospital, prehospital support, or air medical transport ALS services are provided. ()

301. AMBULANCE EMS AGENCY -- PERSONNEL REQUIREMENTS.

Each ambulance agency must ensure that there are two (2) crew members on each patient transport or transfer. The crew member providing patient care, at a minimum, must be a licensed EMT. ()

302. AIR MEDICAL EMS AGENCY -- PERSONNEL REQUIREMENTS.

Each air medical agency must ensure that there are two (2) crew members, not including the pilot, on each patient transport or transfer. The crew member providing patient care, at a minimum, must be a licensed EMT. An air medical agency must also demonstrate that the following exists. ()

01. Personnel for Air Medical I Agency. An Air Medical I agency must ensure that each flight includes at a minimum, one (1) licensed professional nurse and one (1) Paramedic. Based on the patient's need, an exception for transfer flights may include a minimum of one (1) licensed respiratory therapist and one (1) licensed professional nurse, or two (2) licensed professional nurses. ()

02. Personnel for Air Medical II Agency. An Air Medical II agency must ensure that each flight includes at a minimum, two (2) licensed patient care providers with one (1) patient care provider licensed at or above the agency's highest clinical level of licensure. ()

303. CRITICAL CARE -- PERSONNEL REQUIREMENTS.

Each ambulance or air medical agency that advertises the provision of critical care clinical capabilities must affiliate and deploy EMS personnel trained and credentialed to provide all critical care skills described in IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission." ()

304. PLANNED DEPLOYMENT -- PERSONNEL REQUIREMENTS.

Planned deployment allows affiliated EMS personnel to act and provide predetermined services outside of their affiliating agency's geographic coverage area. It can allow EMS personnel licensed at a higher clinical level to provide patient care within their credentialed scopes of practice even when the agency into which the planned deployment occurs is licensed at a lower clinical level. A planned deployment agreement must be formally documented and meet all the requirements listed in Section 603 of these rules. ()

305. AMBULANCE-BASED CLINICIANS -- PERSONNEL REQUIREMENTS.

01. Ambulance-Based Clinician Certified by Department. An EMS agency that advertises or provides out-of-hospital patient care by affiliating and utilizing a currently licensed

professional nurse, advanced practice professional nurse, or physician assistant, as defined in IDAPA 16.01.02, “Emergency Medical Services (EMS) - Rule Definitions,” must ensure that those individuals maintain a current ambulance-based clinician certificate issued by the Department. See Section 306 of these rules for exceptions to this requirement. ()

02. Obtaining an Ambulance-Based Clinician Certificate. An agency, on behalf of an individual who desires an ambulance-based clinician certificate, must provide the following information on the Department’s application for a certificate: ()

a. Documentation that the individual holds a current, unrestricted license to practice issued by the Board of Medicine or Board of Nursing; and ()

b. Documentation that the individual has successfully completed an ambulance-based clinician course; or ()

c. Documentation that the individual has successfully completed an EMT course. ()

03. Maintaining an Ambulance-Based Clinician Certificate. An ambulance-based clinician certificate is valid for as long as the holder of the certificate is continuously licensed by his respective licensing board. ()

04. Revocation of an Ambulance-Based Clinician Certificate. The Department may revoke an ambulance-based clinician certificate based on the procedures for administrative license actions described in IDAPA 16.01.12, “Emergency Medical Services (EMS) -- Complaints, Investigations, and Disciplinary Actions.” ()

05. Currently Practicing Ambulance-Based Clinicians. In order to continue the utilization of an ambulance-based clinician, an EMS agency must ensure that its currently practicing clinicians have obtained the Department-issued ambulance-based clinician certificate by July 1, 2015. ()

06. Licensed Personnel Requirements and Ambulance-Based Clinicians. An EMR/BLS, EMT/BLS, or AEMT/ILS agency may use ambulance-based clinicians to meet the licensed personnel requirements for agency licensure. ()

07. Agency Responsibilities for Ambulance-Based Clinicians. The agency must verify that each ambulance-based clinician possess a current ambulance-based clinician certificate issued by the Department. The agency must ensure that any ambulance-based clinician meets additional requirements of the corresponding licensing board. ()

306. UTILIZING PHYSICIAN ASSISTANTS, LICENSED PROFESSIONAL NURSES OR ADVANCED PRACTICE PROFESSIONAL NURSES.

An AEMT/ILS ambulance agency may use a non-certified physician assistant, licensed professional nurse, or advanced practice professional nurse as the crew member who is providing ILS patient services, only when accompanied by a licensed EMT in the patient compartment of the transport vehicle. ()

307. -- 399. (RESERVED)

**EMS Agency Vehicle Requirements
(SECTIONS 400-499)**

400. EMS AGENCY -- VEHICLE REQUIREMENTS.

Not all EMS agencies are required to have emergency response vehicles. An agency's need for emergency response vehicles is based on the deployment needs of the agency that is declared on the most recent agency licensure application. An agency with a deployment pattern that requires emergency response vehicles must meet the following requirements: ()

01. Condition of Response Vehicles. Each of the agency's EMS response vehicles must be in sound, safe, working condition. ()

02. Quantity of Response Vehicles. Each EMS agency must possess a sufficient quantity of EMS response vehicles to ensure agency personnel can respond to the anticipated call volume of the agency. ()

03. Motor Vehicle Licensing Requirements. Each EMS agency's response vehicles must meet the applicable Idaho motor vehicle license and insurance requirements. ()

04. Configuration and Standards for EMS Response Vehicles. Each of the EMS agency's response vehicles must be appropriately configured in accordance with the declared capabilities on the most recent agency license. Each EMS response vehicle must meet the minimum requirements for applicable federal, state, industry, or trade specifications and standards for ambulance or air ambulance vehicles as appropriate. Uniquely configured EMS response vehicles must be approved by the Department prior to being put into service. ()

05. Location of Emergency Response Vehicles. Each agency's EMS response vehicles must be stationed or staged within the agency's declared geographic coverage area in a manner that allows agency personnel to effectively respond to the anticipated volume and distribution of requests for service. ()

401. NON-TRANSPORT EMS AGENCY -- VEHICLES.

A licensed non-transport EMS agency may use ambulance vehicles to provide non-transport services. ()

402. EMS AGENCY -- MINIMUM EQUIPMENT INSPECTION REQUIREMENTS.

Any newly acquired EMS response vehicle must be inspected by the Department for medical care supplies and devices as specified in the "Minimum Equipment Standards for Licensed EMS Services," before being put into service, except when the newly acquired vehicle is a replacement vehicle and all equipment and supplies are transferred from the vehicle being taken out of service. ()

403. EMS AGENCY -- GROUND VEHICLE SAFETY INSPECTION REQUIREMENTS.

Each EMS agency that deploys emergency vehicles titled and registered for use on roads and

highways, with the exception of all-terrain vehicles and utility vehicles, must meet the following inspection requirements. ()

01. New Vehicle Inspection. Each newly acquired, used EMS response vehicle must successfully pass a safety inspection conducted by an inspector authorized to perform Department of Transportation (DOT) vehicle safety inspections prior to the vehicle being put in service. ()

02. Response Vehicle Involved in a Crash. Each EMS response vehicle, that is involved in a crash that could result in damage to one (1) or more of the vehicle systems identified in Subsection 403.03 of this rule, must successfully pass a safety inspection conducted by an inspector authorized to perform DOT vehicle safety inspections prior to being put back in service. ()

03. Vehicle Inspection Standards. Each vehicle safety inspection must verify conformity to the fuel system, exhaust, wheels and tires, lights, windshield wipers, steering, suspension, brakes, frame, and electrical system elements of a DOT vehicle safety inspection defined in Appendix G to Subchapter B of Chapter III at 49 CFR Section 396.17. ()

04. Vehicle Inspection Records. Each EMS agency must keep records of all emergency response vehicle safety inspections. These records must be made available to the Department upon request. ()

404. -- 499. (RESERVED)

**EMS Agency Requirements And Waivers
(SECTIONS 500-599)**

500. EMS AGENCY -- GENERAL EQUIPMENT REQUIREMENTS AND MODIFICATIONS.

Each EMS agency must meet the requirements of the “Minimum Equipment Standards for Licensed EMS Services,” incorporated by reference in Section 004 of these rules, in addition to the following requirements: ()

01. Equipment and Supplies. Each EMS agency must maintain sufficient quantities of medical care supplies and devices specified in the minimum equipment standards to ensure availability for each response. ()

02. Safety and Personal Protective Equipment. Each EMS agency must maintain safety and personal protective equipment for licensed personnel and other vehicle occupants as specified in the minimum equipment standards. This includes equipment for body substance isolation and protection from exposure to communicable diseases and pathogens. ()

03. Modifications to an EMS Agency’s Minimum Equipment List. An EMS agency’s minimum equipment list may be modified upon approval by the Department. Requests for equipment modifications must be submitted to the Department and include clinical and operational justification for the modification and be signed by the EMS agency’s medical director.

Approved modifications are granted by the Department as either an exception or an exemption.

()

a. Exceptions to the agency’s minimum equipment list requirements may be granted by the Department upon inspection or review of a modification request, when the circumstances and available alternatives assure that appropriate patient care will be provided for all anticipated incidents.

()

b. Exemptions that remove minimum equipment and do not provide an alternative may be granted by the Department following review of a modification request. The request must describe the agency’s deployment model and why there is no anticipated need for the specified equipment to provide appropriate patient care.

()

04. Review of an Equipment Modification Request. Each request from an EMS agency for equipment modification may be reviewed by either the EMS Advisory Committee (EMSAC), or the EMS Physician Commission (EMSPC), or both. The recommendations from EMSAC and EMSPC are submitted to the Department which has the final authority to approve or deny the modification request.

()

a. A modification request of an operational nature will be reviewed by EMSAC;

()

b. A modification request of a clinical nature will be reviewed by the EMSPC; and

()

c. A modification request that has both operational and clinical considerations will be reviewed by both.

()

05. Denial of an Equipment Modification Request. An EMS agency may appeal the denial of an equipment modification request under the provisions in IDAPA 16.05.03, “Rules Governing Contested Case Proceedings and Declaratory Rulings.”

()

06. Renewal of Equipment Modification. An EMS agency’s equipment modification must be reviewed and reaffirmed as follows:

()

a. Annually, with the agency license renewal application; or

()

b. When the EMS agency changes its medical director.

()

501. AIR MEDICAL EMS AGENCY -- EQUIPMENT REQUIREMENTS AND MODIFICATIONS.

Each air medical agency must meet the requirements outlined in Section 500 of these rules, as well as the following:

()

01. FAA 135 Certification. The air medical agency must hold a Federal Aviation Administration 135 certification.

()

02. Configuration and Equipment Standards. Aircraft and equipment configuration

that does not compromise the ability to provide appropriate care or prevent emergency care providers from safely performing emergency procedures, if necessary, while in flight. ()

502. -- 509. (RESERVED)

510. EMS AGENCY -- COMMUNICATION REQUIREMENTS.

Each EMS agency must meet the following communication requirements to obtain or maintain agency licensure. ()

01. Air Medical EMS Agency. Each air medical agency must have mobile radios of sufficient quantities to ensure that every aircraft and ground crew has the ability to communicate on the frequencies 155.340 MHZ and 155.280 MHZ, with continuous tone coded squelch system encoding capabilities to allow access to the Idaho EMS radio communications system. ()

02. Ambulance EMS Agency. Each ambulance EMS agency must have mobile radios of sufficient quantities to ensure that every vehicle crew has the ability to communicate on the frequencies 155.340 MHZ and 155.280 MHZ, with continuous tone coded squelch system encoding capabilities to allow access to the Idaho EMS radio communications system. ()

03. Non-transport EMS Agency. Each non-transport EMS agency must have mobile or portable radios of sufficient quantities to ensure that agency personnel at an emergency scene have the ability to communicate on the frequencies 155.340 MHZ and 155.280 MHZ, with continuous tone coded squelch system encoding capabilities to allow access to the Idaho EMS radio communications system. ()

511. EMS AGENCY -- DISPATCH REQUIREMENTS.

Each EMS agency must have a twenty-four (24) hour dispatch arrangement. ()

511. -- 519. (RESERVED)

520. EMS AGENCY -- RESPONSE REQUIREMENTS AND WAIVERS.

Each EMS agency must respond to calls on a twenty-four (24) hour a day basis within the agency's declared geographic coverage area unless a waiver exists. ()

521. NON-TRANSPORT EMS AGENCY -- WAIVER OF RESPONSE REQUIREMENT.

The controlling authority of a non-transport agency may petition the Department for a waiver of the twenty-four (24) hour response requirement if one (1) or more of the following conditions exist: ()

01. Not Populated on 24-Hour Basis. The community, setting, industrial site, or event being served by the agency is not populated on a twenty-four (24) hour basis. ()

02. Not on Daily Basis Per Year. The community, setting, industrial site, or event being served by the agency does not exist on a three hundred sixty-five (365) day per year basis. ()

03. Undue Hardship on Community. The provision of twenty-four (24) hour

response would cause an undue hardship on the community being served by the agency. ()

04. Abandonment of Service. The provision of twenty-four (24) hour response would cause abandonment of the service provided by the agency. ()

522. NON-TRANSPORT EMS AGENCY -- PETITION FOR WAIVER.

01. Submit Petition for Waiver. The controlling authority of an existing non-transport agency desiring a waiver of the twenty-four (24) hour response requirement must submit a petition for waiver to the Department. ()

02. Waiver Declared on Initial Application. The controlling authority of an applicant non-transport agency desiring a waiver of the twenty-four (24) hour response requirement must declare the request for waiver on the initial application for agency licensure to the Department. ()

03. Not Populated on a 24-Hour or Daily Basis -- Petition Content. A non-transport agency with a service area with less than twenty-four (24) hours population or less than three-hundred sixty-five (365) days per year population must include the following information on the petition for waiver of the twenty-four (24) hour response requirement: ()

a. A description of the hours or days the geographic area is populated. ()

b. A staffing and deployment plan that ensures EMS response availability for the anticipated call volume during the hours or days of operation. ()

04. Undue Hardship or Abandonment of Service Waiver -- Petition Content. A non-transport agency must include the following information on the application for waiver of the twenty-four (24) hour response requirement when that provision would cause an undue hardship on the community being served by the agency or abandonment of service: ()

a. A description of the applicant's operational limitations to provide twenty-four (24) hour response. ()

b. A description of the initiatives underway or planned to provide twenty-four (24) hour response. ()

c. A staffing and deployment plan identifying the agency's response capabilities and back up plans for services to the community when the agency is unavailable. ()

d. A description of the collaboration that exists with all other EMS agencies providing services within the applicant's geographic response area. ()

05. Renewal of Waivers. The controlling authority of a non-transport agency desiring to renew a waiver of the twenty-four (24) hour response requirement must declare the request for renewal of the waiver on the annual renewal application for agency licensure to the Department. ()

523. -- 524. (RESERVED)

525. AMBULANCE OR AIR MEDICAL EMS AGENCY -- WAIVER OF RESPONSE REQUIREMENT.

The controlling authority of a existing ambulance or air medical agency may petition the Board of Health and for a waiver of the twenty-four (24) hour response requirement if one (1) or more of the following conditions exist: ()

01. Undue Hardship on Community. The provision of twenty-four (24) hour response would cause an undue hardship on the community being served by the agency. ()

02. Abandonment of Service. The provision of twenty-four (24) hour response would cause abandonment of the service provided by the agency. ()

526. AMBULANCE OR AIR MEDICAL EMS AGENCY -- PETITION FOR WAIVER.

01. Submit Petition for Waiver. The controlling authority of an existing ambulance or air medical agency desiring a waiver of the twenty-four (24) hour response requirement must submit a petition for waiver to the Board. ()

02. Undue Hardship or Abandonment of Service Waiver -- Petition Content. An ambulance EMS agency must include the following information on the petition for waiver of the twenty-four (24) hour response: ()

a. A description of the petitioner's operational limitations to provide twenty-four (24) hour response. ()

b. A description of the initiatives underway or planned to provide twenty-four (24) hour response. ()

c. A staffing and deployment plan identifying the agency's response capabilities and back-up plans for services to the community when the agency is unavailable. ()

d. A description of the collaboration that exists with all other EMS agencies providing services within the petitioner's geographic response area. ()

527. -- 529. (RESERVED)

530. EMS AGENCY -- MEDICAL SUPERVISION REQUIREMENTS.

Each EMS agency must comply with medical supervision plan requirements and designate a physician as the agency medical director who is responsible for the supervision of medical activities defined in IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission." ()

531. -- 534. (RESERVED)

535. EMS AGENCY -- DATA COLLECTION AND SUBMISSION REQUIREMENTS.

Each EMS agency must comply with the data collection and submission requirements required in

IDAPA 16.02.03, "Emergency Medical Services," Section 435. ()

536. -- 599. (RESERVED)

**EMS Agency Agreements, Plans, And Policies
(SECTIONS 600-699)**

600. EMS AGENCY -- AGREEMENTS, PLANS, AND POLICIES.

When applicable, each EMS agency must make the following agreements, plans, and policies, described in Sections 600 through 699 of these rules, available to the Department upon request. ()

601. EMS AGENCY -- PATIENT CARE INTEGRATION.

01. Cooperative Agreements for Common Geographic Coverage Area. Each ground EMS agency that shares common geographic coverage areas with other EMS agencies must develop cooperative written agreements that address integration of patient care between the agencies. A ground agency can not provide a level of care that exceeds the clinical level of a prehospital agency receiving the patient, unless the written patient integration plan specifically addresses the continuation of the higher level of care throughout the patient transport. ()

02. Cooperative Agreement for Non-Transport Agency. Each non-transport EMS agency must have a cooperative written agreement with a prehospital agency that will provide patient transportation. The agreement must address integration of patient care between the agencies. A non-transport prehospital agency may not provide a level of care that exceeds the clinical level of the responding transport prehospital agency unless the integration plan specifically addresses the continuation of the higher level of care throughout the patient transport. ()

602. AIR MEDICAL EMS AGENCY -- PATIENT CARE INTEGRATION.

Each air medical agency must declare and make available its patient care integration policies to the Department upon request. ()

603. EMS AGENCY -- PLANNED DEPLOYMENT AGREEMENTS.

Each EMS agency that utilizes a planned deployment must develop a cooperative planned deployment agreement between the EMS agencies. The agreement must include the following: ()

01. Chief Administrative Officials. Approval of the chief administrative officials of each EMS agency entering into the agreement either as the receiver of the planned deployment or the provider of the planned deployment. ()

02. Medical Directors. Approval of the medical directors of each EMS agency entering into the agreement either as the receiver of the planned deployment or the provider of the planned deployment. ()

03. Geographic Locations and Services. The agreement must provide the geographic

locations and the services to be provided by the planned deployment. ()

04. Shared Resources. The agreement must provide for any sharing of resources between each EMS agency covered by the planned deployment. ()

05. Equipment and Medication. The agreement must provide for the availability and responsibility of equipment and medications for each EMS agency covered by the planned deployment. ()

06. Patient Integration of Care. The agreement must provide patient integration of care by each EMS agency covered by the planned deployment. ()

07. Patient Transport. The agreement must provide for patient transport considerations by each EMS agency covered by the planned deployment. ()

08. Medical Supervision. The agreement must have provisions for medical supervision of each EMS agency covered by the planned deployment. ()

09. Quality Assurance. The agreement must provide for quality assurance and retrospective case reviews by each EMS agency covered by the planned deployment. ()

604. -- 649. (RESERVED)

650. AIR MEDICAL EMS AGENCY -- REQUIRED POLICIES.

Each air medical EMS agency must have the following policies on file with the Department: ()

01. Non-Discrimination Policy. Each air medical EMS agency must have written non-discrimination policies to ensure that requests for service are not evaluated based on the patient's ability to pay. ()

02. Weather Turn Down Policy. Each air medical EMS agency must immediately notify other air medical agencies in common geographical areas and the Idaho EMS State Communications Center about any requests for services declined or aborted due to weather. Notification to other agencies of flights declined or aborted due to weather must be documented. ()

03. Patient Destination Procedure. Each air medical EMS agency must maintain written procedures for the determination of patient destination. These procedures must: ()

a. Consider the licensed EMS agency destination protocol and medical supervision received; ()

b. Be made available to licensed EMS agencies that utilize their services; ()

c. Honor patient preference if: ()

i. The requested facility is capable of providing the necessary medical care; and

()
ii. The requested facility is located within a reasonable distance not compromising patient care or the EMS system. ()

04. Safety Program Policy. Each air medical EMS agency must maintain a safety program policy that includes: ()

- a. Designation of a safety officer; ()
- b. Designation of a multi-disciplinary safety committee that includes: pilot, medical personnel, mechanic, communication specialist, and administrative staff; ()
- c. Post-Accident Incident Plan; ()
- d. Fitness for Duty Requirements; ()
- e. Annual Air Medical Resource Management Training; ()
- f. Procedures for allowing a crew member to decline or abort a flight; ()
- g. Necessary personal equipment, apparel, and survival gear appropriate to the flight environment. Helmets must be required for each EMS crew member and pilot during helicopter operations; and ()
- h. A procedure to review each flight for safety concerns and report those concerns to the safety committee. ()

05. Training Policy. Each air medical EMS agency must have written documentation of initial and annual air medical specific recurrent training for air ambulance personnel. Education content must include: ()

- a. Altitude physiology; ()
- b. Stressors of flight; ()
- c. Air medical resource management; ()
- d. Survival; ()
- e. Navigation; and ()
- f. Aviation safety issues including emergency procedures. ()

651. -- 699. (RESERVED)

EMS Agency Utilization of Air Medical Services

(SECTIONS 700-799)

700. EMS AGENCY -- CRITERIA TO REQUEST AN AIR MEDICAL RESPONSE.

Each ground EMS agency must establish written criteria for the agency's licensed EMS personnel that provides decision-making guidance for requesting an air medical response to an emergency scene. This criteria must be approved by the agency's medical director. The following conditions must be included in the criteria: ()

01. Clinical Conditions. Each licensed EMS agency must develop written criteria based on best medical practice principles for requesting an air medical response for the following clinical conditions: ()

- a. The patient has a penetrating or crush injury to head, neck, chest, abdomen, or pelvis; ()
- b. Neurological presentation suggestive of spinal cord injury; ()
- c. Evidence of a skull fracture (depressed, open, or basilar) as detected visually or by palpation; ()
- d. Fracture or dislocation with absent distal pulse; ()
- e. A glasgow coma score of ten (10) or less; ()
- f. Unstable vital signs with evidence of shock; ()
- g. Cardiac arrest; ()
- h. Respiratory arrest; ()
- i. Respiratory distress; ()
- j. Upper airway compromise; ()
- k. Anaphylaxis; ()
- l. Near drowning; ()
- m. Changes in level of consciousness; ()
- n. Amputation of an extremity; and ()
- o. Burns greater than twenty percent (20%) of body surface or with suspected airway compromise. ()

02. Complications to Clinical Conditions. Each licensed EMS agency must develop a written policy that provides guidance for requesting an air medical response when there are complicating conditions associated with the clinical conditions listed in Subsection 700.01 of this

rule. The complicating conditions must include the following: ()

- a. Extremes of age; ()
- b. Pregnancy; and ()
- c. Patient “do not resuscitate” status as described in IDAPA 16.02.03, “Emergency Medical Services,” Section 400. ()

03. Operational Conditions for Air Medical Response. Each licensed EMS agency must have written criteria to provide guidance to the licensed EMS personnel for the following operational conditions: ()

- a. Availability of local hospitals and regional medical centers; ()
- b. Air medical response to the scene and transport to an appropriate hospital will be significantly shorter than ground transport time; ()
- c. Access to time sensitive medical interventions such as percutaneous coronary intervention, thrombolytic administration for stroke, or cardiac care; ()
- d. When the patient's clinical condition indicates the need for advanced life support and air medical is the most readily available access to advanced life support capabilities; ()
- e. As an additional resource for a multiple patient incident; ()
- f. Remote location of the patient; and ()
- g. Local destination protocols. ()

701. EMS AGENCY -- EMS PERSONNEL REQUEST FOR AIR MEDICAL RESPONSE.

Licensed EMS personnel en route to or at the emergency scene have the primary responsibility and authority to request the response of air medical services using the local incident management system and licensed EMS agency written criteria described in Section 700 of these rules. ()

702. EMS AGENCY -- CANCELLATION OF AN AIR MEDICAL RESPONSE.

Following dispatch of air medical services, an air medical response may only be cancelled upon completion of a patient assessment performed by licensed EMS personnel. ()

703. EMS AGENCY -- ESTABLISHED CRITERIA FOR SIMULTANEOUS DISPATCH.

A ground EMS agency may establish criteria for simultaneous dispatch for air and ground medical response. Air medical services will not launch to an emergency scene unless requested in accordance with Subsection 720.01 of these rules. ()

704. EMS AGENCY-- SELECTION OF AIR MEDICAL AGENCY.

Each EMS agency has the responsibility to select an appropriate air medical service EMS agency.

()

01. Written Policy to Select Air Medical Agency. Each EMS agency must have a written policy that establishes a process to select an air medical service. ()

02. Policy for Patient Requests. The written policy must direct EMS personnel to honor a patient request for a specific air medical service when the circumstances will not jeopardize patient safety or delay patient care. ()

705. -- 719. (RESERVED)

720. EMS AGENCY -- COMMUNICATIONS WITH AIR MEDICAL SERVICES.

01. Responsibility to Request an Air Medical Response. In compliance with the local incident management system, each EMS agency must establish a uniform method of communication to request an air medical response. ()

02. Required Information to Request an Air Medical Response. Requests for an air medical response must include the following information as it becomes available: ()

a. Type of incident; ()

b. Landing zone location or GPS (latitude/longitude) coordinates, or both; ()

c. Scene contact unit or scene incident commander, or both; ()

d. Number of patients if known; ()

e. Need for special equipment; ()

f. Estimated weight of the patient; ()

g. How to contact on scene EMS personnel; and ()

h. How to contact the landing zone officer. ()

03. Notification of Air Medical Response. The air medical agency must notify the State EMS Communication Center within ten (10) minutes of launching an aircraft in response to a request for medical transport. Notification must include: ()

a. The name of the requesting entity; ()

b. Location of the landing zone; and ()

c. Scene contact unit and scene incident commander, if known. ()

04. Estimated Time of Arrival at the Specified Landing Zone. Upon receipt of a request for air medical emergency services, the air medical agency must provide the requesting

entity with an estimated time of arrival (ETA) at the location of the specified landing zone. All changes to that ETA must immediately be reported to the requesting entity. ETAs are to be reported in clock time, specific to the appropriate time zone. ()

05. Confirmation of Air Medical Response Availability. Upon receipt of a request for an air medical response, the air medical agency must inform the requesting entity whether the specified air medical unit is immediately available to respond. ()

721. -- 729. (RESERVED)

730. EMS AGENCY -- LANDING ZONE PROCEDURES FOR AIR MEDICAL RESPONSE.

01. Establish Landing Zone Procedures. A licensed ambulance or non-transport EMS agency in conjunction with an air medical agency must have written procedures for the establishment of a landing zone. These procedures must be compatible with the local incident management system. ()

02. Responsibilities of Landing Zone Officer. The procedures for establishment of a landing zone must include identification of a Landing Zone Officer who is responsible for the following: ()

- a.** Landing zone preparation; ()
- b.** Landing zone safety; and ()
- c.** Communication between the ground EMS agency and the air medical agency. ()

03. Final Decision to Use Established Landing Zone. The air medical pilot may refuse the use of an established landing zone. In the event of a pilot's refusal to land, the landing zone officer must initiate communications to identify an alternate landing zone. ()

731. EMS AGENCY -- REVIEW OF AIR MEDICAL RESPONSES.

Each EMS agency must provide incident specific patient care related data identified and requested by the Department in the review of air medical response criteria. ()

732. -- 799. (RESERVED)

**EMS Agency Inspections
(SECTIONS 800-899)**

800. EMS AGENCY -- INSPECTIONS BY THE DEPARTMENT.

Representatives of the Department are authorized to enter an agency's facility at reasonable times to inspect an agency's vehicles, equipment, response records, and other necessary items to determine that the EMS agency is in compliance with governing Idaho statutes and administrative rules. ()

801. EMS AGENCY -- INSPECTION REQUESTS AND SCHEDULING.

An applicant eligible for agency inspection must contact the Department to schedule an inspection. In the event that the acquisition of capital equipment, hiring or licensure of personnel is necessary for the inspection process, the applicant must notify the Department when ready for the inspection. ()

802. EMS AGENCY -- INSPECTION TIMEFRAME AFTER NOTIFICATION OF ELIGIBILITY.

An applicant must schedule and have an inspection completed within six (6) months of notification of eligibility by the Department. An application without an inspection completed within six (6) months is void and must be resubmitted as an initial application. ()

803. -- 804. (RESERVED)

805. EMS AGENCY -- INITIAL AGENCY INSPECTION.

The Department will perform an initial inspection, which is an integral component of the application process, to ensure the EMS Agency applicant is in compliance regarding the following: ()

01. Validation of Initial Application. Validate the information contained in the application. ()

02. Verification of Compliance. Verify the applicant is in compliance with governing Idaho statutes and administrative rules. ()

03. Observations and Assistance. When requested by the applicant, the Department will provide observations and assistance where appropriate. ()

806. EMS AGENCY -- DEMONSTRATION OF CAPABILITIES DURING INSPECTION.

The Department will review historical and current information during the annual, random and targeted inspections whereas an applicant must demonstrate the following during the initial inspection process: ()

01. Validation of Ability to Submit Data. Each EMS agency applicant must demonstrate the ability to submit data described in Section 535 of these rules. ()

02. Validation of Ability to Communicate. Each EMS agency applicant must demonstrate the ability to communicate via radio with the state EMS communications center, local dispatch center, neighboring EMS agencies on which the applicant will rely for support, first response, air and ground patient transport, higher level patient care, or other purposes. ()

807. -- 809. (RESERVED)

810. EMS AGENCY -- ANNUAL AGENCY INSPECTION.

The Department will perform an annual inspection which is an integral component of the agency license renewal process that serves to: ()

01. Review EMS Agency History. Review the agency's history of compliance during the most recent licensure period. ()

02. Verification of Compliance. Verify current agency compliance with governing Idaho statutes and administrative rules. ()

03. Observations and Assistance. When requested by the applicant, the Department will provide observations and assistance where appropriate. ()

811. EMS AGENCY -- RANDOM AGENCY INSPECTION.

The Department will perform a random inspection serves to: ()

01. Verification of Compliance. Validate the agency's continual compliance with governing Idaho statutes and administrative rules. ()

02. Observations and Assistance. When requested by the applicant, the Department will provide observations and assistance where appropriate. ()

812. EMS AGENCY -- TARGETED AGENCY INSPECTION.

A targeted EMS agency inspection serves to answer specific concerns related to the agency's compliance with governing Idaho statutes and administrative rules. ()

813. -- 814. (RESERVED)

815. NON-TRANSPORT EMS AGENCY -- EQUIPMENT TO BE INSPECTED.

Each non-transport EMS agency must have the minimum equipment specified in the "Minimum Equipment Standards for Licensed EMS Services," incorporated by reference in Section 004 of these rules. ()

01. Access to Equipment. Licensed personnel must have access to the required equipment as specified in the agency minimum equipment standards. ()

02. Equipment Storage. The equipment must be stored on a dedicated response vehicle or be in the possession of licensed personnel. ()

816. AMBULANCE EMS AGENCY -- EQUIPMENT TO BE INSPECTED.

Each ambulance EMS agency must have the minimum equipment specified in the "Minimum Equipment Standards for Licensed EMS Services," incorporated by reference in Section 004 of these rules. ()

01. Medical Care Supplies. Each ambulance must be equipped with medical care supplies and devices as specified in the agency minimum equipment standards unless Subsection 816.02 or 816.03 of this rule applies. ()

02. Public Safety Answering Point Dispatch. An agency dispatched by a public safety answering point (PSAP) that uses an emergency medical dispatch (EMD) process to determine the clinical needs of the patient must ensure the availability of medical care supplies

and devices as specified in the agency minimum equipment standards that are appropriate for each response. ()

03. Agency Transferring Patients. An agency transferring patients from one (1) medical care facility included in their designated geographic coverage area to another will be equipped with medical care supplies and devices appropriate for the patient identified by the sending facility. ()

817. AIR MEDICAL EMS AGENCY -- EQUIPMENT TO BE INSPECTED.

Each air medical EMS agency must have the medical equipment specified in the agency minimum equipment standards available for each response. ()

818. -- 819. (RESERVED)

820. EMS AGENCY -- VEHICLES TO BE INSPECTED.

01. Initial Agency Inspections. Each EMS response vehicle must be inspected for medical care supplies and devices specified in the “Minimum Equipment Standards for Licensed EMS Services,” incorporated by reference in Section 004 of these rules during an initial agency inspection. ()

02. Annual Inspections. A random sample of vehicles may be selected for inspection during annual inspections provided the agency has a vehicle stockage and inventory plan that provides assurance that all response vehicles meet the minimum equipment standards. If vehicles selected for random sampling fail to demonstrate compliance with the minimum equipment standards, the entire fleet of EMS response vehicles may be inspected. ()

03. Targeted Inspections. A targeted inspection will focus on the specific elements of concern and may not include any vehicle inspections. ()

821. -- 824. (RESERVED)

825. EMS AGENCY -- MULTIPLE ORGANIZATION EMS AGENCY INSPECTIONS.

During an agency’s renewal inspection, its deployment strategy will be reviewed for that point in time and the system’s vehicles and equipment will be inspected accordingly. ()

826. -- 829. (RESERVED)

830. EMS AGENCY -- CONDITION THAT RESULTS IN VEHICLE OR AGENCY OUT OF SERVICE.

Upon discovery of a condition during inspection that could reasonably pose an immediate threat to the safety of the public or agency staff, the Department may declare the condition unsafe and remove the vehicle or agency from service until the unsafe condition is corrected. ()

831. -- 839. (RESERVED)

840. EMS AGENCY -- EXEMPTIONS FOR AGENCIES CURRENTLY ACCREDITED BY A NATIONALLY RECOGNIZED PROFESSIONAL EMS ACCREDITATION AGENCY.

Upon petition by the accredited agency, the Department will review the accreditation standards under which the accredited agency was measured and may waive specific duplicated annual inspection requirements where appropriate. If an external accreditation inspection is found to be more rigorous than that of the Department, the Department may elect to relax the frequency of Department annual inspections or waive Department annual inspections altogether. ()

841. -- 899. (RESERVED)

**EMS Agency Licensure Process
(SECTIONS 900-999)**

900. EMS AGENCY -- APPLICATION FOR INITIAL LICENSURE.

To be considered for initial EMS agency licensure an organization seeking licensure must request, complete, and submit the standardized EMS agency initial license application form provided by the Department. ()

901. EMS AGENCY -- LICENSURE EXPIRATION.

01. Duration of Agency License. Each EMS agency license, unless otherwise declared on the license, is valid for one (1) year from the end of the month of issuance by the Department. ()

02. Agency License Expiration Dates. To the extent possible, each EMS agency license expiration date is established depending on the geographic location of the agency. The geographic distribution of expiration dates can be obtained from the Department. See Section 005 of these rules for contact information. ()

902. -- 909. (RESERVED)

910. EMS AGENCY -- INFORMATION REQUIRED ON INITIAL APPLICATION.

Each application for initial licensure must contain the required information listed in Sections 911 through 922 of these rules. The information must be submitted on the Department's standardized agency license application form. ()

911. CALL VOLUME.

Each applicant must submit a categorized breakdown of call volume projections for the first full year of operation in each of the following categories: ()

01. Operational Declarations. The total call volume for each operational declaration within the applicant's geographic coverage area. ()

02. Patient Transport Percentage. The percentage of patients requiring transport. ()

912. GEOGRAPHIC COVERAGE AREA.

Each applicant must provide a specific description of the Idaho jurisdictions that the applicant will serve using known geopolitical boundaries or geographic coordinates and a graphic representation of the same. ()

01. Declare Coverage Area for Service Types and Operations. Each applicant must declare a geographic coverage area for each requested service type and operational declaration. Each service type and operational declaration can have a different geographic coverage area. ()

02. Transfer or Air Medical Transfer Declarations. Each applicant with the operational declaration of transfer or air medical transfer will establish its geographic coverage area by declaring which sending facilities they routinely respond to if requested. ()

913. STAFFING.

Each applicant must submit staffing projections for the first full year of operation that includes the following. ()

01. Personnel Roster. The roster must identify all licensed personnel by name and licensure level. ()

02. Proof of Licensure. Applicant must provide documentation that ensures all licensed personnel are appropriately licensed and credentialed. ()

03. Identify Compensation Type. Identify each individual listed as: ()

a. Uncompensated volunteer; ()

b. Compensated volunteer; ()

c. Part-time paid; or ()

d. Full-time paid. ()

04. Staffing Pattern. Provide a description of how the staffing pattern will ensure appropriately licensed personnel are available to provide the required care. ()

914. VEHICLES AND EQUIPMENT.

Each applicant must submit a list of the agency's vehicles and equipment. ()

01. Shared Vehicles and Equipment. The applicant must declare all vehicles and equipment that are shared with another agency, other license category, or operational declaration. ()

02. Station and Use of Vehicles and Equipment. The applicant must describe how the vehicle or equipment is stationed, used, and the frequency of use by each license category, operational declaration, and agency. ()

915. COMMUNICATIONS.

Each applicant must submit a list of the agency's communications equipment as provided in Section 510 of these rules. ()

916. DISPATCH AGREEMENT.

Each applicant must submit a copy of the dispatch agreement and include it in the agency's application. The dispatch agreement must be signed by an official from the dispatch organization and by the applicant. ()

917. EXTRICATION SERVICE PROVIDER.

Each applicant that intends to provide prehospital care, but does not plan to perform extrication services, must identify what organizations, if any, will perform extrication operations in its geographical response area. ()

918. AGENCY COSTS AND REVENUE.

For informational purposes, the applicant must submit a categorized breakdown of cost and revenue projections for the first full year of operation in each of the following categories: ()

01. Projected Operating Costs. Operating costs specific to the EMS operation. ()

02. Projected Revenue. Revenues specific to the EMS operation. ()

03. Projected Capital. Capital resources and purchases specific to the EMS operation; ()

04. Projected Personnel Costs. Personnel costs specific to the EMS operation; and ()

05. Projected Tax-Based Revenue. Tax-based revenue and support specific to the EMS operation. ()

919. RESPONSE TIMES.

Each applicant must submit a statement of response time projections described below. ()

01. Projected Response Times with Data. An applicant in an area where response time data for a similar agency exists will describe how the model declared in the application will change known response times within the geographic coverage areas. Applicants will submit, on the agency application, declarations of the following: ()

a. The longest response time recorded in the preceding twenty-four (24) months by a similar agency within the geographic coverage area, responding to an emergency call in ideal weather during daylight hours. The longest known response time declaration will include a description of the beginning and ending points of the response and a description of how the applicant will affect this response time. ()

b. The projected longest response time within the geographic coverage area, responding to an emergency call in ideal weather during daylight hours. The longest projected

response time declaration will include a description of the beginning and ending points of the response and the predicted frequency of calls to the area with the longest projected response time. ()

c. The average recorded response time in the preceding twenty-four (24) months by a similar agency within the geographic coverage area, responding to an emergency call in ideal weather during daylight hours. ()

d. An applicant's projected average response time within the geographic coverage area, responding to an emergency call in ideal weather during daylight hours and a description of how the applicant will achieve this average response time. ()

02. Projected Response Times with No Data. An applicant in an area where no response time data for a similar agency exists will only be required to submit response time projections. Applicants will submit, on the agency application, declarations of the following: ()

a. The projected longest response time within the geographic coverage area, responding to an emergency call in ideal weather during daylight hours. The longest projected response time declaration will include a description of the beginning and ending points of the response and the predicted frequency of calls to the area with the longest projected response time. ()

b. An applicant's projected average response time within the geographic coverage area, responding to an emergency call in ideal weather during daylight hours and a description of how the applicant will achieve this average response time. ()

920. CLINICAL BENEFITS.

Each applicant must submit a narrative describing the projected clinical benefits that will result from licensure. The narrative must include the following: ()

01. Description from Medical Director for Change. An endorsement from the applicant's medical director that describes the rationale for change. ()

02. Description of Changes to Level of Care. A description of the projected change in the level of care provided for patients within the geographic coverage area. ()

03. Description of Changes to Response for Treatment. A description of the projected change in time to treatment for patients within the geographic coverage area. ()

04. Description of Planned Location of Resources. A description of the location of agency resources and equipment available to the applicant. ()

05. Description of Impact on Community. A description of the impact on other resources and the community. ()

06. Description of Personnel Training. A description of the process to train personnel. ()

921. MEDICAL SUPERVISION PLAN.

Each applicant must include a Medical Supervision Plan described in IDAPA 16.02.02, “Rules of the Emergency Medical Services (EMS) Physician Commission.” ()

922. MEDICAL DIRECTOR AGREEMENT.

Each applicant must have a signed agreement with its medical director described in IDAPA 16.02.02, “Rules of the Idaho Emergency Medical Services (EMS) Physician Commission.” ()

923. -- 929. (RESERVED)

930. AGENCY APPLICATION REVIEW AND NOTIFICATIONS.

The Department will review the application for completeness upon receipt. The Department will make the following notifications following the review of an agency application: ()

01. Reply to Applicant. The Department will send a written reply to the applicant within fourteen (14) days of receipt verifying the application or any subsequent application material was received and found to be either complete or incomplete. ()

02. Notification of Incomplete Application. An applicant, whose application is determined to be incomplete, will be given the opportunity to address the findings of the Department’s initial review and resubmit documentation needed to complete the application. ()

03. No Action After Notification of Incomplete Application. Any incomplete application having no action taken by the applicant within sixty (60) days of notification by the Department is considered void and will need to be resubmitted as an initial application. ()

04. Notification to Other Jurisdictions. Within fourteen (14) days of receipt of a completed application for agency licensure, which includes an ongoing license duration and operational declarations other than non-public, the Department will send a written notice to all cities, counties, and other units of local government that have any geographic coverage area in common with the applicant. ()

05. Content of Notification. The notice will provide the applicant's proposed licensure status that includes: ()

a. Geographic coverage area; ()

b. Agency type; ()

c. Clinical level of services; ()

d. Operational declarations; and ()

e. A summary of any declarations made by the applicant that assume knowledge, cooperation, or collaboration of any of the cities, counties, and other units of local government

that have any geographic coverage area in common with the applicant. ()

06. Notification to EMS Agencies in Geographic Coverage Area. A notice will be sent to EMS agencies that share a geographic coverage area with applications requesting a license with limited duration. ()

931. -- 939. (RESERVED)

940. APPLICATION EVALUATION.

01. Department Evaluation. The Department evaluates the application for compliance with the standards established in governing Idaho statutes and administrative rules that are in effect at the time the application is submitted. ()

02. Actions Following Notification. An applicant, whose application is determined to be other than compliant, is given the opportunity to address the findings of the Department review and resubmit documentation needed to either bring the application into compliance or address the concerns found in the initial Department review. ()

03. Appeals for Refusal to License. Appeals for refusal to issue an agency license are processed according to IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ()

04. Compliant Application. An applicant, whose application is found to be in compliance with Sections 56-1011 through 56-1023, Idaho Code, and governing administrative rules in effect, will receive an acknowledgment of eligibility for an agency inspection with its notification of compliance. ()

941. -- 949. (RESERVED)

950. EMS AGENCY LICENSURE RENEWAL.

01. Request Renewal Application. Each EMS agency seeking to renew its license must request the most current standardized EMS license renewal application provided by the Department. The most current standardized renewal application can be obtained by contacting the Department. ()

02. Timeframe to Submit Renewal Application. Each EMS agency must submit a completed application for license renewal to the Department no earlier than ninety (90) days and no later than sixty (60) days prior to the expiration date of the current license. ()

951. INFORMATION REQUIRED ON THE AGENCY RENEWAL APPLICATION. Each application for license renewal must contain the required information listed in Sections 952 through 960 of these rules on the Department's standardized agency license renewal application form. ()

952. HISTORICAL CALL VOLUME. Each agency must submit a categorized breakdown of historical call volume for the preceding

year of operation in each of the following categories:: ()

01. Total Call Volume. The total call volume for the applicant's geographic coverage area; and ()

02. Percentage Requiring Transport. The percentage of patients requiring transport. ()

953. CHANGES TO GEOGRAPHIC COVERAGE AREA.

Any changes made to the geographic coverage area made by agency annexation must be described on the renewal application. Any other changes to the geographic coverage area requires an initial license application. ()

954. CURRENT STAFFING PLAN.

Each agency must submit its current staffing plan that includes: ()

01. Current Personnel Roster. The roster must identify all current licensed personnel by name and license level. ()

02. Current Personnel Are Licensed. The agency must ensure that all licensed personnel are appropriately licensed and credentialed. ()

03. Current Compensation Identification. The agency must identify current individuals listed as: ()

a. Uncompensated volunteer; ()

b. Compensated volunteer; ()

c. Part-time paid; or ()

d. Full-time paid. ()

04. Description of Current Staffing Plan. The agency must describe how the staffing pattern continues to ensure appropriately licensed personnel are available to provide the required care. ()

955. VERIFICATION OF VEHICLES AND EQUIPMENT.

Each agency will verify on the renewal application a list of vehicles and equipment in use by the agency. ()

01. Current Shared Vehicles and Equipment. The agency must declare any vehicles and equipment that are shared with another agency or other license category. ()

02. How Currently Stationed and Used. The agency must describe how the vehicle or equipment is stationed, used, and the frequency of use by each license category and agency. ()

956. VERIFICATION OF COMMUNICATIONS.

Each agency must verify its list of communications equipment in use by the agency. ()

957. VERIFICATION OF DISPATCH AGREEMENT.

Each agency must verify that no changes have been made to the dispatch agreement included in its prior agency application. ()

958. HISTORICAL RESPONSE TIMES.

Each agency must submit a historical review of response times as described below. ()

01. Longest Response Time. ()

a. The longest response time within the geographic coverage area, responding to an emergency call in ideal weather during daylight hours; and ()

b. The longest known response time declaration must include a description of the beginning and ending points of the response and the frequency of calls to the area with the longest projected response time. ()

02. Average Response Time. The agency's average response time within the geographic coverage area when responding to an emergency call in ideal weather during daylight hours. ()

959. CHANGES TO MEDICAL SUPERVISION PLAN.

Each agency must include any changes made to its Medical Supervision Plan. ()

960. CHANGES TO EXTRICATION SERVICE PROVIDER.

Each agency must include any changes made to organizations providing extrication for the agency. ()

961. -- 964. (RESERVED)

965. ADDITIONAL INFORMATION REQUIRED AFTER JULY 1, 2014.

After July 1, 2014, each agency that obtains a new license, changes the clinical level of licensed personnel it utilizes, changes its geographic coverage area (except by agency annexation), begins or discontinues providing patient transport services, or adds prehospital or transfer operational declarations must submit the following on the renewal application: ()

01. Costs and Revenue. A categorized breakdown of costs and revenue in each of the categories listed on the initial agency renewal application. ()

02. Narrative of Clinical Benefits. A narrative describing the actual clinical benefits that resulted from licensure that includes a review of the declarations made on the agency license application. ()

966. EVALUATION OF COMPLETED RENEWAL APPLICATIONS.

01. Evaluation of Completed Renewal Application. When an application is

received, the Department will, within fourteen (14) days of receipt, evaluate the application for completeness and compliance with the standards in governing Idaho statutes and administrative rules that are in effect at the time of application submission. ()

02. Notification of Renewal Evaluation Findings. The Department will notify the agency in writing that the evaluation found the application to be one of the following: ()

a. Compliant; ()

b. Incomplete; ()

c. Complete with concerns; or ()

d. Non-compliant. ()

03. Renewal Application Not in Compliance. An agency whose renewal application is determined to be other than complete and compliant will be given the opportunity to address the findings of the Department's initial review and resubmit documentation needed to either bring the renewal application into compliance or address the concerns found in the Department's review.³ ()

967. INCOMPLETE OR NONCOMPLIANT APPLICATION AT LICENSE EXPIRATION.

If an application is not complete and compliant and is not resolved prior to the expiration date of the license, an agency license will not lapse while undergoing review by the Department provided the agency submitted a timely application and takes action to meet licensure requirements within thirty (30) days of notification by the Department. ()

968. APPEALS PROCESS.

An appeal for refusal to grant renewal of an agency license will be processed under IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ()

969. COMPLETE AND COMPLIANT RENEWAL APPLICATION.

When a renewal application is found to be complete and in compliance, the Department will notify the agency and provide a list of not less than five (5) available dates and times within a thirty (30) day period in which to schedule the required renewal inspection. ()

970. TIMEFRAME FOR RENEWAL INSPECTIONS.

Each agency must successfully complete an annual inspection within the thirty (30) day period described in Sections 800 through 809 of these rules in order to obtain a renewed license. ()

971. LAPSED LICENSE.

01. Application Not Submitted Prior to Expiration of Current License. An agency that does not submit a complete application as prescribed in these rules will be considered lapsed. The license will no longer be valid. ()

02. Grace Period. No grace periods or extensions to an expiration date will be granted

when an agency has not submitted a completed renewal application within the timeframes described in Section 950 of these rules. ()

03. Lapsed License. An agency that has a lapsed license cannot provide EMS services. ()

04. To Regain Agency Licensure. An agency with a lapsed license will be considered an applicant for initial licensure and is bound by the same requirements and processes as an initial applicant. ()

972. -- 979. (RESERVED)

980. EMS AGENCY LICENSE -- NONTRANSFERABLE.

An EMS agency license issued by the Department cannot be transferred or sold. ()

981. CHANGES TO A CURRENT LICENSE.

An agency's officials must submit an agency update to the Department within sixty (60) days of any of the following changes: ()

01. Changes Requiring Update to Department. An agency's officials must submit an agency update to the Department within sixty (60) days of any of the following changes: ()

a. Changes made to the geographic coverage area by agency annexation; ()

b. Licensed personnel added or removed from the agency affiliation roster. If licensed personnel are removed for cause, a description of the cause must be included; ()

c. Vehicles or equipment added or removed from the agency; ()

d. Changes to the agency communication plan or equipment; ()

e. Changes to the agency dispatch agreement; or ()

f. Changes to the agency Medical Supervision Plan. ()

02. Changes Requiring Initial Licensure Application. When an agency decides to make any of the following changes, it must submit an initial agency application to the Department and follow the initial application process described in Sections 900 through 922 of these rules: ()

a. Clinical level of licensed personnel it utilizes; ()

b. Geographic coverage area changes, except by agency annexation; ()

c. A non-transport agency that intends to provide patient transport or an ambulance agency that intends to discontinue patient transport and become a non-transport agency; or ()

- d. An agency that intends to add prehospital or transfer operational declarations. ()

982. -- 989. (RESERVED)

990. TRANSITION TO THE LICENSURE MODELS DESCRIBED IN THIS CHAPTER OF RULES.

01. Timeframe to Transition to the New Licensing Model. Each EMS agency licensed by the Department prior to July 1, 2014, will transition to a licensing model described in these rules at the expiration of its current agency license. A currently licensed agency must submit a licensure transition application, provided by the Department, in order to renew its agency license. ()

02. Review Process of Transition Applications. Each licensure transition application submitted by a currently licensed agency is subject to the same Department application evaluation process described in Section 966 of these rules. ()

991. -- 999. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.01.07 - EMERGENCY MEDICAL SERVICES (EMS) -- PERSONNEL LICENSING REQUIREMENTS

DOCKET NO. 16-0107-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice, the pending rule becomes final and effective on July 1, 2014, after review by the legislature, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-1011 through 56-1023, Idaho Code.

DESCRIPTIVE SUMMARY: There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 7, 2013, Idaho Administrative Bulletin, [Vol. 13-8, pages 160 through 164](#).

Over the past several years, meetings have been held to negotiate and discuss the rewrite and update of the Emergency Medical Services (EMS) chapters of rules. The changes made to this chapter align these rules with the new “EMS - Rule Definitions” chapter being implemented under Docket 16-0102-1301 in this Bulletin. A name change in the Department for the Bureau of Emergency Services and Preparedness has also been included in this docket.

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

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Chris Stoker at (208) 334-4000.

DATED this 21st day of November, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor

P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-1011 through 56-1023 (Board), and 56-1003 (Director), Idaho Code.

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

Thursday, August 22, 2013 6:00 p.m. - 7:00 p.m.	Monday, August 26, 2013 3:30 p.m. - 4:30 p.m.	Wednesday, August 28, 2013 6:00 p.m. - 7:00 p.m.
Coeur d'Alene Public Library Community Room 702 E. Front Ave. Coeur d'Alene, ID 83814	EMS Bureau Conference Room 650 W. State St. B-25 Boise, ID 83702	Fire Station #2 Training Room 1539 N Hayes Pocatello, ID 83204

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

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

Over the past several years, meetings have been held to negotiate and discuss the rewrite and update of the Emergency Medical Services chapters of rules. The changes being made to this chapter align these rules with new EMS chapters being implemented to update definitions for the ever-changing technology used by emergency medical services providers across the state, and referencing the new EMS Agency Licensing chapter. These rules need to be amended to avoid confusion and ensure all EMS chapters use consistent terminology and are in compliance with statutes and rules.

These rules changes will align this chapter with the new chapters of rules by adding references to the new chapters and removing sections that are no longer needed or required to be in this chapter.

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

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

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is intended to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 3, 2013, [Vol. 13-4, page 13 and 14](#), and May 1, 2013, [Vol. 13-5, page 75 and 76](#), Idaho Administrative Bulletins, under Docket No. 16-0203-1301, for “Emergency Medical Services.” In addition to the negotiated townhall meetings held around the state, a task force committee, comprised of EMS professionals and interested stakeholder groups, met to develop the rule concepts.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Chris Stoker at (208) 334-4000.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 28, 2013.

DATED this 1st day of July, 2013.

[LSO Rules Analysis Memo](#)

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0107-1301

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE NUMBER -- INTERNET WEBSITE.

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the state of Idaho. (3-29-12)

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. (3-29-12)

03. Street Address. (3-29-12)

a. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. (3-29-12)

b. The EMS Bureau of Emergency Medical Services and Preparedness is located at 650 W. State Street, Suite B-17, Boise, Idaho 83702. ~~(3-29-12)~~()

04. Telephone. (3-29-12)

a. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. (3-29-12)

b. The telephone number for the EMS Bureau of Emergency Medical Services and Preparedness is (208) 334-4000. The toll-free, phone number is 1-877-554-3367. ~~(3-29-12)~~()

05. Internet Websites. (3-29-12)

a. The Department's internet website is found at <http://www.healthandwelfare.idaho.gov>. (3-29-12)

b. The Bureau of Emergency Medical Services Bureau's and Preparedness internet website is found at <http://www.idahoems.org>. ~~(3-29-12)~~()

(BREAK IN CONTINUITY OF SECTIONS)

010. DEFINITIONS ~~AND ABBREVIATIONS.~~

For the purposes of this chapter, ~~of rules, the following terms~~ the definitions in IDAPA 16.01.02, "Emergency Medical Services (EMS) -- Rule Definitions" apply. ~~(3-29-12)~~()

~~01: Advanced Emergency Medical Technician (AEMT). An AEMT is a person who:~~ (3-29-12)

~~a: Has met the qualifications for licensure in Sections 56-1011 through 56-1023, Idaho Code, and these rules;~~ (3-29-12)

~~b: Is licensed by the EMS Bureau under Sections 56-1011 through 56-1023, Idaho Code;~~ (3-29-12)

~~c: Carries out the practice of emergency medical care within the scope of practice for AEMT determined by the Idaho Emergency Medical Services Physicians Commission (EMSPC), under IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physicians Commission;" and~~ (3-29-12)

~~d: Practices under the supervision of a physician licensed in Idaho.~~ (3-29-12)

~~02: Affiliation. The formal association that exists between an agency and those~~

~~licensed personnel who appear on the agency's roster, which includes active participation, collaboration, and involvement. Affiliation can be demonstrated by the credentialing of licensed personnel by the agency medical director. (3-29-12)~~

~~**03. Agency-EMS.** Any organization required to be licensed under the provisions in IDAPA 16.02.03, "Emergency Medical Services," by the EMS Bureau that operates an air medical service, ambulance service, or nontransport service. (3-29-12)~~

~~**04. Board.** The Idaho Board of Health and Welfare. (3-29-12)~~

~~**05. Candidate.** Any individual who is requesting an EMS personnel license under Sections 56-1011 through 56-1023, Idaho Code. (3-29-12)~~

~~**06. Certificate of Eligibility.** Documentation that an individual is eligible for affiliation with an EMS agency, having satisfied all requirements for an EMS Personnel Licensure except for affiliation, but is not licensed to practice. (3-29-12)~~

~~**07. Commission.** The Idaho Emergency Medical Services Physician Commission. (3-29-12)~~

~~**08. Competency.** The expected behavior, skill performance and knowledge identified in the description of the profession and the allowable skills and interventions as defined by the scope of practice in the EMS Physicians Commissions Standards Manual incorporated in Section 004 of these rules. (3-29-12)~~

~~**09. Department.** The Idaho Department of Health and Welfare. (3-29-12)~~

~~**10. Emergency Medical Care.** The care provided to a person suffering from a medical condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the person's health in serious jeopardy, or in causing serious impairments of bodily function or serious dysfunction of any bodily organ or part. (3-29-12)~~

~~**11. Emergency Medical Responder (EMR).** An EMR is a person who: (3-29-12)~~

~~**a.** Has met the qualifications for licensure in Sections 56-1011 through 56-1023, Idaho Code, and these rules; (3-29-12)~~

~~**b.** Is licensed by the EMS Bureau under Sections 56-1011 through 56-1023, Idaho Code; (3-29-12)~~

~~**c.** Carries out the practice of emergency medical care within the scope of practice for EMR determined by the Idaho Emergency Medical Services Physicians Commission (EMSPC), under IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physicians Commission"; and (3-29-12)~~

~~**d.** Practices under the supervision of a physician licensed in Idaho. (3-29-12)~~

~~12. **Emergency Medical Services (EMS).** The services utilized in responding to a perceived individual need for immediate care in order to prevent loss of life or aggravation of physiological or psychological illness or injury. (3-29-12)~~

~~13. **EMS Bureau.** The Emergency Medical Services (EMS) Bureau of the Idaho Department of Health and Welfare. (3-29-12)~~

~~14. **Emergency Medical Technician (EMT).** An EMT is a person who: (3-29-12)~~

~~a. Has met the qualifications for licensure in Sections 56-1011 through 56-1023, Idaho Code, and these rules; (3-29-12)~~

~~b. Is licensed by the EMS Bureau under Sections 56-1011 through 56-1023, Idaho Code; (3-29-12)~~

~~c. Carries out the practice of emergency medical care within the scope of practice for EMT determined by the Idaho Emergency Medical Services Physicians Commission (EMSPC), under IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physicians Commission"; and (3-29-12)~~

~~d. Practices under the supervision of a physician licensed in Idaho. (3-29-12)~~

~~15. **Licensed Personnel.** Those individuals who are emergency medical responders, emergency medical technicians, advanced emergency medical technicians, and paramedics. (3-29-12)~~

~~16. **National Registry of Emergency Medical Technicians (NREMT).** An independent, non-governmental, not for profit organization which prepares validated examinations for the state's use in evaluating candidates for licensure. (3-29-12)~~

~~17. **Paramedic.** A paramedic is a person who: (3-29-12)~~

~~a. Has met the qualifications for licensure in Sections 56-1011 through 56-1023, Idaho Code, and these rules; (3-29-12)~~

~~b. Is licensed by the EMS Bureau under Sections 56-1011 through 56-1023, Idaho Code; (3-29-12)~~

~~c. Carries out the practice of emergency medical care within the scope of practice for paramedic determined by the Idaho Emergency Medical Services Physicians Commission (EMSPC), under IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physicians Commission"; and (3-29-12)~~

~~d. Practices under the supervision of a physician licensed in Idaho. (3-29-12)~~

~~18. **Patient.** A sick, injured, incapacitated, or helpless person who is under medical care or treatment. (3-29-12)~~

- ~~19. **Patient Assessment.** The evaluation of a patient by EMS licensed personnel intending to provide treatment or transportation to that patient. (3-29-12)~~
- ~~20. **Patient Care.** The performance of acts or procedures under emergency conditions in responding to a perceived individual need for immediate care in order to prevent loss of life or aggravation of physiological or psychological illness or injury. (3-29-12)~~
- ~~21. **Skills Proficiency.** The process overseen by an EMS agency medical director to verify competency in psychomotor skills. (3-29-12)~~
- ~~22. **Supervision.** The medical direction by a licensed physician of activities provided by licensed personnel affiliated with a licensed ambulance, air medical, or nontransport service, including: establishing standing orders and protocols, reviewing performance of licensed personnel, providing instructions for patient care via radio or telephone, and other oversight. (3-29-12)~~
- ~~23. **State Health Officer.** The Administrator of the Division of Public Health. (3-29-12)~~

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.01.12 - EMERGENCY MEDICAL SERVICES (EMS) -- COMPLAINTS,
INVESTIGATIONS, AND DISCIPLINARY ACTIONS

DOCKET NO. 16-0112-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice, the pending rule becomes final and effective on July 1, 2014, after review by the legislature, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-1011 through 56-1023, Idaho Code.

DESCRIPTIVE SUMMARY: There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 7, 2013, Idaho Administrative Bulletin, [Vol. 13-8, pages 165 through 173](#).

Over the past several years, meetings have been held to negotiate and discuss the rewrite and update of the Emergency Medical Services (EMS) chapters of rules. The changes made to this chapter align these rules with the new “EMS - Rule Definitions” chapter and the “EMS - Agency Licensing” chapter being implemented under Dockets 16-0102-1301 and 16-0103-1301 in this Bulletin. A name change in the Department for the Bureau of Emergency Services and Preparedness has also been included in this docket.

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

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Chris Stoker at (208) 334-4000.

DATED this 21st day of November, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor

P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-1011 through 56-1023 (Board), and 56-1003 (Director), Idaho Code.

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

Thursday, August 22, 2013 6:00 p.m. - 7:00 p.m.	Monday, August 26, 2013 3:30 p.m. - 4:30 p.m.	Wednesday, August 28, 2013 6:00 p.m. - 7:00 p.m.
Coeur d'Alene Public Library Community Room 702 E. Front Ave. Coeur d'Alene, ID 83814	EMS Bureau Conference Room 650 W. State St. B-25 Boise, ID 83702	Fire Station #2 Training Room 1539 N Hayes Pocatello, ID 83204

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

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

Over the past several years, meetings have been held to negotiate and discuss the rewrite and update of the Emergency Medical Services chapters of rules. The changes being made to this chapter align these rules with new EMS chapters being implemented to update definitions for the ever-changing technology used by emergency medical services providers across the state. The amendments to this rule remove sections no longer needed and reference the new EMS Rule Definitions and EMS Agency Licensing chapters that have been published in this Bulletin under Docket No. 16-0102-1301 and Docket No. 16-0103-1301.

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

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

The Emergency Medical Services (EMS) program is funded through dedicated funds. This

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 3, 2013, [Vol. 13-4, page 13 and 14](#), and May 1, 2013, [Vol. 13-5, page 75 and 76](#), Idaho Administrative Bulletins, under Docket No. 16-0203-1301, for “Emergency Medical Services.” In addition to the negotiated townhall meetings held around the state, a task force committee, comprised of EMS professionals and interested stakeholder groups, met to develop the rule concepts.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Chris Stoker at (208) 334-4000.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 28, 2013.

DATED this 1st day of July, 2013.

[LSO Rules Analysis Memo](#)

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0112-1301

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE NUMBER -- INTERNET WEBSITE.

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the state of Idaho. (3-29-12)

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. (3-29-12)

03. Street Address. (3-29-12)

a. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. (3-29-12)

b. The EMS Bureau of Emergency Medical Services and Preparedness is located at 650 W. State Street, Suite B-17, Boise, Idaho 83702. (3-29-12)

04. Telephone. (3-29-12)

a. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. (3-29-12)

b. The telephone number for the EMS Bureau of Emergency Medical Services and Preparedness is (208) 334-4000. The toll-free, phone number is 1-877-554-3367. ~~(3-29-12)~~()

05. Internet Websites. (3-29-12)

a. The Department's internet website is found at <http://www.healthandwelfare.idaho.gov>. (3-29-12)

b. The Bureau of Emergency Medical Services ~~Bureau's~~ and Preparedness internet website is found at <http://www.idahoems.org>. ~~(3-29-12)~~()

(BREAK IN CONTINUITY OF SECTIONS)

010. DEFINITIONS ~~AND ABBREVIATIONS.~~

For the purposes of this chapter, ~~of rules the following terms~~ the definitions in IDAPA 16.01.02, "Emergency Medical Services (EMS) - Rule Definitions" apply. ~~(3-29-12)~~()

~~01. Affiliating EMS Agency. The licensed EMS agency, or agencies, under which licensed personnel are authorized to provide patient care. (3-29-12)~~

~~02. Board. The Board of Health and Welfare. (3-29-12)~~

~~03. Certified EMS Instructor. An individual approved by the EMS Bureau, who has met the requirements in IDAPA 16.02.03, "Emergency Medical Services," to provide EMS education and training. (3-29-12)~~

~~04. Department. The Idaho Department of Health and Welfare. (3-29-12)~~

~~05. Emergency Medical Services (EMS). The system utilized in responding to a perceived individual need for immediate care in order to prevent loss of life or aggravation of physiological or psychological illness or injury. (3-29-12)~~

~~06. EMS Agency. An organization licensed by the EMS Bureau to provide air medical, ambulance, or non-transport services. (3-29-12)~~

~~07. EMS Agency Medical Director. A physician who supervises the medical activities of licensed personnel affiliated with an EMS agency. (3-29-12)~~

~~08. **EMS Bureau.** The Emergency Medical Services (EMS) Bureau of the Idaho Department of Health and Welfare. (3-29-12)~~

~~09. **EMS Physicians Commission (EMSPC).** The Idaho Emergency Medical Services Physician Commission as created under Section 56-1013A, Idaho Code, hereafter referred to as “the Commission.” (3-29-12)~~

~~10. **Investigation.** Research of the facts concerning a complaint or issue of non-compliance which may include performing or obtaining interviews, inspections, document review, detailed subject history, phone calls, witness statements, other evidence and collaboration with other jurisdictions of authority. (3-29-12)~~

~~11. **National Registry of Emergency Medical Technicians (NREMT).** An independent, non-governmental, not-for-profit organization that prepares validated examinations for the state’s use in evaluating candidates for licensure. (3-29-12)~~

~~12. **Personnel License or Certificate Holder.** Individuals who possess a valid license or certificate issued by the EMS Bureau. Includes individuals who are Emergency Medical Responders (EMR), Emergency Medical Technicians (EMT), Advanced Emergency Medical Technicians (AEMT), Paramedics, and Certified EMS Instructors. (3-29-12)~~

~~13. **Physician.** In accordance with Section 54-1803, Idaho Code, a person who holds a current active license issued by the State Board of Medicine to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine in Idaho and is in good standing with no restrictions upon, or actions taken against, his license. (3-29-12)~~

(BREAK IN CONTINUITY OF SECTIONS)

110. REPORTING SUSPECTED VIOLATION.

01. Suspected Violations. Any person ~~who~~ may report a suspected ~~a~~ violation of any law or rule governing EMS, including: ()

a. Sections 56-1011 through 56-1023, Idaho Code; ()

b. IDAPA 16.02.02, “Rules of the Idaho Emergency Medical Services (EMS) Physician Commission;” ()

c. IDAPA 16.01.03, “Emergency Medical Services (EMS) -- Agency Licensing Requirements;” ()

d. IDAPA 16.01.07, “Emergency Medical Services (EMS) -- Personnel Licensing Requirements;” or ()

e. IDAPA 16.02.03, “Emergency Medical Services;” ~~may report the violation to the EMS Bureau.~~ (3-29-12)()

02. Report Violation. To report a suspected violation, contact the EMS Bureau described in Section 005 of these rules. ()

(BREAK IN CONTINUITY OF SECTIONS)

200. EMS BUREAU INITIATES OFFICIAL INVESTIGATION.

An official investigation will be initiated when the any of the following occurs: (3-29-12)

01. Complaint with Allegations. A complaint with an allegation that, if substantiated, would be in violation of any law or rule governing EMS, including: ()

a. Sections 56-1011 through 56-1023, Idaho Code; ()

b. IDAPA 16.01.03, “Emergency Medical Services (EMS) -- Agency Licensing Requirements”; ()

c. IDAPA 16.01.07, “Emergency Medical Services (EMS) -- Personnel Licensing Requirements;” ()

d. IDAPA 16.01.12, “Emergency Medical Services (EMS) -- Complaints, Investigations, and Disciplinary Actions”; ()

e. IDAPA 16.02.02, “Rules of the Idaho Emergency Medical Services (EMS) Physician Commission;” or ()

f. IDAPA 16.02.03, “Emergency Medical Services.” (3-29-12)()

02. Discovery of Potential Violation of Statute or Administrative Rule. EMS Bureau staff or other authorities discover a potential violation of any law or rule governing EMS, including: ()

a. Sections 56-1011 through 56-1023, Idaho Code; ()

b. IDAPA 16.01.03, “Emergency Medical Services (EMS) -- Agency Licensing Requirements”; ()

c. IDAPA 16.01.07, “Emergency Medical Services (EMS) -- Personnel Licensing Requirements;” ()

d. IDAPA 16.01.12, “Emergency Medical Services (EMS) -- Complaints, Investigations, and Disciplinary Actions”; ()

e. IDAPA 16.02.02, “Rules of the Idaho Emergency Medical Services (EMS) Physician Commission”; or ()

f. IDAPA 16.02.03, “Emergency Medical Services.” (3-29-12)()

201. -- 209. (RESERVED)

210. VIOLATIONS THAT MAY RESULT IN ADMINISTRATIVE ACTIONS.

The EMS Bureau may impose an administrative action, such as denial, revocation, suspension, under conditions that include, but are not limited to, those specified in these rules. Administrative actions may be imposed on any of the following: the holder of a license or certificate, or on an applicant or candidate for an EMS license or certificate. Administrative actions may be imposed on any of the previously mentioned for any action, conduct, or failure to act that is inconsistent with the professionalism, standards, or both, established by statute or rule. (3-29-12)

01. Violation of Statute or Administrative Rules. (3-29-12)

a. Sections 56-1011 through 56-1023, Idaho Code; (3-29-12)

b. IDAPA 16.01.03, “Emergency Medical Services (EMS) -- Agency Licensing Requirements”; ()

b.c. IDAPA 16.01.07, “Emergency Medical Services (EMS) -- Personnel Licensing Requirements”; ()

d. IDAPA 16.01.12, “Emergency Medical Services (EMS) -- Complaints, Investigations, and Disciplinary Actions”; ()

e. IDAPA 16.02.02, “Rules of the Idaho Emergency Medical Services (EMS) Physician Commission”; and ()

f. IDAPA 16.02.03, “Emergency Medical Services,” and this chapter of rules.” (3-29-12)()

02. Unprofessional Conduct. Any act that violates professional standards required under IDAPA 16.01.07, “EMS -- Personnel Licensure Requirements.” (3-29-12)

03. Failure to Maintain Standards of Knowledge, Proficiency, or Both. Failure to maintain standards of knowledge, or proficiency, or both, required under: ()

a. IDAPA 16.01.07, “Emergency Medical Services (EMS) -- Personnel Licensure Requirements”; and ()

b. IDAPA 16.02.02, “Rules of the Idaho Emergency Medical Services (EMS) Physician Commission.” (3-29-12)()

04. Mental Incompetency. A lawful finding of mental incompetency by a court of competent jurisdiction. (3-29-12)

05. Impairment of Function. Performance of duties pursuant to an EMS personnel license while under the influence of alcohol, illegal substance, or legal drug or medication causing impairment of function. (3-29-12)

06. Denial of Criminal History Clearance. Any conduct, action, or conviction that does or would result in denial of a criminal history clearance under IDAPA 16.05.06, "Criminal History and Background Checks." (3-29-12)

07. Discipline, Restriction, Suspension, or Revocation. Discipline, restriction, suspension, or revocation by any other jurisdiction. (3-29-12)

08. Danger or Threat to Persons or Property. Any conduct, condition, or circumstance determined by the EMS Bureau that constitutes a danger or threat to the health, safety, or well-being of persons or property. (3-29-12)

09. Performing Medical Procedure or Providing Medication that Exceeds the Scope of Practice of the Level of Licensure. Performing any medical procedure or providing medication that deviates from or exceeds the scope of practice for the corresponding level of licensure established under IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission." (3-29-12)

10. Falsification of Applications or Reports. The submission of fraudulent or false information in any report, application, or documentation to the EMS Bureau. (3-29-12)

11. Attempting to Obtain a License by Means of Fraud. Misrepresentation in an application, or documentation, for licensure by means of concealment of a material fact. (3-29-12)

(BREAK IN CONTINUITY OF SECTIONS)

330. ADMINISTRATIVE ACTIONS IMPOSED FOR LICENSURE OR CERTIFICATION.

The EMS Bureau may impose the following administrative actions: (3-29-12)

01. Deny or Refuse to Renew EMS Personnel License or Certification. The EMS Bureau may deny an EMS personnel license or certification, or refuse to renew an EMS personnel license or certification: (3-29-12)

a. When the application for licensure or certification is not complete or the individual does not meet the eligibility requirements provided in Sections 56-1011 through 56-1023, Idaho Code, IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements," IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission," IDAPA 16.02.03, "Emergency Medical Services"; or (3-29-12)

b. Pending final outcome of an EMS investigation or criminal proceeding when criminal charges or allegations indicate an imminent danger or threat to the health, safety, or well-being of persons or property. (3-29-12)

c. For any reason that would justify an administrative action according to Section 210 of these rules. (3-29-12)

d. Decisions to deny or refuse to renew an EMS license will be reviewed by the Idaho EMS Physicians Commission at the Commission's next available meeting. (3-29-12)

02. Deny or Refuse to Renew EMS Agency License. The EMS Bureau may deny an EMS agency license or refuse to renew a EMS agency license: (3-29-12)

a. When the application for licensure is not complete or does not meet the eligibility requirements provided in Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.021.03, "Emergency Medical Services **(EMS) -- Agency Licensing Requirements**"; or ~~(3-29-12)~~()

b. Pending final outcome of an EMS investigation or criminal proceeding when criminal charges or allegations indicate an imminent danger or threat to the health, safety, or well-being of persons or property. (3-29-12)

c. For any reason that would justify an administrative action according to Section 210 of these rules. (3-29-12)

03. Retain with Probationary Conditions for Personnel License or Certification. The EMS Bureau may allow an EMS personnel license or certificate holder to retain a license or certificate as agreed to in a negotiated resolution, settlement, or with conditions imposed by the EMS Bureau. Decisions to retain an EMS personnel license with probationary conditions will be reviewed by the Idaho EMS Physician Commission at the Commission's next available meeting. (3-29-12)

04. Retain with Probationary Conditions for Agency License. The EMS Bureau may allow an EMS agency to retain a license as agreed to in a negotiated resolution, settlement, or with conditions imposed by the EMS Bureau. (3-29-12)

05. Suspend EMS Personnel License or Certificate. The EMS Bureau may suspend an EMS personnel license or certificate for: (3-29-12)

a. A period of time up to twelve (12) months, with or without conditions; or (3-29-12)

b. Pending final outcome of an EMS investigation or criminal proceeding when criminal charges or allegations indicate an imminent danger or threat to the health, safety, or well-being of persons or property. (3-29-12)

c. Decisions to suspend an EMS personnel license will be reviewed by the Idaho EMS Physician Commission at the Commission's next available meeting. (3-29-12)

06. Revoke EMS Personnel License or Certificate. The EMS Bureau may revoke an EMS personnel license or certificate when: (3-29-12)

- a.** A peer review team recommends license or certificate revocation; or (3-29-12)
- b.** The license holder is found to no longer be eligible for criminal history clearance per IDAPA 16.05.06, "Criminal History and Background Checks." (3-29-12)
- c.** Decisions to revoke an EMS personnel license will be reviewed by the Idaho EMS Physician Commission at the Commission's next available meeting. (3-29-12)

07. Revoke EMS Agency License. The EMS Bureau may revoke an EMS agency license when: (3-29-12)

- a.** A peer review team recommends license revocation; (3-29-12)
- b.** The EMS Bureau will notify the city, fire district, hospital district, ambulance district, dispatch center, and county in which the EMS agency provides emergency prehospital response that the EMS Bureau is considering license revocation. (3-29-12)

331. -- 339. (RESERVED)

340. VIOLATIONS THAT MAY RESULT IN FINES BEING IMPOSED ON EMS AGENCY.

In addition to administrative license actions provided in Section 56-1022, Idaho Code, and these rules, a fine may be imposed by the EMS Bureau upon recommendation of a peer review team on a licensed EMS agency as a consequence of agency violations. Fines may be imposed for the following violations: (3-29-12)

01. Operating An Unlicensed EMS Agency. Operating without a license required in IDAPA 16.021.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements," including: ~~(3-29-12)~~()

- a.** Failure to obtain an initial license; (3-29-12)
- b.** Failure to obtain a license upon change in ownership; or (3-29-12)
- c.** Failure to renew a license and continues to operate as an EMS agency. (3-29-12)

02. Unlicensed Personnel Providing Patient Care. Allowing an unlicensed individual to provide patient care without first obtaining an EMS personnel license required in IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements," at the appropriate level for the EMS agency. (3-29-12)

03. Failure to Respond. Failure of the EMS agency to respond to a 911 request for service within the agency primary response area in a typical manner of operations when dispatched to a medical illness or injury, under licensure requirements in IDAPA 16.021.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements," except when the

responder reasonably determines that: ~~(3-29-12)~~()

- a. There are disaster conditions; (3-29-12)
- b. Scene safety hazards are present or suspected; or (3-29-12)
- c. Law enforcement assistance is necessary to assure scene safety, but has not yet allowed entry to the scene. (3-29-12)

04. Unauthorized Response by EMS Agency. Responding to a request for service which deviates from or exceeds those authorized by the EMS agency license requirements in IDAPA 16.021.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements." ~~(3-29-12)~~()

05. Failure to Allow Inspections. Failure to allow the EMS Bureau or its representative to inspect the agency facility, equipment, records, and other licensure requirements provided in IDAPA 16.02.03, "Emergency Medical Services." (3-29-12)

06. Failure To Correct Unacceptable Conditions. Failure of the EMS agency to correct unacceptable conditions within the time frame provided in a negotiated resolution settlement, or a warning letter issued by the EMS Bureau. Including the following: (3-29-12)

- a. Failure to maintain an EMS vehicle in a safe and sanitary condition; (3-29-12)
- b. Failure to have available minimum EMS Equipment; (3-29-12)
- c. Failure to correct patient or personnel safety hazards; or (3-29-12)
- d. Failure to retain an EMS agency medical director: (3-29-12)

07. Failure to Report Patient Care Data. Failure to submit patient care data as required in IDAPA 16.021.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements." ~~(3-29-12)~~()

(BREAK IN CONTINUITY OF SECTIONS)

350. REINSTATEMENT OF EMS LICENSE FOLLOWING REVOCATION.

An application of any revoked EMS agency or personnel license may be filed with the EMS Bureau no earlier than one (1) year from the date of the license revocation. (3-29-12)

01. Peer Review for Reinstatement. The EMS Bureau will conduct a peer review to consider the reinstatement application. (3-29-12)

02. Recommendation of Peer Review Team. The peer review team will make a recommendation to the EMS Bureau to accept or reject the application for reinstatement.

(3-29-12)

03. Reinstatement Determination. The EMS Bureau will accept or reject the reinstatement application based on the peer review team recommendation and other extenuating circumstances. (3-29-12)

a. Reinstatement of a revoked EMS personnel license is subject to the lapsed license reinstatement requirements in IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements." (3-29-12)

b. Reinstatement of a revoked EMS agency license will be subject to an initial agency application requirements in IDAPA 16.0~~2~~1.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements." ~~(3-29-12)~~()

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.02.02 - RULES OF THE IDAHO EMERGENCY MEDICAL SERVICES
(EMS) PHYSICIAN COMMISSION

DOCKET NO. 16-0202-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice, the pending rule will become final and effective on July 1, 2014, after review by the legislature, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant Sections 56-1013A and 56-1023, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

To best protect the public's health and safety, the EMS Physician Commission is revising its Standards Manual that is incorporated by reference in this chapter of rules. This revision to rule will ensure that the most recent edition of the manual has the force and effect of law. Also, minor amendments were proposed for the text of the rule itself to bring it into alignment with changes in the Standards Manual approved in the 2012 Legislative Session.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the July 3, 2013, Idaho Administrative Bulletin, [Vol. 13-7, pages 55 and 56](#).

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

There is no anticipated fiscal impact to the state general fund related to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Wayne Denny at (208) 334-4000.

DATED this 25th day of November, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-1013A and 56-1023, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than July 17, 2013.

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

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

To best protect the public's health and safety, the EMS Physician Commission is revising its Standards Manual that is incorporated by reference in this chapter of rules. This revision to rule will ensure that the most recent edition of the manual has the force and effect of law.

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

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

There is no anticipated fiscal impact to the state general fund related to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted and deemed not feasible because the content of the proposed updates to the EMS Physician Commission Standards Manual and to this chapter of rules already represents extensive input from stakeholders gathered during 2012 and early 2013.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the

Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, edition 2014-1, is being incorporated by reference into these rules to give it the force and effect of law. The document is not being published in this chapter of rules due to its length and format, but it is available upon request from Idaho EMS.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Wayne Denny at (208) 334-4000.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 24, 2013.

DATED this 16th day of May, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0202-1301

004. INCORPORATION BY REFERENCE.

The Idaho Emergency Medical Services (EMS) Physician Commission has adopted the Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, edition 201~~3~~⁴-1, and hereby incorporates this Standards Manual by reference. Copies of the manual may be obtained on the Internet at www.emspsc.dhw.idaho.gov or from the EMS Bureau located at 650 W. State Street, Suite B-17, Boise, Idaho, 83702, whose mailing address is P.O. 83720, Boise, Idaho 83720-0036. (~~7-1-13~~)()

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.02.03 - EMERGENCY MEDICAL SERVICES

DOCKET NO. 16-0203-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice, the pending rule becomes final and effective on July 1, 2014, after review by the legislature, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-1011 through 56-1023, Idaho Code.

DESCRIPTIVE SUMMARY: There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 7, 2013, Idaho Administrative Bulletin, [Vol. 13-8, pages 174 through 192](#).

Over the past several years, meetings have been held to negotiate and discuss the rewrite and update of the Emergency Medical Services (EMS) chapters of rules. The changes made to this chapter align these rules with the new “EMS - Rule Definitions” chapter being implemented under Docket 16-0102-1301 in this Bulletin and with the new “EMS - Agency Licensing Requirements” chapter being implemented under Docket 16-0103-1301 in this Bulletin. A name change in the Department for the Bureau of Emergency Services and Preparedness has also been included in this docket.

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

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Chris Stoker at (208) 334-4000.

DATED this 21st day of November, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720

Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-1011 through 56-1023, Idaho Code.

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

Thursday, August 22, 2013 6:00 p.m. - 7:00 p.m.	Monday, August 26, 2013 3:30 p.m. - 4:30 p.m.	Wednesday, August 28, 2013 6:00 p.m. - 7:00 p.m.
Coeur d'Alene Public Library Community Room 702 E. Front Ave. Coeur d'Alene, ID 83814	EMS Bureau Conference Room 650 W. State St. B-25 Boise, ID 83702	Fire Station #2 Training Room 1539 N Hayes Pocatello, ID 83204

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

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

Over the past several years, meetings have been held to negotiate and discuss the rewrite and update of the Emergency Medical Services chapters of rules. Sections in this chapter have been written and implemented in new chapters for Definitions and Agency Licensure published in this Bulletin under Docket 16-0102-1301 and Docket 16-0103-1301. In order to avoid confusion and ensure compliance with the new chapters, the following amendments to the rules:

1. Remove agency licensure requirements and air medical utilization requirements;
2. Remove definitions;
3. Add, remove, and update references to new chapters as needed; and
4. Update required sections to meet requirements of the Office of the Administrative Rules Coordinator rules.

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

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on

the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year:

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is intended to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 3, 2013, [Vol. 13-4, page 13 and 14](#), and May 1, 2013, [Vol. 13-5, page 75 and 76](#), Idaho Administrative Bulletins, under Docket No. 16-0203-1301, for “Emergency Medical Services.” In addition to the negotiated townhall meetings held around the state, a task force committee, comprised of EMS professionals and interested stakeholder groups, met to develop the rule concepts.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Chris Stoker at (208) 334-4000.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 28, 2013.

DATED this 9th day of July, 2013.

[LSO Rules Analysis Memo](#)

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0203-1301

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.02.03, “Emergency Medical Services.” (3-29-12)

02. Scope. These rules include criteria for education programs, certification of instructors, ~~licensure of ambulance services and nontransport services including required agency personnel, licensure of ambulances and nontransport vehicles,~~ establishment of fees for training, inspections, and certifications. (3-29-12)()

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, ~~this Bureau has an EMS Standards Manual that contains policy and interpretation of these rules and the documentation of compliance with these rules. Copies of the Standards Manual may be obtained from the EMS Bureau, 650 W. State Street, Suite B-17, Boise, Idaho 83702, P.O. Box 83720, Boise, Idaho 83720-0036~~ the Department may have written statements that pertain to the interpretation of this chapter, or to the documentation of compliance with these rules. (3-29-12)()

(BREAK IN CONTINUITY OF SECTIONS)

004. INCORPORATION BY REFERENCE.

~~The Board of Health and Welfare has adopted the Minimum Equipment Standards for Licensed EMS Services, 2011 edition, Version 1.0, as its standard on required EMS equipment and hereby incorporates the Equipment Standards by reference. Copies of the Equipment Standards may be obtained from the EMS Bureau, 650 W. State Street, Suite B-17, Boise, Idaho 83702, P.O. Box 83720, Boise, Idaho 83720-0036.~~ There are no documents incorporated by reference into this chapter of rules. (3-29-12)()

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE NUMBER -- INTERNET WEBSITE.

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the state of Idaho. (4-6-05)

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. (4-6-05)

03. Street Address. (3-29-12)

a. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. (4-6-05)

b. The EMS Bureau of Emergency Medical Services and Preparedness is located at 650 W. State Street, Suite B-17, Boise, Idaho 83702. (3-29-12)()

04. Telephone. (3-29-12)

a. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. (4-6-05)

b. The telephone number for the EMS Bureau of Emergency Medical Services and Preparedness is (208) 334-4000. The toll-free, phone number is 1-877-554-3367. (3-29-12)()

05. Internet Websites. (4-6-05)

a. The Department's internet website is found at <http://>

www.healthandwelfare.idaho.gov. (4-6-05)

b. The Emergency Medical Services Bureau's internet website is found at <http://www.idahoems.org>. (4-6-05)

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS ACT COMPLIANCE AND REQUESTS.

01. Confidentiality of Records. Any disclosure of confidential information used or disclosed in the course of the Department's business is subject to the restrictions in state or federal law, federal regulation, and Idaho Department of Health and Welfare Rules, IDAPA 16.05.01, "Use and Disclosure of Department Records." (4-6-05)

02. Public Records Act. ~~Individuals have a right to review and copy records maintained by the Department, subject to the provisions of the Idaho Public Records Act, Title 9, Chapter 3, Idaho Code, these rules, and state and federal laws that make records confidential. The Department's Administrative Procedures Section (APS) and designated custodians in Department offices receive and respond to public records requests. The APS can be reached at the mailing address for the Department's business office. Non-identifying or non-confidential information provided to the public by the Department in the ordinary course of business are not required to be reviewed by a public records custodian. Original records must not be removed from the Department by individuals who make public records requests. The Department will comply with Sections 9-337 through 9-350, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure.~~ (4-6-05)()

007. -- 009. (RESERVED)

010. DEFINITIONS ~~AND ABBREVIATIONS.~~

For the purposes of ~~these rules, the following terms and abbreviations will be used, as defined below:~~ this chapter, the definitions in IDAPA 16.01.02, "Emergency Medical Services (EMS) -- Rule Definitions" apply. (7-1-80)()

~~**01. Advanced Emergency Medical Technician (AEMT).** A person who has met the qualifications for AEMT licensure defined in Section 56-1012, Idaho Code, and in IDAPA 16.01.07, "Emergency Medical Services -- Personnel Licensing Requirements."~~ (3-29-12)

~~**02. Advanced Life Support (ALS).** The provision of medical care, medication administration and treatment with medical devices that correspond to the knowledge and skill objectives in the Paramedic curriculum currently approved by the State Health Officer in accordance with Subsection 201.04 of these rules and within the scope of practice defined in IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission," by persons licensed as Paramedics by the EMS Bureau.~~ (3-29-12)

~~**03. Advertise.** Communication of information to the public, institutions, or to any person concerned, by any oral, written, or graphic means including handbills, newspapers, television, radio, telephone directories, and billboards.~~ (4-5-00)

~~04. **Agency.** Any organization required to be licensed by the EMS Bureau that operates an air medical service, ambulance service, or nontransport service. (3-29-12)~~

~~05. **Air Ambulance.** Any privately or publicly owned fixed wing aircraft or rotary wing aircraft used for, or intended to be used for, the transportation of persons experiencing physiological or psychological illness or injury who may need medical attention during transport. This may include dual or multipurpose vehicles that comply with Sections 56-1011 through 56-1023, Idaho Code. (3-29-12)~~

~~06. **Air Medical Response.** The deployment of an aircraft licensed as an air ambulance to an emergency scene intended for the purpose of patient treatment and transportation. (3-29-12)~~

~~07. **Air Medical Service.** An agency required to be licensed by the EMS Bureau that responds to requests for patient care and transportation from hospitals and EMS agencies using a fixed wing aircraft or rotary wing aircraft. (3-29-12)~~

~~08. **Ambulance.** Any privately or publicly owned motor vehicle or nautical vessel, used for, or intended to be used for, the transportation of sick or injured persons who may need medical attention during transport. This may include dual or multipurpose vehicles that comply with Sections 56-1011 through 56-1023, Idaho Code. (3-29-12)~~

~~09. **Ambulance-Based Clinicians.** Licensed Professional Nurses, Advanced Practice Professional Nurses, and Physician Assistants with current licenses from the Board of Nursing or the Board of Medicine, who are personnel provided by licensed EMS services. (4-5-00)~~

~~10. **Ambulance Service.** An agency required to be licensed by the EMS Bureau operated with the intent to provide personnel and equipment for medical treatment at an emergency scene, during transportation, or during transfer of persons experiencing physiological or psychological illness or injury who may need medical attention during transport. (3-29-12)~~

~~11. **Applicant.** Any organization that is requesting an agency license under these rules and includes the following: (3-29-12)~~

~~a. An organization seeking a new license; (3-29-12)~~

~~b. An existing agency that intends to change the level of licensed personnel it utilizes; (3-29-12)~~

~~c. An existing agency that intends to change its geographic coverage area, except by agency annexation; (3-29-12)~~

~~d. An existing nontransport service that intends to provide ambulance service; and (3-29-12)~~

~~e. An existing ambulance service that intends to discontinue transport and become a nontransport service. (3-29-12)~~

- ~~12. **Board.** The Idaho Board of Health and Welfare. (3-29-12)~~
- ~~13. **Certification.** A credential issued to an individual by the EMS Bureau for a specified period of time indicating that minimum standards have been met. (3-29-12)~~
- ~~14. **Critical Care Transfer (CCT).** The transportation of a patient with continuous care, monitoring, medication or procedures requiring knowledge or skills not contained within the Paramedic curriculum approved by the State Health Officer. Interventions provided by Paramedics are governed by the scope of practice defined in IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physicians Commission." (3-29-12)~~
- ~~15. **Commission.** The Idaho Emergency Medical Services Physician Commission (EMSPC). (3-29-12)~~
- ~~16. **Department.** The Idaho Department of Health and Welfare. (3-29-12)~~
- ~~17. **Director.** The Director of the Idaho Department of Health and Welfare or his designee. (3-29-12)~~
- ~~18. **Division.** The Idaho Division of Public Health, Department of Health and Welfare. (3-29-12)~~
- ~~19. **Emergency.** A medical condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the person's health in serious jeopardy, or in causing serious impairments of bodily function or serious dysfunction of any bodily organ or part. (4-5-00)~~
- ~~20. **Emergency Medical Responder (EMR).** A person who has met the qualifications for EMR licensure defined in Section 56-1012, Idaho Code, and in IDAPA 16.01.07, "Emergency Medical Services Personnel Licensing Requirements." (3-29-12)~~
- ~~21. **Emergency Medical Services (EMS).** The system utilized in responding to a perceived individual need for immediate care in order to prevent loss of life or aggravation of physiological or psychological illness or injury. (3-29-12)~~
- ~~22. **Emergency Medical Technician (EMT).** A person who has met the qualifications for EMT licensure defined in Section 56-1012, Idaho Code, and in IDAPA 16.01.07, "Emergency Medical Services Personnel Licensing Requirements." (3-29-12)~~
- ~~23. **Emergency Scene.** Any setting (including standbys) outside of a hospital, with the exception of the inter-facility transfer, in which the provision of EMS may take place. (4-11-06)~~
- ~~24. **EMS Bureau.** The Emergency Medical Services (EMS) Bureau of the Idaho Department of Health and Welfare. (11-19-76)~~
- ~~25. **EMS Standards Manual.** A manual published by the EMS Bureau detailing policy information including EMS education, certification, licensure, and data collection. (3-29-12)~~

- ~~26. **Glasgow Coma Score (GCS).** A scale used to determine a patient's level of consciousness. It is a rating from three (3) to fifteen (15) of the patient's ability to open his eyes, respond verbally, and move normally. The GCS is used primarily during the examination of patients with trauma or stroke. (4-11-06)~~
- ~~27. **Ground Transport Time.** The total elapsed time calculated from departure of the ambulance from the scene to arrival of the ambulance at the patient destination. (4-11-06)~~
- ~~28. **Licensed EMS Services.** Air medical services, ambulance services, and nontransport services licensed by the EMS Bureau to function in Idaho. (3-29-12)~~
- ~~29. **Licensed Personnel.** Individuals licensed by the EMS Bureau who are Emergency Medical Responders (EMR), Emergency Medical Technicians (EMT), Advanced Emergency Medical Technicians (AEMT), and Paramedics. (3-29-12)~~
- ~~30. **Local Incident Management System.** The local system of interagency communications, command, and control established to manage emergencies or demonstrate compliance with the National Incident Management System. (4-11-06)~~
- ~~31. **National Emergency Medical Services Information System (NEMSIS) Technical Assistance Center.** An organization that validates software for compliance with the EMS data set defined by the United States Department of Transportation National Highway Traffic Safety Administration. (3-29-12)~~
- ~~32. **National Registry of Emergency Medical Technicians (NREMT).** An independent, non-governmental, not for profit organization which prepares validated examinations for the state's use in evaluating candidates for licensure. (3-29-12)~~
- ~~33. **Nontransport Service.** An agency required to be licensed by the EMS Bureau that is operated with the intent to provide personnel or equipment for medical stabilization at an emergency scene, but that is not intended to be the service that will actually transport sick or injured persons. (3-29-12)~~
- ~~34. **Nontransport Vehicle.** Any vehicle that is operated by an agency with the intent to provide personnel or equipment for medical stabilization at an emergency scene, but that is not intended as the vehicle that will actually transport sick or injured persons. (3-29-12)~~
- ~~35. **Out-of-Hospital.** Any setting outside of a hospital, including inter-facility transfers, in which the provision of EMS may take place. (4-5-00)~~
- ~~36. **Paramedic.** A person who has met the qualifications for paramedic licensure defined in Section 56-1012, Idaho Code, and in IDAPA 16.01.07, "Emergency Medical Services Personnel Licensing Requirements." (3-29-12)~~
- ~~37. **Patient Assessment.** The evaluation of a patient by EMS licensed personnel intending to provide treatment or transportation to that patient. (3-29-12)~~

~~38. **Patient Care.** The performance of acts or procedures under emergency conditions in responding to a perceived individual need for immediate care in order to prevent loss of life or aggravation of physiological or psychological illness or injury. (3-29-12)~~

~~39. **Physician.** In accordance with Section 54-1803, Idaho Code, a person who holds a current active license issued by the State Board of Medicine to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine in Idaho and is in good standing with no restrictions upon, or actions taken against, his license. (3-29-12)~~

~~40. **Pre-Hospital.** Any setting, including standbys, outside of a hospital, with the exception of the inter-facility transfer, in which the provision of EMS may take place. (3-29-12)~~

~~41. **State Health Officer.** The Administrator of the Division of Public Health. (3-29-12)~~

~~42. **Supervision.** The medical direction by a licensed physician of activities provided by licensed personnel affiliated with a licensed ambulance, air medical, or nontransport service, including: (3-29-12)~~

~~a. Establishing standing orders and protocols; (3-29-12)~~

~~b. Reviewing performance of licensed personnel; (3-29-12)~~

~~c. Providing instructions for patient care via radio or telephone; and (3-29-12)~~

~~d. Other oversight. (3-29-12)~~

~~43. **Transfer.** The transportation of a patient from one (1) medical care facility to another. (3-29-12)~~

011. -- 0745. (RESERVED)

~~075. **INVESTIGATION OF COMPLAINTS FOR EMS LICENSING VIOLATIONS.** Investigation of complaints and disciplinary actions for EMS agency licensing are provided under IDAPA 16.01.12, "Emergency Medical Services (EMS) - Complaints, Investigations, and Disciplinary Actions." (3-29-12)~~

(BREAK IN CONTINUITY OF SECTIONS)

204. INSPECTION.

Representatives of the EMS Bureau are authorized to enter the training facility at reasonable times, for the purpose of assuring that the training program meets or exceeds the provisions of these rules ~~and the EMS Standards Manual.~~ (7-1-97)()

(BREAK IN CONTINUITY OF SECTIONS)

300. ~~AMBULANCE SERVICE STANDARDS~~ REQUIRED RECORDS.

~~To qualify for licensing as an ambulance service under Section 56-1016, Idaho Code, the applicant must demonstrate compliance with the following: The following records must be maintained by EMS Agencies as required in IDAPA 16.01.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements. (4-6-05)()~~

~~**01. Ambulance Vehicles.** All ambulance and air ambulance vehicles must meet one (1) of the following conditions to be licensed: (3-29-12)~~

~~**a.** The vehicle meets or exceeds any federal, industry, or trade specifications or standards for ambulance and air ambulance vehicles as identified by the applicant. (3-29-12)~~

~~**b.** The vehicle has been uniquely configured or modified to meet specialized needs and has been inspected and approved by the EMS Bureau. (7-1-97)~~

~~**02. Required Ambulance and Air Ambulance Equipment.** Each ambulance must be equipped with the following: (3-29-12)~~

~~**a.** Medical care supplies and devices as specified in the Minimum Equipment Standards for Licensed EMS Services. Exceptions to the minimum equipment requirements may be granted by the EMS Bureau upon inspection, when the circumstances and available alternatives assure that appropriate patient care will be provided for all foreseeable incidents. (7-1-97)~~

~~**b.** Mobile radio on 155.340 MHz and 155.280 MHz frequencies with encoding capabilities to allow access to the Idaho EMS radio communications system; and (11-19-76)~~

~~**c.** Safety equipment and personal protective supplies for licensed personnel and other vehicle occupants as specified in the Minimum Equipment Standards, including materials to provide for body substance isolation and protection from exposure to communicable diseases and pathogens under Section 56-1017, Idaho Code. (3-29-12)~~

~~**03. Ambulance Personnel.** The ambulance service must demonstrate that a sufficient number of personnel are affiliated with the service to accomplish a twenty-four (24) hour a day, seven (7) day a week response capability in accordance with Section 56-1016, Idaho Code. The service must describe its anticipated staffing patterns per vehicle and shift on the application supplied by the EMS Bureau. The annual inspection by the EMS Bureau must include a review of the ambulance service personnel staffing configuration. (4-6-05)~~

041. Records to be Maintained by Ambulance and Air Medical Agencies. The ambulance ~~service~~ agencies must maintain records of each ambulance and air ambulance response and submit them to the EMS Bureau at least quarterly in a form approved by the EMS Bureau. These records must include at least the following information: (3-29-12)()

a. Name of ambulance service; (3-29-12)

- b. Date of response; (3-29-12)
- c. Time call received; (3-29-12)
- d. Time en route to scene; (3-29-12)
- e. Time arrival at scene; (3-29-12)
- f. Time service departed scene; (3-29-12)
- g. Time arrival at hospital; (3-29-12)
- h. Location of incident; (3-29-12)
- i. Description of illness/injury; (3-29-12)
- j. Description of patient management; (3-29-12)
- k. Patient destination; (3-29-12)
- l. Ambulance unit identification; (3-29-12)
- m. Identification and licensure level of each ambulance crew member on the response; and (3-29-12)
- n. Response outcome. (7-1-97)

~~05. **Communications.** Ambulance service dispatch must be in accordance with Section 56-1016, Idaho Code. The application for licensure must describe the radio, telephonic, or other electronic means by which patient care instructions from an authorized medical source will be obtained. The annual inspection by the EMS Bureau will include a review of the ambulance service dispatch and communications configuration. (4-6-05)~~

~~06. **Medical Control Plan.** The ambulance service must describe the extent and type of supervision by a licensed physician that is available to licensed personnel. The annual inspection by the EMS Bureau will include a review of the ambulance service medical control configuration. (3-29-12)~~

~~07. **Medical Treatment Protocols.** The ambulance service must submit a complete copy of the medical treatment protocols and written standing orders under which its licensed personnel will function with the application for licensure. (3-29-12)~~

~~08. **Training Facility Access.** The applicant must describe the arrangements which will provide access to clinical and didactic training locations, in the initial application for service licensure. (4-6-05)~~

~~09. **Geographic Coverage Description.** Each application for initial licensure must~~

~~contain a specific description of the Idaho jurisdiction(s) that the ambulance service will serve using known geopolitical boundaries or geographic coordinates. (4-6-05)~~

~~**10. Required Application.** The applicant must submit a completed application to the EMS Bureau to be considered for licensure. The most current standardized form will be available from the EMS Bureau. An additional application may be required prior to subsequent annual inspection by the EMS Bureau. (4-6-05)~~

~~**11. Inspection.** Representatives of the EMS Bureau are authorized to enter the applicant's facility or other location as designated by the applicant at reasonable times, for the purpose of inspecting the ambulance services' vehicle(s) and equipment, ambulance and air ambulance response records, and other necessary items to determine eligibility for licensing by the state of Idaho in relation to the minimum standards in Section 56-1016, Idaho Code. (3-29-12)~~

~~**12. License.** Ambulance services must be licensed on an annual basis by the EMS Bureau. (7-1-97)~~

~~**301. NONTRANSPORT SERVICE STANDARDS.**~~

~~In order to qualify for licensing as a nontransport service under Section 56-1016, Idaho Code, the applicant must demonstrate compliance with the following: (4-6-05)~~

~~**01. Vehicles.** All vehicles must meet one (1) of the following conditions to be licensed: (7-1-97)~~

~~**a.** The vehicle meets or exceeds standards for that type vehicle, including federal, industry, or trade specifications, as identified by the applicant and recognized and approved by the EMS Bureau. (7-1-97)~~

~~**b.** The vehicle has been uniquely configured or modified to meet specialized needs and has been inspected and approved by the EMS Bureau. (7-1-97)~~

~~**02. Required Equipment for Nontransport Services.** Licensed personnel must have access to required equipment. The equipment must be stored on a dedicated response vehicle, or in the possession of licensed personnel. The application for licensure as a nontransport service must include a description of the following: (3-29-12)~~

~~**a.** Medical care supplies and devices as specified in the Minimum Equipment Standards for Licensed EMS Services. Exceptions to the minimum equipment requirements may be granted by the EMS Bureau upon inspection, when the circumstances and available alternatives assure that appropriate patient care will be provided for all foreseeable incidents. (7-1-97)~~

~~**b.** Mobile or portable radio(s) on 155.340 MHZ and 155.280 MHZ frequencies with encoding capabilities to allow access to the Idaho EMS radio communications system; and (7-1-97)~~

~~**e.** Safety equipment and personal protective supplies for licensed personnel and~~

~~other vehicle occupants as specified in the Minimum Equipment Standards for Licensed EMS Services, including materials to provide for body substance isolation and protection from exposure to communicable diseases under Section 56-1023, Idaho Code. (3-29-12)~~

~~**03. Nontransport Service Personnel.** The nontransport service must demonstrate that a sufficient number of licensed personnel are affiliated with the service to accomplish a twenty-four (24) hour a day, seven (7) day a week response capability. Exceptions to this requirement may be granted by the EMS Bureau when strict compliance with the requirement would cause undue hardship on the community being served, or would result in abandonment of the service. The annual inspection by the EMS Bureau will include a review of the personnel staffing configuration. (3-29-12)~~

042. Records to Be Maintained by Non-Transport Agencies. The non-transport service agencies must maintain records of each EMS response in a form approved by the EMS Bureau. All applicant non-transport services who submit an application to the EMS Bureau after July 1, 2009, must submit records of each EMS response to the EMS Bureau at least quarterly in a form approved by the EMS Bureau. These records must include at least the following information: (3-29-12)()

- a. Identification of nontransport service; (3-29-12)
 - b. Date of response; (3-29-12)
 - c. Time call received; (3-29-12)
 - d. Time en route to scene; (3-29-12)
 - e. Time arrival at scene; (3-29-12)
 - f. Time service departed scene; (3-29-12)
 - g. Location of incident; (3-29-12)
 - h. Description of illness/injury; (3-29-12)
 - i. Description of patient management; (3-29-12)
 - j. Patient destination; (3-29-12)
 - k. Identification and licensure level of nontransport service personnel on response; (3-29-12)
- and
- l. Response outcome. (7-1-97)

~~**05. Communications.** The application for licensure must describe the radio, telephonic, or other electronic means by which patient care instructions from an authorized medical source will be obtained. The annual inspection by the EMS Bureau will include a review of the nontransport service dispatch and communications configuration. (4-6-05)~~

~~06. **Medical Control Plan.** The nontransport service must describe the extent and type of supervision by a licensed physician that is available to licensed personnel. The annual inspection by the EMS Bureau will include a review of the nontransport service medical control configuration. (3-29-12)~~

~~07. **Medical Treatment Protocols.** The nontransport service must submit a complete copy of the medical treatment protocols and written standing orders under which its licensed personnel will function with the initial application for licensure. (3-29-12)~~

~~08. **Training Facility Access.** The applicant must describe the arrangements which will provide access to clinical and didactic training locations in the initial application for service licensure. (4-6-05)~~

~~09. **Geographic Coverage Description.** Each application for initial licensure must contain a specific description of the Idaho jurisdiction(s) that the nontransport service will serve using known geopolitical boundaries or geographic coordinates. (4-6-05)~~

~~10. **Required Application.** The applicant must submit a completed application to the EMS Bureau to be considered for licensure. The most current standardized form is available from the EMS Bureau. An additional application may be required prior to subsequent annual inspection by the EMS Bureau. (4-6-05)~~

~~11. **Inspection.** Representatives of the Department are authorized to enter the applicant's facility or other location as designated by the applicant at reasonable times, for the purpose of inspecting the nontransport services' vehicle(s) and equipment, nontransport response records, and other necessary items to determine eligibility for licensing by the state of Idaho. (7-1-97)~~

~~12. **License.** Nontransport services must be licensed on an annual basis by the EMS Bureau. (7-1-97)~~

~~302.—319. (RESERVED)~~

~~320. **DESIGNATION OF CLINICAL CAPABILITY.**~~

~~All ambulance and nontransport licenses issued by the EMS Bureau must indicate the clinical level of service which can be provided by the ambulance or nontransport service after verification of compliance with Section 300 or Section 301 of these rules. Agencies which provide licensed personnel at the EMR or EMT level will be designated as Basic Life Support services. Agencies which provide licensed personnel at the AEMT level will be designated as Intermediate Life Support services. Agencies which provide licensed personnel at or above the paramedic level will be designated as Advanced Life Support services under Section 340 of these rules. Licensed EMS Services may function at one (1) or more ALS levels corresponding to the designation issued by the EMS Bureau as a result of the application and inspection process required in Sections 300 and 301 of these rules. (3-29-12)~~

~~321.—324. (RESERVED)~~

~~325. PRE-HOSPITAL ADVANCED LIFE SUPPORT (ALS) STANDARDS.~~

~~Pre-hospital ALS designation of an agency by the EMS Bureau is required for any agency which will advertise or supply clinical personnel and equipment capabilities which are within the scope of practice established for ALS under IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission," for the purposes of responding to emergencies in any 911 service area, standby, or other area on an emergency basis. Designation is for the same duration as the license issued to the EMS agency. An agency which has demonstrated compliance with Section 300 or Section 301 of these rules may qualify for Pre-hospital ALS designation if the following criteria are met:~~ (3-29-12)

~~**01. Personnel.** The agency must have a sufficient number of Paramedics to assure availability of such personnel corresponding to the anticipated call volume of the agency. The agency is specifically prohibited from utilizing other licensed health care providers for pre-hospital and emergency responses to requests for EMS unless they are accompanied by or cross-trained and licensed as a Paramedic.~~ (3-29-12)

~~**a.** Paramedic personnel must hold a current paramedic license issued by the EMS Bureau under IDAPA 16.01.07, "Emergency Medical Services (EMS) — Personnel Licensing Requirements."~~ (3-29-12)

~~**b.** An agency may use Ambulance-Based Clinicians who function with a Paramedic or are cross-trained and licensed as a Paramedic. The agency must verify that all Ambulance-Based Clinicians have successfully completed a formal education program of pre-hospital medical care which meets or exceeds the objectives of the curriculum approved by the State Health Officer. The agency must assure that any Ambulance-Based Clinicians meet additional requirements of the corresponding licensing board.~~ (3-29-12)

~~**c.** Personnel must initiate advanced life support as authorized by the physician designated as the Medical Director of the agency, and other physicians providing on-line medical supervision as specified in IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission."~~ (3-29-12)

~~**02. Required Documentation.** The employment status and ongoing proficiency maintenance of the licensed personnel and Ambulance-Based Clinicians associated with the agency must be documented on a periodic basis to the EMS Bureau.~~ (3-29-12)

~~**a.** The agency must submit a roster of all licensed personnel and Ambulance-Based Clinicians with the application for licensure. Any change in the roster due to attrition or hiring must be documented to the EMS Bureau in writing within sixty (60) calendar days of the change.~~ (3-29-12)

~~**b.** The agency must maintain documentation of continuing education, refresher courses, and proficiency assurance of all licensed personnel and Ambulance-Based Clinicians in accordance with the EMS Standards Manual in effect at the time of designation and any EMS Standards Manual which takes effect during the designation period.~~ (3-29-12)

~~**03. Required Equipment.** The agency vehicle(s) must be equipped with the Minimum Required Equipment listed in the ALS section of the Minimum Equipment Standards incorporated~~

~~in these rules. The agency must disclose all additional medical equipment routinely carried on the agency vehicle(s) not included in the Minimum Equipment Standards in the application provided by the EMS Bureau. (4-6-05)~~

~~**04. Administrative License Action.** A pre-hospital ALS designation may be revoked under IDAPA 16.01.12, "Emergency Medical Services (EMS) — Complaints, Investigations, and Disciplinary Actions." The agency is specifically prohibited from advertising as or responding to requests for critical care transfer service unless the agency also holds a Critical Care Transfer Service designation under Section 335 of these rules. (3-29-12)~~

~~326.—329. (RESERVED)~~

~~**330. ADVANCED LIFE SUPPORT (ALS) TRANSFER STANDARDS.**~~

~~ALS Transfer designation of an agency by the EMS Bureau is required for any agency which will advertise or supply clinical personnel and equipment capabilities which are within the scope of practice established for ALS under IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission," for the purposes of providing medical care and transportation between medical care facilities. Designation is for the same duration as the license issued to the EMS agency. An agency which has demonstrated compliance with Section 300 or Section 301 of these rules may qualify for ALS Transfer designation if the following criteria are met: (3-29-12)~~

~~**01. Personnel.** The agency must have a sufficient number of personnel to assure availability corresponding to the anticipated call volume of the agency. (4-5-00)~~

~~**a.** Paramedic personnel must hold a current paramedic license issued by the EMS Bureau under IDAPA 16.01.07, "Emergency Medical Services (EMS) — Personnel Licensing Requirements." (3-29-12)~~

~~**b.** An agency which will advertise or provide ALS transfer of patients may use Ambulance-Based Clinicians as the medical care provider for those patients. The agency must verify that all Ambulance-Based Clinicians have successfully completed a formal education program of out-of-hospital medical care which meets or exceeds the objectives of the curriculum approved by the State Health Officer. The agency must assure that any Ambulance-Based Clinicians meet additional requirements of the corresponding licensing board. (3-29-12)~~

~~**c.** Personnel will initiate advanced life support as authorized by the physician designated as the Medical Director of the agency, and other physicians providing on-line medical supervision as specified in IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission." (3-29-12)~~

~~**02. Required Documentation.** The employment status and ongoing proficiency maintenance of the licensed personnel and Ambulance-Based Clinicians associated with the agency must be documented on a periodic basis to the EMS Bureau. (3-29-12)~~

~~**a.** The agency must submit a roster of all licensed personnel and Ambulance-Based Clinicians with the application for licensure. Any change in the roster due to attrition or hiring must be documented to the EMS Bureau in writing within sixty (60) calendar days of the change.~~

~~(3-29-12)~~

~~**b.** The agency must maintain documentation of continuing education, refresher courses, and proficiency assurance of all licensed personnel and Ambulance-Based Clinicians in accordance with the EMS Standards Manual in effect at the time of designation and any EMS Standards Manual which takes effect during the designation period.~~ (3-29-12)

~~**03. Required Equipment.** The agency vehicle(s) must be equipped with the Minimum Required Equipment listed in the ALS section of the Minimum Equipment Standards incorporated in these rules. The agency must disclose all additional medical equipment routinely carried on the agency vehicle(s) not included in the Minimum Equipment Standards in the application provided by the EMS Bureau.~~ (4-6-05)

~~**04. Administrative License Action.** An ALS Transfer designation may be revoked under IDAPA 16.01.12, "Emergency Medical Services (EMS) – Complaints, Investigations, and Disciplinary Actions." The agency is specifically prohibited from advertising or responding to pre-hospital and emergency requests for ALS unless the agency also holds a pre-hospital ALS designation in accordance with Section 325 of these rules. The agency is specifically prohibited from advertising as or responding to requests for critical care transfer service unless the agency also holds a Critical Care Transfer (CCT) Service designation in accordance with Section 335 of these rules.~~ (3-29-12)

~~331.—334. (RESERVED)~~

~~**335. CRITICAL CARE TRANSFER (CCT) SERVICE STANDARDS.**~~

~~Critical Care Transfer (CCT) Service designation of an agency by the EMS Bureau is required for any agency which will advertise or supply clinical personnel and equipment capabilities requiring knowledge or skills not contained within the Paramedic curriculum approved by the State Health Officer. Designation will be for the same duration as the license issued to the EMS agency. An agency which has demonstrated compliance with Section 300 of these rules may qualify for Critical Care Transfer (CCT) Service designation if the following criteria are met:~~ (3-29-12)

~~**01. Personnel.** The agency must have a sufficient number of personnel to assure availability corresponding to the anticipated call volume of the agency.~~ (4-5-00)

~~**a.** Paramedic personnel must hold a current paramedic license issued by the EMS Bureau under IDAPA 16.01.07, "Emergency Medical Services (EMS) – Personnel Licensing Requirements." Paramedics who will be the primary or the only care provider during critical care transfers must have successfully completed a formal education program in critical care transport which meets or exceeds the objectives of the curriculum approved by the State Health Officer.~~ (3-29-12)

~~**b.** An agency which will advertise or provide CCT transfer of patients may use Ambulance-Based Clinicians as the medical care provider for those patients. The agency must verify that all Ambulance-Based Clinicians have successfully completed a formal education program of out-of-hospital medical care which meets or exceeds the objectives of the curriculum approved by the State Health Officer. The agency must assure that any Ambulance-Based~~

~~Clinicians meet additional requirements of the corresponding licensing board. (3-29-12)~~

~~e. Personnel will initiate critical care as authorized by the physician designated as the Medical Director of the agency, and other physicians providing on-line medical supervision as specified in IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission." (3-29-12)~~

~~02. **Required Documentation.** The employment status and ongoing proficiency maintenance of the licensed personnel and Ambulance-Based Clinicians associated with the agency must be documented on a periodic basis to the EMS Bureau. (3-29-12)~~

~~a. The agency must submit a roster of all licensed personnel and Ambulance-Based Clinicians with the application for licensure. Any change in the roster due to attrition or hiring must be documented to the EMS Bureau in writing within sixty (60) calendar days of the change. (3-29-12)~~

~~b. The agency must maintain documentation of continuing education, refresher courses, and proficiency assurance of all licensed personnel and Ambulance-Based Clinicians in accordance with the EMS Standards Manual in effect at the time of designation and any EMS Standards Manual which takes effect during the designation period. (3-29-12)~~

~~03. **Required Equipment.** The agency vehicle(s) must be equipped with the Minimum Required Equipment listed in the ALS section of the Minimum Equipment Standards incorporated in these rules. The agency must disclose all additional medical equipment routinely carried on the agency vehicle(s) not included in the Minimum Equipment Standards in the application provided by the EMS Bureau. (4-6-05)~~

~~04. **Administrative License Action.** A Critical Care Transfer Service designation may be revoked under IDAPA 16.01.12, "Emergency Medical Services (EMS) — Complaints, Investigations, and Disciplinary Actions." The agency is specifically prohibited from advertising or responding to pre-hospital and emergency requests for ALS unless the agency also holds pre-hospital ALS designation under Section 325 of these rules. (3-29-12)~~

~~336.—339. (RESERVED)~~

~~340. **ADVANCED LIFE SUPPORT (ALS) DESIGNATION CATEGORIES.**~~

~~Licensed EMS services are permitted to hold any combination of designations achieved by meeting the standards in Sections 325, 330, and 335 of these rules. Licenses or the designations associated with them can not be assigned or transferred. A standard system of designation must be used by the EMS Bureau to define which combination of clinical capabilities has been demonstrated by each ALS licensed EMS service. (4-6-05)~~

~~01. **An ALS Level I.** An ALS Level I license must be issued by the EMS Bureau to any applicant who meets the requirements in Sections 325, 330 and 335 of these rules. (4-6-05)~~

~~02. **An ALS Level II.** An ALS Level II license must be issued by the EMS Bureau to any applicant who meets the requirements in Sections 325 and 330 of these rules. (4-6-05)~~

~~03. An ALS Level III. An ALS Level III license must be issued by the EMS Bureau to any applicant who meets the requirements in Sections 330 and 335 of these rules. (4-6-05)~~

~~04. An ALS Level IV. An ALS Level IV license must be issued by the EMS Bureau to any applicant who meets the requirements in Section 330 of these rules. (4-6-05)~~

~~05. An ALS Level V. An ALS Level V license must be issued by the EMS Bureau to any applicant who meets the requirements in Section 325 of these rules. (4-6-05)~~

3401. -- 399. (RESERVED)

400. ADVANCE DO NOT RESUSCITATE (DNR) DIRECTIVES.

01. Protocols. (11-10-94)

a. The EMS Advisory Committee described in IDAPA 16.01.01, "Emergency Medical Services (EMS) -- Advisory Committee." will establish standard protocols for EMS personnel to respond to advance DNR directives. ~~(11-10-94)~~()

b. The protocol will be reviewed at least annually by the EMS Advisory Committee to determine if changes in protocol should be made to reflect technological advances. (11-10-94)

c. The Department will notify Idaho EMS personnel of DNR protocols and any subsequent changes. (3-29-12)

02. Do Not Resuscitate (DNR) Order. (3-29-12)

a. A standard DNR form will be made available to physicians by the Department or its designee. (11-10-94)

b. One (1) copy will be maintained in the patient's file and one (1) copy will be kept by the patient. (11-10-94)

03. Do Not Resuscitate (DNR) Identification. (3-29-12)

a. Only a physician signed DNR order or a Department approved bracelet or necklace will be honored by EMS personnel. (11-10-94)

b. The bracelet or necklace will have an easily identifiable logo that solely represents a DNR code. (11-10-94)

c. The Department will advise EMS personnel of what constitutes an acceptable identification. (11-10-94)

d. No DNR identification may be issued without a valid DNR order in place. (11-10-94)

e. Only vendors authorized by the Department may sell or distribute DNR

identifications. (11-10-94)

401. -- 404. (RESERVED)

405. ~~STANDARDS FOR THE APPROPRIATE USE OF~~ AIR MEDICAL **EDUCATION AND TRAINING ~~AGENCIES BY LICENSED EMS PERSONNEL AT EMERGENCY SCENES.~~**

01. ~~Who Establishes Education Curricula and Continuing Education Requirements for Air Medical Criteria?~~ The EMS Bureau will incorporate education and training regarding the air medical criteria established in Subsection 4205.02 of these this rules into initial training curricula and required continuing education of licensed EMS personnel. (3-29-12)()

02. ~~Who Must Establish Written Criteria Guiding Decisions to Request an Air Medical Response?~~ Each licensed EMS service must establish written criteria, approved by the EMS service medical director, to guide the decisions of the service's licensed EMS personnel to request an air medical response to an emergency scene. The criteria will include patient conditions found in Section 415 of these rules. (3-29-12)

03. ~~What Written Criteria is Required for EMS Service Licensure?~~ Written criteria guiding decisions to request an air medical response will be required for all initial and renewal applications for EMS service licensure for licenses effective on November 1, 2006, or later. (4-11-06)

04. ~~Who Is Responsible for Requesting an Air Medical Response?~~ Licensed EMS personnel en route to or at the emergency scene have the primary responsibility and authority to request the response of air medical services using the local incident management system and licensed EMS service written criteria. (3-29-12)

05. ~~When Can Licensed EMS Personnel Cancel an Air Medical Response?~~ Licensed EMS personnel must complete a patient assessment prior to their cancellation of an air medical response. (3-29-12)

06. ~~Who May Establish Criteria for Simultaneous Dispatch?~~ The licensed EMS service may establish criteria for simultaneous dispatch for air and ground medical response. Air medical services will not respond to an emergency scene unless requested. (4-11-06)

07. ~~Who Is Responsible for Selecting an Appropriate Air Medical Service?~~ Selection of an appropriate air medical service is the responsibility of the licensed EMS service. (4-11-06)

a. The licensed EMS service, through written policy, will establish a process of air medical selection. (4-11-06)

b. The written policy must direct EMS personnel to honor a patient request for a specific air medical service when the circumstances will not jeopardize patient safety or delay patient care. (4-11-06)

406. — 414. (RESERVED)

~~415. AIR MEDICAL RESPONSE CRITERIA.~~

~~The need for an air medical request will be determined by the licensed EMS service licensed personnel based on their patient assessment and transport time. Each licensed EMS service must develop written criteria based on best medical practice principles. The following conditions must be included in the criteria: (3-29-12)~~

~~01. What Clinical Conditions Require Written Criteria? The licensed EMS service written criteria will provide guidance to the licensed EMS personnel for the following clinical conditions: (3-29-12)~~

- ~~a. The patient has a penetrating or crush injury to head, neck, chest, abdomen, or pelvis; (4-11-06)~~
- ~~b. Neurological presentation suggestive of spinal cord injury; (4-11-06)~~
- ~~c. Evidence of a skull fracture (depressed, open, or basilar) as detected visually or by palpation; (4-11-06)~~
- ~~d. Fracture or dislocation with absent distal pulse; (4-11-06)~~
- ~~e. A Glasgow Coma Score of ten (10) or less; (4-11-06)~~
- ~~f. Unstable vital signs with evidence of shock; (4-11-06)~~
- ~~g. Cardiac arrest; (4-11-06)~~
- ~~h. Respiratory arrest; (4-11-06)~~
- ~~i. Respiratory distress; (4-11-06)~~
- ~~j. Upper airway compromise; (4-11-06)~~
- ~~k. Anaphylaxis; (4-11-06)~~
- ~~l. Near drowning; (4-11-06)~~
- ~~m. Changes in level of consciousness; (4-11-06)~~
- ~~n. Amputation of an extremity; and (4-11-06)~~
- ~~o. Burns greater than twenty percent (20%) of body surface or with suspected airway compromise. (4-11-06)~~

~~02. What Complicating Conditions Require Written Criteria? When associated with clinical conditions in Subsection 415.01 of these rules, the following complicating conditions require written guidance for EMS personnel: (4-11-06)~~

- ~~a. Extremes of age; (4-11-06)~~
- ~~b. Pregnancy; and (4-11-06)~~
- ~~c. Patient “do not resuscitate” status as described in Section 400 of these rules. (4-11-06)~~
- ~~03. What Operational Conditions Require Written Guidance for an Air Medical Response? The licensed EMS service written criteria will provide guidance to the licensed EMS personnel for the following operational conditions: (3-29-12)~~
- ~~a. Availability of local hospitals and regional medical centers; (4-11-06)~~
- ~~b. Air medical response to the scene and transport to an appropriate hospital will be significantly shorter than ground transport time; (4-11-06)~~
- ~~c. Access to time sensitive medical interventions such as percutaneous coronary intervention, thrombolytic administration for stroke, or cardiac care; (4-11-06)~~
- ~~d. When the patient's clinical condition indicates the need for advanced life support and air medical is the most readily available access to advanced life support capabilities; (4-11-06)~~
- ~~e. As an additional resource for a multiple patient incident; (4-11-06)~~
- ~~f. Remote location of the patient; and (4-11-06)~~
- ~~g. Local destination protocols. (4-11-06)~~
- ~~416.—419. (RESERVED)~~
- ~~420. COMMUNICATIONS.~~
- ~~01. Who Is Responsible for Requesting an Air Medical Response? The licensed EMS service will establish a uniform method of communication, in compliance with the local incident management system, to request air medical response. (4-11-06)~~
- ~~02. What Information Must Be Given When Requesting an Air Medical Response? Requests for an air medical response must include the following information as it becomes available: (4-11-06)~~
- ~~a. Type of incident; (4-11-06)~~
- ~~b. Landing zone location or GPS (latitude/longitude) coordinates, or both; (4-11-06)~~
- ~~c. Scene contact unit or scene incident commander, or both; (4-11-06)~~
- ~~d. Number of patients if known; (4-11-06)~~

~~e. Need for special equipment; (4-11-06)~~

~~f. How to contact on scene EMS personnel, and (4-11-06)~~

~~g. How to contact the landing zone officer. (4-11-06)~~

~~03. Who Is Notified of a Request for an Air Medical Response? The air medical service will notify the State EMS Communication Center within ten (10) minutes of launching an aircraft in response to a request for emergency services. Notification will include: (4-11-06)~~

~~a. The name of the requesting entity; (4-11-06)~~

~~b. Location of the landing zone; and (4-11-06)~~

~~c. Scene contact unit and scene incident commander, if known. (4-11-06)~~

~~04. Who Is Provided the Estimated Time of Arrival at the Specified Landing Zone? Upon receipt of a request for emergency services, the air medical service will provide the requesting entity with an estimated time to arrival in hours and minutes at the location of the specified landing zone and any changes to that estimated time. (4-11-06)~~

~~05. Who Must Confirm Availability of an Air Medical Response? Upon receipt of a request, the air medical service will inform the requesting entity if the air medical service is not immediately available to respond. (4-11-06)~~

~~421.—424. (RESERVED)~~

~~425. LANDING ZONE AND SAFETY.~~

~~01. Who Is Responsible for Setting Up Landing Zone Procedures? The licensed EMS service in conjunction with the air medical service(s) must have written procedures for establishment of landing zones. Such procedures will be compatible with the local incident management system. (4-11-06)~~

~~02. What Are the Responsibilities of Landing Zone Officers? The procedures for establishment of landing zones must include identification of Landing Zone Officers with responsibility for the following: (4-11-06)~~

~~a. Landing zone preparation; (4-11-06)~~

~~b. Landing zone safety; and (4-11-06)~~

~~c. Communication between ground and air agencies. (4-11-06)~~

~~032. What Training Is Required for Landing Zone Officers? The Each licensed EMS service agency will assure that EMS licensed personnel, designated as Landing Zone Officers, have completed training in establishing an air medical landing zone based on the~~

following elements:

~~(3-29-12)~~()

- a. The required size of a landing zone; (4-11-06)
- b. The allowable slope of a landing zone; (4-11-06)
- c. The allowable surface conditions; (4-11-06)
- d. Hazards and obstructions; (4-11-06)
- e. Marking and lighting; (4-11-06)
- f. Landing zone communications; and (4-11-06)
- g. Landing zone safety. (4-11-06)

~~04. What Is the Deadline for Obtaining Training as Landing Zone Officers? Current EMS licensed personnel, designated as Landing Zone Officers, must complete the required training described in Subsection 425.03 of this rule by June 30, 2007. (3-29-12)~~

~~05. What Is the Deadline for Training as a Landing Zone Officer for EMS License Renewal? All EMS certified personnel will complete training described in Subsection 425.03 of this rule as a component of required continuing education for license renewal not later than September 30, 2010. (3-29-12)~~

~~06. Who Has the Final Decision to Use an Established Landing Zone? The air medical pilot may refuse the use of an established landing zone. In the event of pilot refusal, the landing zone officer will initiate communications to identify an alternate landing zone. (4-11-06)~~

~~426. — 429. (RESERVED)~~

~~430. PATIENT DESTINATION.~~

~~The air medical service must have written procedures for determination of patient destination. (4-11-06)~~

~~01. Procedures for Destination Protocol and Medical Supervision. The air medical service written procedure will consider the licensed EMS service destination protocol and medical supervision received. (3-29-12)~~

~~02. Availability of Written Procedures. The air medical service must make the written procedures available to licensed EMS services that utilize their services. (4-11-06)~~

~~03. Determination of Destination Will Honor Patient Preference. The air medical procedures for determination of destination will honor patient preference if the requested facility is capable of providing the necessary medical care and if the requested facility is located within a reasonable distance not compromising patient care or the EMS system. (4-11-06)~~

~~43106. -- 434. (RESERVED)~~

435. PERIODIC REVIEW OF EMS SYSTEM DATA.

The ~~Department of Health and Welfare~~, EMS Bureau, will periodically review service response data with other EMS system data such as those found in the Trauma Registry maintained in accordance with Title 57, Chapter 20, Idaho Code. (4-11-06)()

01. ~~How Often Will the Department Conduct a Review of Air Medical Criteria?~~
Every Three Years. The ~~Idaho~~ EMS Bureau will review the rules, utilization and effectiveness of air medical criteria every three (3) years ~~with the first review being completed no later than June 30, 2009.~~ (4-11-06)()

02. ~~What May Be Included During the Review of Air Medical Criteria?~~ **to be Reviewed.** The EMS Bureau review of air medical criteria may include the following: (4-11-06)()

- a. Licensed EMS service response data; (4-11-06)
- b. Licensed EMS service guidelines; (4-11-06)
- c. Patient treatment and outcome information; and (4-11-06)
- d. Trauma Registry data. (4-11-06)

03. ~~What Information Must Be Provided During the Review of Air Medical Response Criteria?~~ ~~Licensed EMS services must provide incident specific patient care related data identified and requested by the EMS Bureau in the review of air medical response criteria.~~ (4-11-06)

043. ~~To Whom Will the EMS Bureau Report the of Aggregate Data and Findings?~~
The EMS Bureau will report the aggregate data and findings from the review of air medical criteria to all licensed EMS ~~services~~ **agencies**, hospitals, county commissioners, and EMS medical directors. (4-11-06)()

436. -- 999. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.01 - ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

DOCKET NO. 16-0301-1301 (CHAPTER REPEAL)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2014. The pending rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and is also adopting a temporary rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-209, 56-236 through 56-240, 56-242, 56-250 through 56-257, 56-260 through 56-266, Idaho Code; and 42 CFR, 45 CFR, and 26 USC Part 36B.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule:

In accordance with Section 67-5226, Idaho Code, the temporary rule notice published in this Bulletin repeals this chapter in its entirety. There are no changes to the pending rule and it is being adopted as originally proposed. The notice of the proposed rule was published in the October 2, 2013, Idaho Administrative Bulletin, [Vol. 13-10, page 148](#). This temporary rule is being adopted because changes in federal laws require implementation on January 1, 2014, that renders this chapter of rules outdated and no longer in compliance. This chapter is repealed in its entirety and is rewritten under companion Docket No. 16-0301-1302 that is being published in this same Bulletin.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b) and (c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate in order to comply with deadlines in amendments to governing law or federal programs, effective January 1, 2014, and to confer a benefit.

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

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

The fiscal impact for this rulemaking is anticipated to be cost neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending and temporary rule, contact Lori Wolff at (208) 334-5815.

DATED this 26th day of November, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-209, 56-236 through 56-240, 56-242, 56-250 through 56-257, 56-260 through 56-266, Idaho Code; and 42 CFR, 45 CFR, and 26 USC Part 36B.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 16, 2013.

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

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

This rulemaking is being done because changes in federal laws that must be implemented by January 1, 2014, will render this chapter of rules outdated and out of compliance with federal law. To avoid confusion and remain in compliance with the new federal requirements, this chapter is being repealed in its entirety and rewritten under companion Docket No. 16-0301-1302 that is being published in this same Bulletin.

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

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

The fiscal impact for this rulemaking is anticipated to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because federal laws require the Department to make changes to these rules and have them in place by January 1, 2014, in order to be in compliance with that law. The changes required by federal law makes these rules non-negotiable.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Shannon Epperley at (208) 334-5969.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 23, 2013.

DATED this 29th day of August, 2013.

[LSO Rules Analysis Memo](#)

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0301-1301

IDAPA 16.03.01 IS BEING REPEALED IN ITS ENTIRETY

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.01 - ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

DOCKET NO. 16-0301-1302 (CHAPTER REWRITE)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the temporary rule is **January 1, 2014**. The pending rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and is also adopting a temporary rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-209, 56-236 through 56-240, 56-242, 56-250 through 56-257, 56-260 through 56-266, Idaho Code; and 42 CFR, 45 CFR, and 26 USC Part 36B.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule:

In accordance with Section 67-5226, Idaho Code, the full text of the temporary rule is being published in this Bulletin following this notice which rewrites this chapter in its entirety. Changes to the pending rule and included in the temporary rule are being made to correct and simplify language, to add presumptive eligibility criteria, and to modify policies related to modified adjusted gross income (MAGI) households. These changes are a result of guidance provided from the Centers for Medicare and Medicaid Services (CMS) after publication of the proposed rule. The complete text of the proposed rule was published in the October 2, 2013, Idaho Administrative Bulletin, **Vol. 13-10, page 149 through 177**.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b) and (c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate in order to comply with deadlines in amendments to governing law or federal programs, effective January 1, 2014, and to confer a benefit.

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

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

The fiscal impact for this rulemaking is anticipated to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending and temporary rule, contact Lori Wolff at (208) 334-5815.

DATED this 27th day of November, 2013.

Tamara Prisock
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THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-209, 56-236 through 56-240, 56-242, 56-250 through 56-257, 56-260 through 56-266, Idaho Code; and 42 CFR, 45 CFR, and 26 USC Part 36B.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 16, 2013.

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

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

This rulemaking is being initiated because of changes in federal law that must be implemented by January 1, 2014. To avoid confusion and remain in compliance with the new federal requirements, the current chapter is being repealed under companion Docket No. 16-0301-1301 and published in this same Bulletin. This chapter of rules is being rewritten to be in compliance with federal law. The rules are being published as proposed in this Bulletin, but will go into effect on January 1, 2014. The new chapter includes:

1. Eligibility criteria;
2. Definitions;
3. Application requirements;
4. Non-financial requirements, including residency and U.S. citizenship, identity, and

verification requirements;

5. Financial requirements including determination of income for eligibility;
6. Health coverage for children, adults, and access to coverage under other health plans;
7. Renewal of eligibility including reporting requirements;
8. References to other chapters of rules as necessary; and
9. Sections needed to meet requirements of the rules of the Office of the Administrative Rules Coordinator.

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

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

The fiscal impact for this rulemaking is anticipated to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because federal laws require the Department to make changes to these rules and have them in place by January 1, 2014, in order to be in compliance with that law. The changes required by federal law makes these rules non-negotiable.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Shannon Epperley at (208) 334-5969.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 23, 2013.

DATED this 30th day of August, 2013.

[LSO Rules Analysis Memo](#)

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0301-1302

IDAPA 16
TITLE 03
CHAPTER 01

16.03.01 - ELIGIBILITY FOR HEALTH CARE ASSISTANCE
FOR FAMILIES AND CHILDREN

000. LEGAL AUTHORITY.

In accordance with Sections 56-202, 56-203, 56-209, 56-239, 56-250, 56-253, 56-255, 56-256 and 56-257, Idaho Code, the Idaho Legislature has authorized the Department of Health and Welfare to adopt and enforce rules for the administration of Title XIX of the Social Security Act (Medicaid), *and* Title XXI of the Social Security Act. ()

001. TITLE AND SCOPE.

01. Title. These rules will be cited as IDAPA 16.03.01, “Eligibility for Health Care Assistance for Families and Children.” ()

02. Scope. These rules provide standards for issuing coverage for Title XIX and Title XXI of the Social Security Act. ()

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency has written statements that pertain to the interpretation of the rules of this chapter, or to the documentation of compliance with the rules of this chapter. The document is available for public inspection and copying at cost at the Department of Health and Welfare, 450 West State Street, P.O. Box 83720, Boise, Idaho, 83720-0036 or at any of the Department's Regional Offices. ()

003. ADMINISTRATIVE APPEALS.

All administrative appeals are governed by provisions of IDAPA 16.05.03, “Contested Case Proceedings and Declaratory Rulings.” ()

004. INCORPORATION BY REFERENCE.

No documents have been incorporated by reference into these rules. ()

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE NUMBER -- INTERNET WEBSITE.

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the state of Idaho. ()

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. ()

03. Street Address. The business office of the Idaho Department of Health and

Welfare is located at 450 West State Street, Boise, Idaho 83702. ()

04. Telephone. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. ()

05. Internet Website. The Department's internet website is <http://www.healthandwelfare.idaho.gov>. ()

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS.

01. Confidential Records. Any information about an individual covered by these rules and contained in the Department's records must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records." ()

02. Public Records. The Department will comply with Sections 9-337 through 9-350, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. ()

007. -- 009. (RESERVED)

010. DEFINITIONS (A THROUGH L).

For the purposes of this chapter, the following terms apply. ()

01. Advanced Payment of Premium Tax Credit. Payment of federal tax credits specified in 26 U.S.C. Part 36B (as added by section 1401 of the Affordable Care Act) which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an exchange in accordance with sections 1402 and 1412 of the Affordable Care Act. ()

02. Adult. Any individual who has passed the month of his nineteenth birthday.()

03. Affordable Care Act. The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152). ()

04. Applicant. A person applying for public assistance from the Department, including individuals referred to the Department from a Health Insurance Exchange or Marketplace. ()

05. Application. An application for benefits including an Application for Assistance (AFA) or other application recognized by the Department, including referrals from a Health Insurance Exchange or Marketplace. ()

06. Application Date. The date the Application for Assistance (AFA) is received by the Department or by the Health Insurance Exchange or Marketplace electronically, telephonically, in person, or the date the application is postmarked, if mailed. ()

- 07. Caretaker Relative.** A caretaker relative is a relative of a dependent child by full- or half-blood, adoption, or marriage with whom the child is living *and* who assumes primary responsibility for the child's care. A caretaker relative is one of the following: ()
- a.** A child's natural, adoptive, or step-parents; ()
 - b.** A child's natural, adoptive, or step-grandparents; ()
 - c.** A child's natural, adoptive, half- or step-siblings; ()
 - d.** A child's natural, adoptive, half- or step-uncle, aunt, first cousin, nephew, niece; first cousin once removed; or ()
 - e.** A current or former spouse of a qualified relative listed above. ()
- 08. Child.** Any individual from birth through the end of the month of his nineteenth birthday. ()
- 09. Citizen.** A person having status as a “national of the United States” defined in 8 U.S.C. 1101(a)(22) that includes both citizens of the United States and non-citizen nationals of the United States. ()
- 10. Cost-Sharing.** A participant payment for a portion of Medicaid service costs such as deductibles, co-insurance, or co-payment amounts. ()
- 11. Creditable Health Insurance.** Creditable health insurance is coverage that provides benefits for inpatient and outpatient hospital services and physicians' medical and surgical services. Creditable coverage excludes liability, limited scope dental, vision, specified disease, or other supplemental-type benefits. ()
- 12. Department.** The Idaho Department of Health and Welfare. ()
- 13. Disenrollment.** The end of an individual's participation in a Health Care Assistance program. ()
- 14. Electronic Account.** An electronic file that includes all information collected and generated by the state regarding each individual's Health Care Assistance eligibility and enrollment, including all documentation required and information collected as part of an eligibility review, or during the course of an appeal. ()
- 15. Eligibility.** The determination of whether or not an individual is eligible for participation in a Health Care Assistance program. ()
- 16. Enrollment.** The process of adding eligible individuals to a Health Care Assistance program. ()
- 17. Extended Medicaid.** Extended Medicaid is four (4) additional months of medical assistance for a parent or relative caretaker who becomes ineligible for Title XIX Medicaid due to

an increase in spousal support payments. ()

18. Federal Poverty Guidelines (FPG). The federal poverty guidelines issued annually by the Department of Health and Human Services (HHS). The Federal Poverty Guidelines (FPG) are available on the U.S. Health and Human Services website at <http://aspe.hhs.gov/poverty>. ()

19. Health Assessment. Health Assessment is an examination performed by a primary care provider in order to determine the appropriate health plan for a Medicaid-eligible individual. ()

20. Health Care Assistance (HCA). Health coverage, including Title XIX or Title XXI benefits granted by the Department for persons or families under the authority of Title 56, Chapter 2, Idaho Code, as well as private health insurance plans purchased with a Premium Tax Credit described in Subsection 010.01 of this rule. ()

21. Health Insurance Exchange or Marketplace. A resource where individuals, families, and small businesses can: ()

- a. Learn about their health coverage options; ()
- b. Compare health insurance plans based on costs, benefits, and other important features: ()
- c. Choose a health coverage plan; and ()
- d. Enroll in health coverage. ()

22. Health Insurance Premium Program (HIPP). The Premium Assistance program in which Title XIX and Title XXI participants may participate. ()

23. Health Plan. A set of health services paid for by Idaho Medicaid, or health insurance coverage obtained through the Health Insurance Exchange or Marketplace. ()

24. Health Questionnaire. A tool used to assist Health and Welfare staff in determining the correct Health Plan for the Medicaid applicant. ()

25. Internal Revenue Code. The federal tax law used to determine eligibility under Title 26 U.S.C. for individual income and self-employment income. ()

26. Internal Revenue Service (IRS). The U.S. government agency in charge of tax laws. These laws are used to determine income eligibility. The IRS website is at <http://www.irs.gov>. ()

27. Insurance Affordability Programs. Insurance affordability programs include Title XIX title XXI and all insurance programs available in the Health Insurance *Exchange or* Marketplace. ()

28. Lawfully Present. An individual who is a qualified non-citizen as described in Section 221 of these rules. ()

29. Lawfully Residing. An individual who is lawfully present in the United States and is a resident of the state in which they are applying for health care coverage. ()

011. DEFINITIONS (M THROUGH Z).

For the purposes of this chapter, the following terms apply. ()

01. MAGI-Based Income. Income calculated using the same financial methodologies used by the IRS to determine modified adjusted gross income for federal tax filers, with the exception that: ()

a. Educational income is excluded in Section 382 of these rules; ()

b. Indian monies excluded by federal law are not included in MAGI-based income; ()

c. Lump sum income is counted only in the month received in Section 384 of these rules; and ()

d. For Medicaid applicants, MAGI-based income is calculated based on income received in the month of application. ()

02. Medicaid. Idaho's Medical Assistance Program administered by the Department and funded with federal and state funds according to Title XIX of the Social Security Act that provides medical care for eligible individuals. ()

03. Modified Adjusted Gross Income (MAGI). Modified Adjusted Gross Income (MAGI), is Adjusted Gross Income as defined by the IRS, plus certain tax-exempt income. ()

04. Newborn Deemed Eligible. A child born to a woman who is eligible for and receiving medical assistance on the date of the child's birth, including during a month of retroactive eligibility for the mother. A child so born is eligible for Medicaid for the first year of his life. ()

05. Non-Citizen. Same as "alien" defined in Section 101(a)(3) of the Immigration and Nationality Act (INA) (8 U.S.C. 1101 (a)(3)), and includes any individual who is not a citizen or national of the United States. ()

06. Parent. For a household with a MAGI-based eligibility determination a parent can be: ()

a. Natural; ()

b. Biological; ()

c. Adoptive; or ()

- d. Step-parent. ()
07. **Participant.** An individual who is eligible for, and enrolled in, a Health Care Assistance program. ()
08. **Pregnant Woman Coverage.** Medical assistance for a pregnant woman that is limited to pregnancy-related services for the period of the pregnancy and sixty (60) days after the pregnancy ends. ()
09. **Premium.** A regular, periodic charge or payment for health coverage. ()
10. **Qualified Hospital.** *A qualified hospital has a Memorandum of Understanding (MOU) with the Department,* participates as a provider under the Medicaid state plan, may assist individuals in completing and submitting applications for Health coverage, and has not been disqualified from doing presumptive eligibility determinations. ()
11. **Qualified Non-Citizen.** Same as “qualified alien” defined at 8 U.S. C.164(b) and (c). ()
12. **Reasonable Opportunity Period.** A period of time allowed for an individual to provide requested proof of citizenship or identity. A reasonable opportunity period extends for ninety (90) days beginning on the 5th day after the notice requesting the proof has been mailed to the applicant. This period may be extended if the Department determines that the individual is making a “good faith” effort to obtain necessary documentation. ()
13. **Sibling.** For household with MAGI-based eligibility determination: Is a natural or biological, adopted, half- or step-sibling. ()
14. **SSI.** Supplemental Security Income. ()
15. **SSN.** Social Security Number. ()
16. **State.** The state of Idaho. ()
17. **TAFI.** Temporary Assistance for Families in Idaho. ()
18. **TANF.** Temporary Assistance to Needy Families. ()
19. **Tax Dependent.** A person, who is a related child, or other qualifying relative or person, according to federal IRS standards for whom another individual can claim a deduction for a personal exemption when filing a federal income tax for a taxable year. ()
20. **Third Party.** Includes a person, institution, corporation, public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a medical assistance participant. ()
21. **Title XIX.** Title XIX of the Social Security Act, known as Medicaid, is a medical

benefits program jointly financed by the federal and state governments and administered by the States. This program pays for medical assistance for certain individuals and families with low income, and for some program types, limited resources. ()

22. Title XXI. Title XXI of the Social Security Act, known as the Children's Health Insurance Program (CHIP), is a federal and state partnership similar to Medicaid, that expands health insurance to targeted, low-income children. ()

23. Working Day. A calendar day when regular office hours are observed by the state of Idaho. Weekends and state holidays are not considered working days. ()

012. -- 099. (RESERVED)

APPLICATION REQUIREMENTS **(Sections 100 Through 199)**

100. PARTICIPANT RIGHTS.

The participant has rights protected by federal and state laws and Department rules. The Department must inform participants of the following rights during the application process and eligibility reviews. ()

01. Right to Apply. Any person has the right to apply for any Health Care Assistance program. Applications may be submitted by paper, electronically, fax, or telephonically. Application information must be in a form or format provided by the Department. ()

02. Right to Hearing. Any participant can request a hearing to contest a Department or Health Insurance Exchange or Marketplace decision under the provisions in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Ruling." ()

03. Right to Request Reinstatement of Benefits. Any participant has the right to request reinstatement of benefits until a hearing decision is made if the request for the reinstatement is made before the effective date of the action taken on the notice of decision. Reinstatement pending a hearing decision is not provided in the case of an application denied because an individual did not provide citizenship or identity documentation during a reasonable opportunity period allowed by the Department. ()

04. Civil Rights. Participants have civil rights under the U.S. and Idaho Constitutions, the Social Security Act, Title IV of the Civil Rights Act of 1964, the Rehabilitation Act of 1973 contained in Title 29 of the U.S. Code, and all other relevant parts of federal and state laws. ()

101. -- 109. (RESERVED)

110. APPLICATION FOR HEALTH CARE ASSISTANCE.

The application must be complete and signed by the participant or authorized representative. By signing the application, the participant or authorized representative agrees, under penalty of perjury, that statements made on the application are truthful. ()

111. SIGNATURES.

An individual who is applying for benefits, receiving benefits, or providing additional information as required by this chapter, may do so with the depiction of the individual's name either handwritten, electronic, or recorded telephonically. Such signature serves as intention to execute or adopt the sound, symbol, or process for the purpose of signing the related record.

()

112. -- 119. (RESERVED)

120. COLLATERAL SOURCES.

A participant's signature on the application is his consent for the Department to contact collateral sources for verification of eligibility requirements. Collateral sources include available electronic data sources to verify eligibility requirements which may include: Homeland Security, IRS, Social Security, State and Federal wage verification systems, child support services, or other electronic sources available to the Department.

()

121. -- 129. (RESERVED)

130. APPLICATION TIME LIMITS.

Each application must be processed as close to real time as practicable, but not longer than forty-five (45) days, from the date of application, unless prevented by events beyond the Department's control.

()

131. -- 139. (RESERVED)

140. ELIGIBILITY EFFECTIVE DATES.

Title XIX and Title XXI coverage begins the first day of the application month. Coverage for a newborn is effective the date of birth if the mother was covered by Medicaid for the child's birth.

()

141. -- 149. (RESERVED)

150. RETROACTIVE MEDICAL ASSISTANCE ELIGIBILITY.

Title XIX and Title XXI can begin up to three (3) calendar months before the application month if the participant is eligible during the prior period. Coverage is provided if services that can be paid by Medicaid were received in the prior period.

()

151. -- 199. (RESERVED)

NON-FINANCIAL REQUIREMENTS
(Sections 200 Through 299)

200. NON-FINANCIAL CRITERIA FOR DETERMINING ELIGIBILITY.

Non-financial criteria are conditions of eligibility, other than income, that must be met before Health Care Assistance can be authorized.

()

201. -- 209. (RESERVED)

210. RESIDENCY.

The participant must live in Idaho and have no immediate intention of leaving, including an individual who has entered the state to look for work, or who has no permanent, fixed address.

()

211. -- 219. (RESERVED)

220. U.S. CITIZENSHIP VERIFICATION.

01. Citizenship Verified. Citizenship must be verified through electronic means when available. If an electronic verification is not immediately obtainable, the Department may request documentation from the applicant. The Department will not deny the application for Health Coverage until the applicant has had a reasonable opportunity period to obtain and provide the necessary proof of U. S. citizenship.

()

02. Benefits During Reasonable Opportunity Period. Benefits are provided during the reasonable opportunity period that is provided to allow the applicant time to obtain and provide documentation to verify U.S. citizenship. No overpayment exists for the reasonable opportunity period if the applicant does not provide necessary documentation during the reasonable opportunity period so that the application results in denial.

()

221. U.S. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.

To be eligible, an individual must be a lawfully present member of one (1) of the following groups:

()

01. U.S. Citizen. A U.S. Citizen or a “national of the United States.”

()

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

()

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

()

b. The child is residing permanently in the U.S. in the legal and physical custody of a parent who is a U.S. Citizen;

()

c. The child is under eighteen (18) years of age;

()

d. The child is a lawful permanent resident; and

()

e. If the child is an adoptive child, the child was residing in the U.S. at the time the parent was naturalized and was in the legal and physical custody of the adoptive parent.

()

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

dependent child of the U.S. Armed Forces member. ()

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Is under the age of eighteen (18) years; or ()

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

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

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

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

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

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

15. Individuals not Meeting the Citizenship or Qualified Non-Citizen Requirements. An individual who does not meet the citizenship or qualified non-citizen requirements in Subsections 221.01 through 221.14 of this rule, may be eligible for emergency medical services if he meets all other conditions of eligibility. ()

222. U.S. CITIZENSHIP AND IDENTITY VERIFICATION REQUIREMENTS.

Any individual who participates in a Title XIX Medicaid or Title XXI CHIP funded program must provide proof of U.S. citizenship and identity unless he has otherwise met the requirements under Section 226 of these rules. ()

01. Electronic Verification. Electronic interfaces initiated by the Department with agencies that maintain citizenship and identity information are the primary sources of verification of U.S. Citizenship and Identity. ()

02. Documents. When verification is not available through an electronic interface, the individual must provide the Department with the most reliable document that is available. Documents can be: ()

a. Originals; ()

b. Photocopies; ()

c. Facsimiles; ()

d. Scanned; or ()

- e. Other type of copy of a document. ()

03. Accepted Documentation. Other forms of documentation are accepted to the same extent as an original document, unless information on the submitted document is: ()

- a. Inconsistent with other information available to the Department; or ()

b. The Department has good cause to question the validity of the document or the information on it. ()

04. Submission of Documents. The Department accepts documents that are submitted: ()

- a. In person; ()

- b. By mail or parcel service; ()

- c. Through an electronic submission; or ()

- d. Through a guardian or authorized representative. ()

223. DOCUMENTATION OF U.S. CITIZENSHIP.

01. Documents Accepted as Stand-Alone Proof of U.S. Citizenship and Identity. The following documents are accepted as proof of both U.S. citizenship and identity: ()

a. A U.S. passport or a U.S. passport card, without regard to expiration date as long as the passport or passport card was issued without limitation; ()

- b. A Certificate of Naturalization; ()

- c. A Certificate of U.S. Citizenship. ()

d. Documented evidence, issued by a federally recognized Indian tribe, including tribes with an international border that identifies: ()

- i. The federally recognized Indian Tribe issuing the document; ()

- ii. The individual by name; ()

- iii. Confirms the individual's membership; and ()

- iv. Enrollment or affiliation with the Tribe. ()

f. Verification of U.S. citizenship by a federal agency or another state on or after July 1, 2006, no further documentation of U.S. citizenship or identity is required. ()

02. Documents Accepted as Evidence of U.S. Citizenship. The following documents are accepted as proof of U.S. citizenship if documented proof in Subsection 223.01 of this rule is not available. These documents are not proof of identity and must be used in combination with a least one (1) document listed in Subsection 223.03 or Section 224 of these rules to establish both citizenship and identity. ()

a. A U.S. birth certificate that shows the individual was born in one (1) of the following: ()

i. United States' fifty (50) states; ()

ii. District of Columbia; ()

iii. Puerto Rico, on or after January 13, 1941; ()

iv. Guam; ()

v. U.S. Virgin Islands, on or after January 17, 1917; ()

vi. America Samoa; ()

vii. Swain's Island; ()

viii. Northern Mariana Islands, after November 4, 1986; or ()

b. A cross match with a state's vital statistics agency that documents birth records. ()

c. A certification of report of birth issued by the Department of State, Forms DS-1350 or FS-545; ()

d. A report of birth abroad of a U.S. Citizen, Form FS 240; ()

e. A U.S. Citizen I.D. card, DHS Form I-197; ()

f. A Northern Mariana Identification Card; ()

g. A final adoption decree showing the child's name and U.S. place of birth, or if the adoption is not final, a statement from the state-approved adoption agency that shows the child's name and U.S. place of birth; ()

h. Evidence of U.S. Civil Service employment before June 1, 1976; ()

i. An official U.S. Military record showing a U.S. place of birth; ()

j. Certification of birth abroad, Form FS-545; ()

k. Verification with the Department of Homeland Security's Systematic Alien

Verification for Entitlements (SAVE) database; ()

l. Evidence of meeting the automatic criteria for U.S. citizenship outlined in the Child Citizenship Act of 2000; ()

m. Medical records from a hospital, clinic, or doctor, admission papers from nursing facility, skilled care facility, or other institution that indicates a U.S. place of birth: ()

n. Life, health, or other insurance record that indicates a U.S. place of birth. ()

o. Officially recorded religious record that indicates a U.S. place of birth; ()

p. School records, including pre-school, Head Start, and daycare that shows the child's name and indicates a U.S. place of birth; ()

q. Federal or state census record that shows U.S. Citizenship or indicates a U.S. place of birth; or ()

r. When an applicant has none of the documents listed in Subsections 223.02.a. through q. of this rule, an affidavit signed by another individual under the penalty of perjury who can reasonably attest to the applicant's citizenship, and that contains the applicant's name, and indicates the date and U.S. place of birth, may be submitted. The affidavit does not need to be notarized. ()

03. Documents Accepted for Evidence of Identity. The following documents are accepted as proof of identity provided the document has a photograph or other identifying information that includes name, age, sex, race, height, weight, eye color, or address. ()

a. A driver's license issued by a state or territory. A driver's license issued by a Canadian government authority is not a valid indicator of identity in the U.S. and cannot be used as evidence of identity. ()

b. An identity card issued by federal, state, or local government; ()

c. School identification card; ()

d. U.S. Military card or draft record; ()

e. Military dependent's identification card; ()

f. U. S. Coast Guard Merchant Mariner card; or ()

g. A finding of identity from a federal or state governmental agency, when the agency has verified and certified the identity of the individual, including public assistance, law enforcement, internal revenue or tax bureau, or corrections agency; ()

h. A finding of identity from another state benefits agency or program provided that it obtained verification of identity as a criterion of participation; ()

i. Two (2) documents containing consistent information that corroborates the applicant's identity including: employer identification cards, high school or high school equivalency diplomas, college diplomas, marriage certificates, divorce decrees, property deeds or titles; ()

j. Identity affidavits are acceptable evidence of identity for individuals living in a residential care facility. ()

k. When an applicant has none of the specified findings or documents listed in Subsections 223.03.a. through j. of this rule, the applicant may submit an affidavit signed by another individual under the penalty of perjury who can reasonably attest to the applicant's identity. The affidavit must contain the applicant's name, and identifying information to establish identity. The affidavit does not need to be notarized. ()

224. IDENTITY RULES FOR CHILDREN.

The following additional sources of documentation of identity for children under nineteen (19) years of age may be used: ()

01. School Records. School records may be used to establish identity, including nursery or day care records. ()

02. Medical Records. Clinic, hospital, or doctor records may be used to establish identity. ()

225. ELIGIBILITY FOR APPLICANTS WHO DO NOT PROVIDE U.S. CITIZENSHIP AND IDENTITY DOCUMENTATION.

01. U.S. Citizenship and Identity not Verified. When the Department is unable to obtain verification of U.S. citizenship and identity through electronic means, or the applicant is unable to provide documentation at the time of application, the applicant will have a reasonable opportunity period of ninety (90) days to provide proof of U.S. citizenship and identity. ()

02. Notice Mailed. The reasonable opportunity period of ninety (90) days to provide needed documentation for proof of U.S. citizenship and identity begins five (5) days after the date the notice requesting the proof of documentation is mailed. ()

03. Medicaid Benefits. If the applicant meets all other eligibility requirements, Medicaid benefits will be approved pending verification of U.S. citizenship and identity. Medicaid benefits will be denied if the applicant refuses to obtain documentation. ()

226. INDIVIDUALS CONSIDERED AS MEETING THE U.S. CITIZENSHIP AND IDENTITY DOCUMENTATION REQUIREMENTS.

The individuals listed in Subsections 226.01 through 226.06 of this rule are considered to have met the U.S. citizenship and identity requirements and are not required to provide further documentation. ()

01. Supplemental Security Income (SSI) Recipients. ()

- 02. Social Security Disability Income (SSDI) Recipients.** ()
- 03. Individuals Entitled or Enrolled in Medicare by SSA.** Individuals determined by the SSA to be entitled or enrolled in any part of Medicare. ()
- 04. Adoptive or Foster Care Children Receiving Assistance.** Adoptive or foster care children receiving under Title IV-B or Title IV-E of the Social Security Act. ()
- 05. Individuals Deemed Eligible for Medicaid.** A waived newborn under Section 530 of these rules. ()
- 06. Individuals Whose Records Match Records of the SSA.** Confirmed records of SSA that match and include: ()
- a.** Name; ()
 - b.** Social Security Number; and ()
 - c.** Declaration of U.S. Citizenship. ()
- 227. ASSISTANCE IN OBTAINING DOCUMENTATION.**
The Department will provide assistance to individuals who need assistance in securing satisfactory documentary evidence of U.S. citizenship. ()
- 228. VERIFICATION OF CITIZENSHIP AND IDENTITY ONE TIME.**
Once an individual's U.S. citizenship and identity have been verified, whether through an electronic data match or by provided documentation, changes in eligibility will not require an individual to provide the verification again. If later verification, documentation, or information provides the Department with good cause to question the validity of the individual's U.S. citizenship or identity, the individual may be requested to provide further verification. ()
- 229. -- 239. (RESERVED)**
- 240. INDIVIDUALS WHO DO NOT MEET THE CITIZENSHIP OR QUALIFIED NON-CITIZEN REQUIREMENTS.**
- 01. Non-Citizen.** An individual who does not meet the citizen or qualified non-citizen requirements may be eligible for emergency medical services if he meets all other conditions of eligibility for a Title XIX or Title XXI program. ()
 - 02. Limited Eligibility.** Eligibility for emergency medical assistance under the Title XIX or Title XXI programs is limited to the dates of the emergency condition. ()
- 241. -- 249. (RESERVED)**
- 250. EMERGENCY MEDICAL CONDITION.**

An individual who meets eligibility criteria for a category of assistance but does not meet U.S. citizenship requirements or eligible non-citizen requirements may receive medical assistance under a Title XIX or Title XXI coverage group as follows: ()

01. Emergency Medical Conditions. An individual not meeting the U.S. citizenship requirement may receive medical services necessary to treat an emergency medical condition, including labor and delivery. Emergency medical conditions have acute symptoms of severity, including severe pain. ()

02. Determination of Emergency Medical Conditions. The Department determines if a condition meets criteria of an emergency medical condition. ()

03. Limitation on Medical Assistance. Medical assistance is limited to the period of time established for the emergency medical condition. ()

04. Documentation Waived. For undocumented individuals with emergency medical conditions, the Social Security Number (SSN) requirement is waived because an SSN cannot be issued. Individuals must be otherwise eligible for Title XIX or XXI. ()

251. SPONSOR DEEMING.

Income of a legal non-citizen's sponsor and the sponsor's spouse are counted in determining eligibility. ()

252. SPONSOR RESPONSIBILITY.

Section 213 of the Immigration and Naturalization Act requires that a sponsor signing Form I-864, Affidavit of Support, reimburse the Department for Health Care Assistance benefits paid for a sponsored, qualified non-citizen. ()

253. -- 269. (RESERVED)

270. SOCIAL SECURITY NUMBER (SSN) REQUIREMENT.

01. SSN Required. An applicant must provide his social security number (SSN), or proof he has applied for an SSN, to the Department before approval of eligibility. If the applicant has more than one (1) SSN, all numbers must be provided. ()

a. The SSN must be verified by the Social Security Administration (SSA) electronically. When an SSN is unverified, the applicant is not eligible for Health Care Assistance. ()

b. The Department must notify the applicant in writing if eligibility is being denied or lost for failure to meet the SSN requirement. ()

02. Application for SSN. The applicant must apply for an SSN, or a duplicate SSN when he cannot provide his SSN to the Department. If the SSN has been applied for, but not issued by the SSA, the Department can not deny, delay, or stop benefits. The Department will help an applicant with required documentation when the applicant applies for an SSN. ()

03. Failure to Apply for SSN. The applicant may be granted good cause for failure to apply for an SSN if they have a well-established religious objection to applying for an SSN. A well-established religious objection means the applicant: ()

- a.** Is a member of a recognized religious sect or division of the sect; and ()
- b.** Adheres to the tenets or teachings of the sect, or division of the sect, and for that reason is conscientiously opposed to applying for or using a national identification number.()

04. SSN Requirement Waived. An applicant may have the SSN requirement waived when he is: ()

- a.** Only eligible for emergency medical services as described in Section 250 of these rules; or ()
- b.** A newborn deemed eligible child as described in Section 530 of these rules.()

271. -- 279. (RESERVED)

280. GROUP HEALTH PLAN ENROLLMENT.

Title XIX and Title XXI participants must apply for and enroll in a cost-effective group health plan if one is available. A cost-effective health plan is one which has premiums and co-payments at a lower cost than Medicaid would pay for full medical services. Medicaid will pay premiums and other co-payments for plans the Department finds cost-effective. ()

281. -- 289. (RESERVED)

290. ASSIGNMENT OF RIGHTS TO MEDICAL SUPPORT AND THIRD PARTY LIABILITY.

By operation of Sections 56-203B and 56-209b(3), Idaho Code, medical support rights are assigned to the Department by signature on the application for assistance. The participant must cooperate to secure medical support from any liable third party. The cooperation requirement may be waived if the participant has good cause for not cooperating. ()

291. MEDICAL SUPPORT COOPERATION.

A Medicaid participant responsible for assigning their rights to medical support must cooperate to identify and locate the noncustodial parent, establish paternity, and establish, modify, and enforce a medical support order. ()

01. Cooperation Defined. Cooperation includes providing all information to identify and locate the non-custodial parent, and identifying other liable third party payers. The participant must provide the first and last name of the non-custodial parent. The participant must also provide at least two (2) of the following pieces of information about the non-custodial parent: ()

- a.** Birth date; ()
- b.** Social Security Number; ()

- c. Current address; ()
- d. Current phone number; ()
- e. Current employer; ()
- f. Make, model, and license number of any motor vehicle owned by the non-custodial parent; or ()
- g. Names, phone numbers, and addresses of the parents of the non-custodial parent. ()

02. Good Cause Defined. The participant may claim good cause for failure to cooperate in securing medical support for a minor child. Good cause is limited to the following reasons: ()

- a. There is proof the child was conceived as a result of incest or rape; ()
- b. There is proof the child’s non-custodial parent may inflict physical or emotional harm to the participant, the child, the custodial parent, or the caretaker relative; ()
- c. A credible explanation is provided showing the participant cannot provide the minimum information regarding the non-custodial parent; or ()
- d. A participant who has good cause for not cooperating as described in Subsection 291.03.b of this rule. ()

03. Conditions for Non-Denial of Medicaid. Medicaid cannot be denied for individuals who meet one (1) of the following conditions: ()

- a. A child or unmarried minor child who cannot legally assign his rights to medical support; or ()
- b. A pregnant woman whose income is at or below the federal poverty guideline, and who does not cooperate in establishing paternity and obtaining medical support from, or derived from, the father of the unborn child. ()

292. COOPERATION WITH HEALTHY CONNECTIONS PROGRAM.

Applicants must cooperate with Healthy Connections in establishing a primary care provider unless exempt under IDAPA 16.03.09, “Medicaid Basic Plan Benefits.” If a primary care provider is not chosen by the applicant, Healthy Connections will choose the primary care provider for the participant. ()

293. COST-SHARING REQUIREMENT.

Participants are required to pay a cost-sharing premium based on the level of the family’s income described in IDAPA 16.03.18, “Medicaid Cost-Sharing.” ()

294. -- 295. (RESERVED)

296. COOPERATION WITH THE QUALITY CONTROL PROCESS.

When the Department or federal government selects a case for review in the quality control process, the participant must cooperate in the review of the case. ()

297. -- 299. (RESERVED)

**FINANCIAL REQUIREMENTS
(Sections 300 Through 344)**

300. HOUSEHOLD COMPOSITION AND FINANCIAL RESPONSIBILITY.

Household composition and financial responsibility are divided into two categories: tax-filing and non-tax filing households. ()

01. Household Composition. The household composition includes: spouses, parents including stepparents, and all children including stepchildren and step siblings under age nineteen (19) who are living together, as members of the same household. ()

02. Financial Responsibility. ()

a. A tax-filing household is one whose individuals file taxes for themselves and their tax dependents. ()

b. A non-tax filing household is one whose individuals neither file a tax return nor are claimed as a tax dependent on someone else's tax return, also referred to as "non-filers." ()

301. TAX FILING HOUSEHOLD.

01. Taxpayers. For an individual filing a federal tax return for the taxable year in which an initial determination or redetermination of eligibility is made, and who is not claimed as a tax dependent by another taxpayer, the tax filing household consists of the taxpayer, *the taxpayer's spouse*, and the taxpayer's tax dependents. ()

02. Individuals Claimed as a Tax-Dependent. For an individual who is claimed as a tax dependent by another taxpayer, the tax filing household is the household of the taxpayer claiming such individual as a tax dependent, with the exception that tax dependents meeting any of the following criteria will be treated as non-filers described in Section 302 of these rules: ()

a. Individuals claimed as a tax dependent by an individual other than a spouse or custodial parent; ()

b. Individuals under age nineteen (19) living with both parents, if the parents are not married, or married filing separately; and ()

c. Individuals under age nineteen (19) claimed as a tax dependent by a parent residing outside of the applicant household. ()

03. Married Couples. *For* married couples living together, each spouse is included in the household *of the other spouse, regardless of* whether a joint federal tax return is filed, *if* one (1) spouse is claimed as a tax dependent by the other spouse, or *if* each filed separately. ()

302. NON-TAX FILING HOUSEHOLD.

01. Individuals Not Filing a Tax Return and Not Claimed as a Tax Dependent. *For an* individual who does not *expect to* file a federal tax return and is not claimed as a tax dependent by a tax *filer*, or meets one (1) of the exceptions in Subsections 301.02.a. through 301.02.c. *of these rules*, the household consists of the individual and, if living with the individual *the following*: ()

a. The individual's spouse; ()

b. The individual's natural, adopted, and stepchildren under age nineteen (19); or ()

c. *In the case of* individuals under age nineteen (19), the individual's natural, adopted, and step parents and natural, adoptive and step siblings under age nineteen (19). ()

02. Married Couples. Married couples living together will be included in the household of the other spouse. ()

303. FINANCIAL ELIGIBILITY.

To be eligible for a Health Care Assistance program, a participant must meet the income limits. Income limits are available on the U.S. Health and Human Services website at <http://aspe.hhs.gov/poverty>. ()

304. -- 344. (RESERVED)

INCOME (Sections 345 Through 394)

345. HOUSEHOLD INCOME.

The sum of calculated Modified Adjusted Gross Income (MAGI-based income) of every individual whose income must be included in the household budget minus a standard disregard in the amount of five percent (5%) of Federal Poverty Guidelines (FPG) by family size, if the disregard is used to establish eligibility. ()

346. DETERMINING INCOME ELIGIBILITY.

01. Financial Eligibility of Applicants. Financial eligibility for Medicaid applicants must be based on calculated monthly household income and household size. Eligibility for Health Care Assistance is determined by comparing the individual's calculated income against the

income limit. ()

02. Financial Eligibility of Participants. To project annual household income of participants at the time of a change or at redetermination of continuing eligibility, include: ()

a. Reasonably predictable future income; ()

b. A predicted decrease or increase in future income, or both, as may be established by: ()

i. A signed contract for employment; ()

ii. A clear history of fluctuating income; or ()

iii. Other clear indicators of future changes in income. ()

c. Future projected increase or decrease in income must be verified in the same manner as other income, including by self-attestation if reasonably compatible with electronic data obtained by the Department. Eligibility for Health Care assistance is determined by comparing the calculated income against the income limit. ()

347. EARNED INCOME.

01. Earned Income. Earned income is derived from labor or active participation in a business. Earned income includes taxable wages, tips, salary, commissions, bonuses, self-employment and any other type of income defined as earnings by the Internal Revenue Service (IRS). Earned income is counted as income when it is received, or would have been received except for the decision of the participant to postpone receipt. Earnings over a period of time and paid at one (1) time, such as the sale of farm crops, livestock, or poultry are annualized and IRS allowable self-employment expenses deducted. ()

02. Determination of Income. The Department determines income eligibility based on *calculated* income in the month of application. ()

348. DEPENDENT CHILD'S EARNED INCOME.

A dependent child's earned income is excluded, unless the child is required to file a tax return based on his own income. ()

349. INCOME PAID UNDER CONTRACT.

The earned income of an employee paid on a contractual basis is prorated over the period of the contract by using the method described in Section 347 of these rules. ()

350. IN-KIND INCOME.

An individual who receives a service, benefit, or durable goods instead of wages is earning in-kind income. In-kind income is excluded. ()

351. SELF-EMPLOYMENT EARNED INCOME.

Income from self-employment is treated as earned income. Calculated self-employment income is

the taxable self-employment income after gross receipts and the IRS allowable costs of producing the self-employment income, when the self-employment is expected to continue as provided in Title 26, U.S.C. ()

01. Allowable Costs of Producing the Self-Employment Income. For a non-farming enterprise, the allowable costs of producing the self-employment income are limited to those costs allowed by the IRS for federal tax purpose found on the IRS website at <http://www.irs.gov>. ()

02. Allowable Costs of Producing Farming Self-Employment Income. Allowable costs of producing farming self-employment income are limited to those costs allowed by the IRS for federal tax purposes found on the IRS website at <http://www.irs.gov>. ()

352. -- 369. (RESERVED)

370. UNEARNED INCOME.

Unearned income is any income the individual receives that is not gained through employment. Unearned income includes payments from pensions, non-business rental of real property, retirement, survivors, disability insurance (RSDI), unemployment compensation, spousal support payments, and capital investment returns, such as dividends and interest. ()

371. SUPPORT INCOME.

Support income is any payment made from a former spouse to the individual. ()

01. Child Support Payment. A received child support payment is excluded income. ()

02. Spousal Support Payment. A received spousal support payment is unearned income to the individual who receives it. ()

372. -- 373. (RESERVED)

374. INTEREST AND DIVIDEND INCOME.

Taxable interest or dividends are unearned income. ()

01. Interest Income. Interest posted to any financial institution account on a monthly, quarterly, or any other regular basis is unearned income in the month received. Interest is counted in the month received or in the total income considered for the tax year. ()

02. Dividend Income. Dividends are unearned income in the month received. ()

03. Tax-Exempt Interest. Tax-exempt interest is not counted as income. ()

375. RETIREMENT, SURVIVORS, AND DISABILITY INSURANCE (RSDI) INCOME OR RAILROAD RETIREMENT BOARD BENEFITS.

The amount of the entitlement to retirement, survivors, and disability insurance (RSDI) or railroad retirement board benefits is counted as unearned income, unless an overpayment is being withheld. If an overpayment is being withheld, the net amount is unearned income. ()

376. -- 377. (RESERVED)

378. DISABILITY INSURANCE PAYMENTS.

Taxable disability payments, paid to an individual through an insurance company, are unearned income in the month received. ()

379. INCOME FROM ROOMER OR BOARDER.

Taxable income from a commercial boarding house is earned income. Income from other room and board situations is unearned income. ()

380. RETIREMENT ACCOUNTS, PENSIONS, AND ANNUITY DISTRIBUTIONS.

Distributions received from an individual retirement account that is reported as income on the most recent year's tax return is included in gross income for the year when determining calculated income for Medicaid. Interest from a retirement account that is withdrawn in one (1) lump sum is unearned income in the month received. ()

381. INCOME FROM SALE OF REAL PROPERTY.

Monthly payments, minus prorated taxes and insurance costs, received by a participant for the sale of real property are unearned income. ()

382. EDUCATIONAL INCOME.

Any student financial assistance provided under Title IV of the Higher Education Act, the Bureau of Indian Affairs education program, Veteran's Administration educational benefits, grants, loans, scholarships, or work study is excluded. ()

383. (RESERVED)

384. LUMP SUM INCOME.

A non-recurring lump sum payment is income in the month the lump sum is received. Lump sum income is a retroactive monthly benefit or a windfall payment. The lump sum may be earned or unearned income that is paid in a single sum. Lump sum income includes retirement, survivors, and disability insurance (RSDI), severance pay, disability insurance, and lottery winnings. ()

01. Lump Sum Received in Initial Month of Eligibility. Lump sum income received in the application month is counted as income for that month. ()

02. Lump Sum Received in Any Other Month of Eligibility. If a lump sum income is anticipated, the lump sum is counted as income in the month the income is expected. ()

03. Prior-Year Tax Refund. Any portion of a prior-year tax refund, which is considered as income on the most recent year's tax return, is included in the gross calculated income for the year when determining calculated annual income for Medicaid. ()

385. INCOME EXCLUDED BY FEDERAL LAW.

Income excluded by federal law is not counted in determining income available to the participant. ()

386. -- 387. (RESERVED)

388. DEPENDENT CHILD'S UNEARNED INCOME.

A child's unearned income is countable towards his household's eligibility, only when the child must file a tax return based on his own income. ()

389. -- 394. (RESERVED)

**DISREGARDS
(Section 395 Through 399)**

395. INCOME DISREGARDS.

A standard disregard in the amount of five percent (5%) of Federal Poverty Guidelines (FPG) by family size is applied to the calculated income of an individual in those situations where the application of the disregard is necessary in order for the individual to be eligible for the highest income limit Health Care coverage for which they may be eligible. ()

396. -- 399. (RESERVED)

**HEALTH COVERAGE FOR ADULTS
(Sections 400 Through 499)**

400. PARENTS AND CARETAKER RELATIVES *ELIGIBLE FOR MEDICAID COVERAGE.*

In order for an adult in a household budget unit to be eligible for Medicaid coverage, the adult must meet the requirements in Subsections 400.01 through 400.06 of this rule. ()

01. *Parent, Caretaker Relative, or a Pregnant Woman.* *The adult must be a parent, caretaker relative, or a pregnant woman in the household budget unit. ()*

02. *Responsible for Eligible Dependent Child.* *The adult must be responsible for an eligible dependent child, which includes the unborn child of a pregnant woman. ()*

03. *Live in Same Household.* *The adult must live in the same household with the eligible dependent child. ()*

04. *MAGI Income Eligibility.* *The adult must meet all income requirements of the Medicaid program for eligibility determined according to MAGI methodologies identified in Sections 300 through 303, and 411 of these rules. Eligibility is based on: ()*

a. *The number of members included in the household budget unit; and ()*

b. *All countable income for the household budget unit. ()*

05. *Member of More Than One Budget Unit.* *No person may receive benefits in more than one (1) budget unit during the same month. ()*

06. More Than One Medicaid Budget Unit in Home. If there is more than one (1) Medicaid budget unit in a home, each budget unit is considered a separate unit. ()

401. FINANCIALLY ELIGIBLE CHILD.

01. Household Income. The household's calculated income does not exceed the threshold established and available on the U.S. Health and Human Services website at <http://aspe.hhs.gov/poverty>. ()

02. SSI Income. The child receives SSI income. ()

402. PERSONS EXEMPT FROM MAGI-BASED ELIGIBILITY DETERMINATION.

01. SSI Recipient. Persons who receive SSI benefits. ()

02. AABD State Supplemented Recipient. Persons who receive AABD cash benefits. ()

03. Ineligible Non-Citizen. Persons who are ineligible non-citizens. ()

04. Title IV-E Foster Child. A child who receives foster care payments from the Department. ()

05. Adoption Assistance. A child who receives adoption assistance payments from any federal, state, or local agency providing adoption assistance payments. ()

06. AABD. An individual who receives Medicaid based on disability, blindness, age (65 or older), or the need for long-term care service. ()

403. -- 409. (RESERVED)

410. DETERMINING MEDICAID ELIGIBILITY.

Calculated income for each individual is compared to the income payment standard. When income exceeds the standards, the individual is ineligible. Income standards are available on the U.S. Health and Human Services website at <http://aspe.hhs.gov/poverty>. ()

411. INCOME LIMITS FOR PARENTS AND CARETAKER RELATIVES.

The income limits are based on the number of household budget unit members. Parents and caretaker relatives, whose MAGI-based income does not exceed the guidelines listed in the table below for their household size, meet the income limit for parent and caretaker relative Medicaid.

TABLE 411 INCOME LIMITS	
Number of Household Members	Income Limit
1	\$233
2	\$289

TABLE 411 INCOME LIMITS	
Number of Household Members	Income Limit
3	\$365
4	\$439
5	\$515
6	\$590
7	\$666
8	\$741
9	\$816
10	\$982
Over 10 Persons	Add \$75 Each

()

412. -- 419. (RESERVED)

420. EXTENDED MEDICAID FOR SPOUSAL SUPPORT INCREASE.

Participants are eligible for four (4) calendar months of Extended Medicaid if an increase in the participant's spousal support causes them to exceed the income limit for their household budget unit size. The participant must have received Medicaid in Idaho in at least three (3) of the six (6) months before the month the participant became income ineligible. ()

421. -- 499. (RESERVED)

**PREGNANCY-RELATED HEALTH COVERAGE
(Sections 500 Through 519)**

500. PREGNANT WOMAN COVERAGE.

A pregnant woman of any age is eligible for the Pregnant Woman coverage if she meets all of the non-financial and financial criteria of the coverage group. Health care assistance for Pregnant Woman coverage is limited to pregnancy-related and postpartum services. The Pregnant Woman medical assistance coverage extends through the sixty (60) day postpartum period if she applied for medical assistance while pregnant and was receiving medical assistance when the child was born. An individual who applies for Pregnant Woman medical assistance after the child is born is not eligible for the sixty-day (60) postpartum period. ()

01. Income Limit. The individual's calculated income must not exceed one hundred thirty-three percent (133%) of the Federal Poverty Guidelines (FPG) for her family size in the application month. ()

02. Household Size. *The household budget unit consists of the pregnant woman, the unborn child or children if expecting more than one (1) child, and any individual determined to be part of the household budget unit based on MAGI methodologies as identified in Sections 300*

through 303, and 411 of these rules. ()

03. Income Disregards. A standard disregard in the amount of five percent (5%) of Federal Poverty Guidelines (FPG) for family size is applied to the MAGI income of the pregnant woman if the disregard is necessary to establish income eligibility. ()

04. Continuing Eligibility. The pregnant woman remains eligible during the pregnancy regardless of changes in income. The woman must report the end of pregnancy to the Department within ten (10) days. ()

501. PREGNANT WOMAN INELIGIBLE BECAUSE OF EXCESS INCOME.

A pregnant woman who receives health care assistance and becomes ineligible because of an increase in income will continue to receive coverage through the end of the month in which the sixtieth day *of her postpartum period* falls. ()

502. PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN.

Presumptively eligible (PE) pregnant woman coverage is designed to provide some prenatal care during the time between the pregnancy diagnosis and the eligibility determination. ()

01. Pregnancy Diagnosis and Eligibility Determination. A pregnant woman can get limited ambulatory prenatal care as a presumptively eligible (PE) pregnant woman through the end of the month after the month the provider completes the PE determination. ()

02. Qualified Provider Completes Eligibility Determination. A qualified PE provider accepts written requests for these services and completes the eligibility determination. ()

03. Formal Application. The qualified PE provider must inform the participant how to complete the formal application process. ()

04. Notification of Eligibility Determination Results. Qualified PE providers are required to send the result of the PE decision and the completed application for the Pregnant Woman coverage to the Department within two (2) working days of the PE determination. ()

05. Presumptive Eligibility Decisions. Notice and hearing rights of the Title XIX Medicaid program do not apply to the PE decisions. An individual is eligible for only one (1) period of PE coverage during each pregnancy. ()

503. -- 519. (RESERVED)

**HEALTH COVERAGE FOR CHILDREN
(Sections 520 Through 529)**

520. FINANCIAL ELIGIBILITY.

Children are eligible for Health Care Assistance when the household's total MAGI-Based income minus a standard disregard in the amount of five percent (5%) of Federal Poverty Guidelines (FPG) by family size is less than or equal to the applicable income limit for the age of the child.

()

01. Title XIX Income Limit. For children age zero (0) to six (6), Title XIX income limit is one hundred forty-*two* percent (14*2*%) of the FPG for the household size. For children age six (6) through age eighteen (18) the income limit is one hundred thirty three percent (133%) of the FPG for the household size. ()

02. Title XXI Income Limit. For children age zero to six (0-6), Title XXI income limit is between one hundred forty-*two* percent (14*2*%) and one hundred eighty-five percent (185%) of the FPG for the household size. For children ages six (6) through eighteen (18) the income limit is between one hundred thirty-three percent (133%) and one hundred eighty five percent (185%) of the FPG for the household size. ()

03. Disregard Applied. A standard disregard in the amount of five percent (5%) of Federal Poverty Guidelines (FPG) by family size is applied to the calculated income used to establish the child's eligibility when applying the disregard is necessary for the child to be financially eligible. ()

521. HOUSEHOLD SIZE AND FINANCIAL RESPONSIBILITY.

Household size and financial responsibility for health coverage for children is determined using the methodology described in Section 300 of these rules. ()

522. (RESERVED)

523. ACCESS TO OR COVERAGE UNDER OTHER HEALTH PLANS.

A child is ineligible for coverage under the CHIP plan if they have access to or are enrolled in other health coverage plans as described below: ()

01. Covered by Creditable Health Insurance. The child is covered by creditable health insurance at the time of application. ()

02. Eligible for Title XIX. The child is eligible under Idaho's Title XIX State Plan. ()

03. Idaho State Employee Benefit Plan. The child is eligible to receive health insurance benefits under Idaho's State employee benefit plan. ()

524. CONTINUOUS HEALTH CARE ASSISTANCE ELIGIBILITY FOR CHILDREN UNDER AGE NINETEEN.

Children under age nineteen (19), who are found eligible for health coverage in an initial determination or at renewal, remain eligible for a period of twelve (12) months. The twelve (12) month continuous eligibility period does not apply if, for any reason, eligibility was determined incorrectly. ()

01. Reasons Continuous Eligibility Ends. Continuous eligibility for children *ends* for one (1) of the following reasons: ()

a. The child is no longer an Idaho resident; ()

- b.** The child dies; ()
- c.** The participant requests closure; or ()
- d.** The child turns nineteen (19) years of age as defined in Subsection 010.05 of these rules. ()

02. Children Not Eligible for Continuous Eligibility. Children are not eligible for continuous eligibility for one (1) of the following reasons: ()

- a.** A child is approved for emergency medical services; or ()
- b.** A child is approved for pregnancy-related services. ()

525. FORMER FOSTER CHILD.

An individual who is between the age of eighteen (18) and twenty-six (26), who was in foster care in Idaho and became ineligible for Medicaid as a foster child due to age, may receive Medicaid coverage until his twenty-sixth birthday. There are no financial eligibility criteria. The only non-financial criteria are the receipt of foster care services and age. ()

526. -- 529. (RESERVED)

SPECIAL CIRCUMSTANCES FOR CHILDREN
(Sections 530 Through 549)

530. NEWBORN CHILD DEEMED ELIGIBLE FOR MEDICAID.

A child is deemed eligible for Medicaid for his first year of life when the following exists. ()

01. Mother Filing an Application. The child is born to a mother who files an application for medical assistance. ()

02. Mother Is Eligible for Medicaid. The mother is eligible for Medicaid in the newborn's birth month, including a month of retroactive coverage. This includes a mother who qualifies for coverage only for the delivery because of her alien status. ()

531. MINOR PARENT LIVING WITH PARENTS.

A minor parent is a child under the age of eighteen (18) who is pregnant or has a child. Minor parents who live with their parents may be eligible for Health Care Assistance for themselves and their children. The minor parent's eligibility is determined according to the Section 300 of these rules related to tax filing households. ()

532. RESIDENT OF AN ELIGIBLE INSTITUTION.

A resident of an eligible institution must meet all nonfinancial and financial criteria of Title XIX or Title XXI. Eligible institutions are medical institutions, intermediate care facilities, child care institutions for foster care, or publicly-operated community residences serving no more than sixteen (16) residents. ()

533. CHILDREN WITH SPECIAL CIRCUMSTANCES AND MEDICAID.

Children who receive foster care or are in adoptive placements are eligible for Medicaid. The children must meet nonfinancial criteria and must meet the financial requirements described for the children's coverage group. ()

534. ADOLESCENT RESIDENT OF IDAHO STATE HOSPITAL SOUTH.

A child, residing in Idaho State Hospital South, may be eligible for Health Care Assistance if the child is: ()

01. Age. The child must be under the age twenty-one (21). ()

02. Calculated Income. The child's calculated income is: ()

a. Two hundred thirty-three dollars (\$233) or less; and ()

b. If necessary, a standard disregard of five percent (5%) of Federal Poverty Guidelines (FPG) by family size is applied to the child's calculated income in order for the child to be eligible for coverage. ()

535. TITLE IV-E FOSTER CARE CHILD.

A child may be eligible for Health Care Assistance as a Title IV-E foster care child if the following conditions are met. ()

01. Court Order or Voluntary Placement. The child must have been living in a parent's or relative's home during the month a court order removes the child or during the month a parent or relative voluntarily signs a written agreement with the Department for foster care. ()

02. Custody and Placement. The child's placement and care are the Department's responsibility and the child is living in a licensed foster home, licensed institution, licensed group home, detention center, or in a relative's home approved for the child by the Department. ()

03. IV-E Foster Care and SSI Eligibility. When a child is eligible for both IV-E-Foster Care and SSI, the caretaker relative or social worker must choose the Medicaid coverage group for the child. ()

536. TITLE XIX FOSTER CHILD.

A child living in a foster home, children's agency, or children's institution who does not meet the conditions of Title IV-E Foster Care may be Medicaid eligible if the following conditions are met: ()

01. Age. The foster child is under age twenty-one (21). ()

02. Department Responsibility. The Department assumes full or partial financial responsibility for the child. ()

03. Calculated Income. The child's calculated income is: ()

a. Two hundred thirty-three dollars (\$233) or less; and ()

b. If necessary, a standard disregard of five percent (5%) of Federal Poverty Guidelines (FPG) by family size is applied to the child's calculated income in order for the child to be eligible for coverage. ()

537. STATE SUBSIDIZED ADOPTION ASSISTANCE CHILD.

A child in a state subsidized adoptive placement may be Medicaid eligible when the following conditions are met. ()

01. **Age.** The child is under age twenty-one (21). ()

02. **Adoption Assistance.** An adoption assistance agreement, other than under Title IV-E between the state and the adoptive parents, is in effect. ()

03. **Special Needs.** The child has special needs for medical or rehabilitative care that prevent adoptive placement without Medicaid. ()

04. **Medicaid.** The child received Medicaid in Idaho prior to the adoption agreement. ()

538. CHILD IN FEDERALLY-SUBSIDIZED ADOPTION ASSISTANCE.

A child in a federally-subsidized adoptive placement under Title IV-E foster care is eligible for Medicaid. No additional conditions must be met. ()

539. THE ADOPTIONS AND SAFE FAMILIES ACT.

The Adoptions and Safe Families Act of 1997 provides health insurance coverage for any child with special needs when they meet the following conditions. ()

01. **Adoption Assistance Agreement.** The child has an adoption assistance agreement. ()

02. **Special Needs.** The state has determined that due to the child's special needs for medical, mental health, or rehabilitative care, the child cannot be placed with adoptive parents without medical assistance. ()

540. -- 544. (RESERVED)

545. PRESUMPTIVE ELIGIBILITY FOR CHILDREN AND PARENTS.

Presumptive eligibility determination for qualifying medical coverage groups can only be provided by a qualified hospital defined in Section 011 or these rules. ()

*01. **Presumptive Eligibility Decisions.** Decisions of presumptive eligibility can only be made for children up to age nineteen (19), parents with eligible children in their household, caretaker relatives, or pregnant women, who meet program requirements for MAGI-based Medicaid coverage for families and children. ()*

02. Presumptive Eligibility Determination. *Presumptive eligibility determinations are made by a qualified hospital when an individual receiving medical services is not covered by health care insurance and the financial assessment by hospital staff indicates the individual is eligible for Medicaid Coverage in Idaho. This determination is made by hospital staff through an online presumptive application process:* ()

a. *Prior to completion of a full Medicaid application; and* ()

b. *Prior to a determination being made by the Department on the full application.* ()

03. Presumptive Eligibility Period. *The presumptive eligibility period begins on the date the presumptive application is filed online and ends with the earlier of the following:* ()

a. *The date the full eligibility determination is completed by the Department; or* ()

b. *The end of the current month the qualified hospital completed the presumptive eligibility determination.* ()

546. QUALIFIED HOSPITAL PRESUMPTIVE ELIGIBILITY PROCESSES.

A qualified hospital must have a Memorandum of Understanding (MOU) with the Department and follow all standards and processes agreed to in the MOU. ()

01. Acceptance of Application. *The qualified hospital accepts the request for services in the same manner as all applications for assistance are accepted.* ()

02. Standards and Processes. *The presumptive eligibility determination must be based on standards and processes provided by the Department.* ()

03. Assistance to Applicant. *The qualified hospital must assist the applicant in completing the Department's application process.* ()

04. Qualified Hospital Staff. *Only qualified hospital staff who are trained in presumptive eligibility standards can make a presumptive eligibility determination.* ()

05. Notice to Applicant. *The qualified hospital or the Department will provide notice to the applicant within two business days on the presumptive eligibility determination.* ()

06. Notice and Hearing Rights. *Presumptive eligibility decisions are not appealable and do not have hearing rights under the Title XIX Medicaid program.* ()

07. Number of Presumptive Eligibility Periods Allowed. *Only one (1) presumptive eligibility period is allowed per applicant in any twelve (12) month period.* ()

547. -- 549. (RESERVED)

MEDICAID DIRECT COVERAGE PLANS
(Sections 550 Through 559)

550. MEDICAID DIRECT COVERAGE GROUPS.

Based on the assessment of the participant's health care needs they are enrolled in one (1) of the following plans: ()

01. Medicaid Basic Plan. The Medicaid Basic Plan is similar to private health insurance plans. The services in this plan are described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." ()

02. Medicaid Enhanced Plan. The Medicaid Enhanced Plan includes all of the benefits found in the Basic Plan, plus additional benefits to cover needs of people with disabilities or special health needs. The services in this plan are described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ()

03. Medicare/Medicaid Coordinated Plan Benefits. The Medicare/Medicaid Coordinated Plan includes the Medicaid benefit plan option that coordinates and integrates health plan benefits for individuals who are eligible for and enrolled in both Medicare and Medicaid. ()

551. HEALTH ASSESSMENT.

A health assessment is required when a participant moves to the enhanced plan. Children who are receiving services from the Department, in foster care, receiving SSI, infant toddler program and children receiving developmentally delayed services, are eligible for the enhanced plan without the need for the health assessment. ()

552. -- 599. (RESERVED)

CASE MAINTENANCE REQUIREMENTS
(Sections 600 Through 701)

600. ANNUAL ELIGIBILITY RENEWAL.

Participants must have an annual eligibility review of all eligibility factors. Exceptions to the annual eligibility renewal are listed in Section 601 of these rules. ()

01. Continuing Eligibility. Continuing eligibility is determined using available electronic verification sources without participant contact, unless: ()

a. Information is not available; ()

b. Information sources provide conflicting information; or ()

c. Information is inconsistent with information provided by the participant. ()

02. Inconsistency Impacts Eligibility. When inconsistency exists from electronic verification sources that impact participant eligibility, information must be verified by the

participant. The Department provides the participant a document that displays household information currently being used to establish eligibility and asks the participant to verify correctness, and if not correct to provide updated information. ()

601. EXCEPTIONS TO ANNUAL RENEWAL.

A participant who receives Title XIX or Title XXI through time-limited coverage does not require an annual renewal when the following exists. ()

01. Extended Medicaid. A participant who receives extended Medicaid is eligible as provided in Section 420 of these rules. ()

02. Pregnant Woman. A participant who receives Medicaid as a Low Income Pregnant Woman is eligible as provided in Section 500 of these rules. ()

03. Newborn Child of Medicaid-Eligible Mother. A participant receiving Medicaid as the newborn child of a Medicaid-eligible mother is eligible as provided in Section 530 of these rules. ()

602. -- 609. (RESERVED)

610. REPORTING REQUIREMENTS.

Changes in family circumstances must be reported to the Department by the tenth of the month following the month in which the change occurred. Report of changes may be made verbally, in writing, through personal contact, telephone, fax, electronic mail, or mail. ()

611. TYPES OF CHANGES THAT MUST BE REPORTED.

Changes in circumstances the participant must report are the following: ()

01. Name or Address. A name change for any participant must be reported. A change of address or location must be reported. ()

02. Household Composition. Changes in family composition must be reported if a parent or relative caretaker receives Medicaid. ()

03. Marital Status. Marriages or divorces of any family member must be reported if a parent or relative caretaker receives Medicaid. ()

04. New Social Security Number. A Social Security Number (SSN) that is newly assigned to a Medicaid Health Care Assistance program participant must be reported. ()

05. Health Insurance Coverage. Enrollment or disenrollment of a participant in a health insurance plan must be reported. ()

06. End of Pregnancy. Pregnant participants must report when pregnancy ends.()

07. Earned Income. Changes in the amount or source of earned income must be reported if a parent or relative caretaker receives Title XIX benefits. ()

08. Unearned Income. Changes in the amount or source of unearned income must be reported if a parent or relative caretaker receives Title XIX benefits. ()

09. Support Income. Changes in the amount of spousal support received by an adult household member. ()

10. Disability. A family member who becomes disabled or is no longer disabled must be reported if a parent or relative caretaker receives Title XIX benefits. ()

612. -- 619. (RESERVED)

620. NOTICE OF CHANGES IN ELIGIBILITY.

The Department will notify the participant of changes in his Health Care Assistance. The notice must give the effective date, the reason for the action, the rule that supports the action, and appeal rights. ()

621. NOTICE OF CHANGE OF PLAN.

The Department is allowed to switch a participant from the Medicaid Basic Plan to the Medicaid Enhanced plan within the same month. Advance notice must be given to the participant when there is a decrease in their benefits and he will be switched from the enhanced plan to the basic plan. ()

622. ADVANCE NOTICE RESPONSIBILITY.

The Department must notify the participant at least ten (10) calendar days before the effective date of when a reported change results in Health Care Assistance closure. The effective date must allow for a five (5) day mailing period for any notice. ()

623. ADVANCE NOTICE NOT REQUIRED.

Advance notice is not required when a condition listed in Subsections 623.01 through 623.08 of this rule exists. The participant must be notified no later than the date of the action. ()

01. Death of Participant. The Department has proof of the participant's death. ()

02. Participant Request. The participant requests closure in writing. ()

03. Participant in Institution. The participant is admitted or committed to an institution. Further payments to the participant do not qualify for federal financial participation under the state plan. ()

04. Nursing Care. The participant is placed in a nursing facility or Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID). ()

05. Participant Address Unknown. The participant's whereabouts are unknown. ()

06. Medical Assistance in Another State. A participant is approved for medical assistance in another state. ()

07. Eligible One Month. The participant is eligible for aid only during the calendar month of his application for aid. ()

08. Retroactive Medicaid. The participant's Title XIX or Title XXI eligibility is for a prior period. ()

624. -- 699. (RESERVED)

700. OVERPAYMENTS.

Health Care Assistance overpayments occur when a participant receives benefits during a month he *was* not eligible. ()

701. RECOVERY OF OVERPAYMENTS.

All Health Care Assistance overpayments are subject to recovery. Overpayments are recovered by direct payment from the participant. ()

01. Notice of Overpayment. The participant must be informed of the Health Care Assistance overpayment and appeal rights. ()

02. Notice of Recovery. The participant must be informed when his Health Care Assistance overpayment is fully recovered. ()

702. -- 999. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.04 - RULES GOVERNING THE FOOD STAMP PROGRAM IN IDAHO
DOCKET NO. 16-0304-1301
NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice, the pending rule will become final and effective on July 1, 2014, after review by the legislature, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-203, Idaho Code; also 7 CFR, Part 273.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

These rule changes were adopted to:

1. Revise rules to exempt federal income tax refunds from resource limits for up to twelve (12) months from the time of receipt as a liquid resource.
2. Allow a standard medical expense deduction for qualifying individuals who can show they have greater than \$35 in allowable medical expenses. This change will streamline the application and recertification process for individuals, especially for vulnerable populations. The change also will result in fewer calculation errors when determining food stamp benefits.
3. Revise rules to conform to federal regulations for changes on which the Department must act. This rule change will allow the Department flexibility to select options allowed under federal regulation when calculating expense changes used for food stamp benefits.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 2, 2013, Idaho Administrative Bulletin, [Vol. 13-10, pages 178 through 185](#).

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

There is no anticipated fiscal impact to the state general fund or any other funds related to this rulemaking. NOTE: The USDA Food and Nutrition Services require that the Department demonstrate cost neutrality prior to implementing the change regarding the medical expense

deduction.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Kristin Matthews at (208) 334-5553.

DATED this 19th day of November, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036

phone: (208) 334-5500; fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

**THE FOLLOWING NOTICE WAS PUBLISHED WITH
THE TEMPORARY AND PROPOSED RULE**

EFFECTIVE DATE: The effective date of the temporary rule is **November 1, 2013**.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Section 56-203, Idaho Code; also 7 CFR, Part 273.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 16, 2013.

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

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

The proposed changes will:

1. Revise rules to exempt federal income tax refunds from resource limits for up to twelve (12) months from the time of receipt as a liquid resource.
2. Allow a standard medical expense deduction for qualifying individuals who can show they have greater than \$35 in allowable medical expenses. This change will streamline the

application and recertification process for individuals, especially for vulnerable populations. The change also will result in fewer calculation errors when determining food stamp benefits.

3. Revise rules to conform to federal regulations for changes on which the Department must act. This rule change will allow the Department flexibility to select options allowed under federal regulation when calculating expense changes used for food stamp benefits.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(b) and (c), Idaho Code, the Governor has found that temporary adoption of the rule is necessary in order to comply with deadlines in amendments to 7 CFR, Part 273. Also, these rule changes confer a benefit by simplifying eligibility requirements for participants.

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: NA

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: There is no anticipated fiscal impact to the state general fund or any other funds related to this rulemaking.

NOTE: The USDA Food and Nutrition Services require that the Department demonstrate cost neutrality prior to implementing the change regarding the medical expense deduction.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because it was not feasible due to the fact that this rulemaking is temporary and is being done to bring this chapter into compliance with federal regulations.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Kristin Matthews at (208) 334-5553.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 23, 2013.

DATED this 29th day of August, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0304-1301

221. DETERMINATION OF HOUSEHOLD COMPOSITION.

Household composition must be determined at application, a ~~six-month or~~ twelve-month contact, recertification, and when **acting on** a reported change in household members ~~would result in an increase in the food stamp benefits~~ *(3-29-12)()*

(BREAK IN CONTINUITY OF SECTIONS)

382. RESOURCES EXCLUDED BY FEDERAL LAW.

Resources listed in Section 382 are excluded by Federal law: (3-15-02)

01. P.L. 91-646. Reimbursements under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policy Act of 1970. (6-1-94)

02. P.L. 92-203. The Alaska Native Claims Settlement Act. (6-1-94)

03. P.L. 93-134 as Amended by P.L. 103-66. Effective January 1, 1994, interest of individual Indians in trust or restricted lands. (6-1-94)

04. P.L. 93-288 as Amended by P.L. 100-707. Payments from Disaster Relief and Emergency Assistance. (6-1-94)

05. P.L. 93-531. Relocation assistance to Navajo and Hopi tribal members. (6-1-94)

06. P.L. 94-114. The submarginal lands held in trust by the U.S. for certain Indian tribal members. (6-1-94)

07. P.L. 94-189. The Sac and Fox Indian Claims Agreement. (6-1-94)

08. P.L. 94-540. Funds to the Grand River Band of Ottawa Indians. (6-1-94)

09. P.L. 95-433. The Confederated Tribes and Bands of the Yakima Indian Nation and the Apache Tribe of the Mescalero Reservation from the Indian Claims Commission. (6-1-94)

10. P.L. 96-420. The Passamaquoddy Tribe and Penobscot Nation funds paid under the Maine Indian Claims Settlement Act of 1980. (6-1-94)

11. P.L. 97-403. Payments to the Turtle Mountain Band of Chippewas, Arizona. (6-1-94)

12. P.L. 97-408. Payments to the Blackfeet, Gros Ventre and Asiniboine Tribes, Montana and the Papago Tribe, Arizona. (6-1-94)

13. P.L. 98-64 and P.L. 97-365. Up to two thousand dollars (\$2,000) of any per capita

payment, and any purchases made with such payment, from funds held in trust by the Secretary of the Interior. (6-1-94)

14. P.L. 98-123. Funds awarded to members of the Red Lake Band of Chippewa Indians. (6-1-94)

15. P.L. 98-500. Funds provided to heirs of deceased Indians under the Old Age Assistance Claims Settlement Act, except for per capita shares in excess of two thousand dollars (\$2,000). (6-1-94)

16. P.L. 99-264. Payments to the White Earth Band of Chippewa Indian Tribe, Michigan. (6-1-94)

17. P.L. 99-346. Payments to the Saginaw Chippewa Indian Tribe, Michigan. (6-1-94)

18. P.L. 99-498 and P.L. 102-523 Student Loans. Financial assistance funded in whole or in part under Title IV of the Higher Education Act. (6-1-94)

19. P.L. 101-41. Payments to the Puyallup Tribe of Indians, Washington. (6-1-94)

20. P.L. 101-277. Payments to the Seminole Nation of Oklahoma, the Seminole Tribe of Florida, the Miccosukee Tribe of Florida and the Independent Seminole Indians of Florida. (6-1-94)

21. P.L. 101-426. Payments from the Radiation Exposure Compensation Act. (6-1-94)

22. P.L. 102-237. Resources of any mixed household member who gets TAFI or SSI. (7-1-98)

23. P.L. 103-286. Effective 8-1-94, payments made to victims of Nazi persecution. (1-1-95)

24. P.L. 103-436. Payments to the Confederated Tribes of the Colville Reservation for the Grand Coulee Dam Settlement. (7-1-97)

25. P.L. 104-204. Payments to children with spina bifida born to Vietnam veterans. (7-1-99)

26. Civil Liberties Act of 1988. Restitution payments to persons of Japanese ancestry who were evacuated, relocated and interned during World War II as a result of government action. These payments are also excluded when paid to the statutory heirs of deceased internees. (6-1-94)

27. SSI Payments Under Zebley v. Sullivan Ruling. Retroactive lump sum SSI payments, for childhood disability, paid as a result of the Zebley v. Sullivan ruling. The payments are excluded resources for six (6) months from receipt. (6-1-94)

28. BIA Education Grant. Bureau of Indian Affairs (BIA) Higher Education Grant Program. (6-1-94)

29. **WIC.** Benefits from the Women, Infants, and Children (WIC) Program. (6-1-94)
30. **WIA.** Payments from the Workforce Investment Act (WIA). (3-15-02)
31. **Energy Assistance.** Payments from Federal, state, or local energy assistance, including insulation and weatherization payments. (6-1-94)
32. **HUD Payments.** HUD retroactive subsidy payments for tax and utilities are excluded the month received and the next month. (6-1-94)
33. **Agent Orange Settlement Fund.** Product liability payments, made by Aetna Life and Casualty from the Agent Orange Settlement Fund. Effective January 1, 1989. (6-1-94)
34. **Federal EITC.** Federal Earned Income Tax Credit (EITC) is excluded *for the month of receipt and the following month. Federal EITC is excluded* for twelve (12) months from receipt *if the household member receives EITC while participating in the Food Stamp program. The exclusion continues only while the household participates in the Food Stamp program without a break, for up to twelve (12) months.* The month of receipt is the first month of the exclusion. (1-1-95)()
35. **Crime Act of 1984 as Amended by P.L. 103-322.** Payments from a crime victim compensation program. (7-1-99)
36. **Federal Tax Refunds.** Federal income tax refunds are excluded as a resource for a period of twelve (12) months from receipt. The month of receipt is the first month of the exclusion. ()

(BREAK IN CONTINUITY OF SECTIONS)

501. INITIAL CHANGES IN FOOD STAMP CASE.

Act on changes in household circumstances found during the application or the initial interview. (6-1-94)

01. Anticipated Changes. A household can be eligible in the application month, but not eligible the month after the application month because of expected changes in circumstances. The household may not be eligible for the application month, but eligible for the next month. The same application form is used for the denial and the next month's eligibility determination. (6-1-94)

02. Food Stamps for the Application Month. The household's Food Stamp issuance for the application month may differ from its issuance in later months. (6-1-94)

03. Food Stamp Issuance Changes. The Department will make changes to the household's Food Stamp issuance when it is required to act on a change. (3-30-07)

04. Change Before Certification. If a household reports a change in household circumstances before certification ~~and the Department can act on the change~~, include the reported information in determining Food Stamp eligibility and amount. (6-1-94)()

05. Change After Certification. If a household reports a change after the initial Food Stamp benefit has been paid, the Department must act on the change ~~if it was required to be reported or would increase the household's Food Stamp benefits under these rules. Changes in the household's expenses will not be acted upon until a six-month or twelve-month contact, or recertification~~ as required by policy for acting on changes within a certification period. Notice of the change must be given to the Food Stamp household. (3-29-12)()

(BREAK IN CONTINUITY OF SECTIONS)

535. MEDICAL EXPENSES.

Elderly or disabled household members that incur ~~M~~medical expenses over thirty-five dollars (\$35), for elderly or disabled household members, are deducted from the household income per month are allowed a Standard Medical Expense (SME) deduction. Eligible households must verify monthly medical expenses of more than thirty-five dollars (\$35) at initial application. Households with medical expenses that exceed the monthly Standard Medical Expense may either verify the minimum amount to receive the SME or request and verify excess costs to receive an actual expense deduction at application and recertification. Allowable medical expense deductions are listed in Subsection 535.01 through 535.14 of these rules. The household must provide proof of the incurred or anticipated cost before a deduction is allowed. (3-30-07)()

01. Medical and Dental Services. Services must be performed by licensed practitioners, physicians, dentists, podiatrists, or other qualified health professionals. Other qualified health professionals include registered nurses, nurse practitioners, licensed physical therapists and licensed chiropractors. (6-1-94)

02. Psychotherapy and Rehabilitation Services. Services must be performed by licensed psychiatrists, licensed clinical psychologists, licensed practitioners, physicians or other qualified health professionals. (6-1-94)

03. Hospital or Outpatient Treatment. Hospital or outpatient treatment includes expenses for hospital, nursing care, State licensed nursing home care, and care to a person immediately before entering a hospital or nursing home. (4-6-05)

04. Prescription Drugs. Prescription drugs and prescribed over-the-counter medication including insulin. (6-1-94)

05. Medical Supplies and Sickroom Equipment. Medical supplies and sickroom equipment including rental or other equipment. (6-1-94)

06. Health Insurance. Health and hospitalization insurance premiums. These do not

include health and accident policies payable in a lump sum for death or dismemberment. These do not include income maintenance policies to make mortgage or loan payments while a beneficiary is disabled. (6-1-94)

07. Medicare Premiums. Medicare premiums related to coverage under Title XVIII of the Social Security Act. (6-1-94)

08. Cost-Sharing or Spend-Down Expenses. Cost-sharing or spend-down expenses incurred by Medicaid recipients. (6-1-94)

09. Artificial Devices. Dentures, hearing aids, and prostheses. (6-1-94)

10. Service Animal. Expenses incurred buying and caring for any animal that has received special training to provide service to a disabled person. Expenses include costs for the service animal's food, training, and veterinary services. (4-4-13)

11. Eyeglasses. Expenses for eye examinations and prescribed eyeglasses. (4-6-05)

12. Transportation and Lodging. Reasonable transportation and lodging expenses incurred to get medical services. (4-6-05)

13. Attendant Care. Attendant care costs necessary due to age, disability, or illness. If attendant care costs qualify for both the excess medical and dependent care expense deductions, the cost is treated as a medical expense. (4-6-05)

14. Attendant Meals. An amount equal to the maximum Food Stamp allotment for a one (1) person household per month is deducted if the household provides most of the attendant's meals. (3-29-10)

(BREAK IN CONTINUITY OF SECTIONS)

573. ACTING ON HOUSEHOLD COMPOSITION CHANGES.

Changes in household composition are not required to be reported. If a household does report a change in household composition, ~~and the change would increase the Food Stamp benefit, proof is needed to act on the change~~ **the Department will act on the change as required by options allowed under 7 CFR 273.12(c).** ~~If proof is provided within ten (10) days, increase the Food Stamp benefits beginning the month immediately following when the change was reported. If proof is not provided within ten (10) days, increase the Food Stamp benefit beginning the month after the proof is provided. If the reported change decreases the Food Stamp benefit, the change is effective at the next six-month or twelve-month contact, or recertification.~~ (3-29-12)()

(BREAK IN CONTINUITY OF SECTIONS)

575. HOUSEHOLD COMPOSITION CHANGES FOR STUDENT.

Ineligible students are defined as non-household members. When a student's status changes, the change is treated as a new person entering or leaving the Food Stamp household. ~~If a household reports a change in student status, and the change would increase the Food Stamp benefit, increase the Food Stamp benefit beginning the month after the proof is provided. If the reported change decreases the Food Stamp benefit, the change is effective at the next recertification or twelve-month (12) contact.~~ (3-29-10)()

(BREAK IN CONTINUITY OF SECTIONS)

613. CHANGES ON WHICH THE DEPARTMENT MUST ACT.

The Department must follow the procedures for acting on reported changes as described in 7 CFR 273.12. ()

~~01. General Changes on Which Department Must Act. Regardless of whether the Food Stamp Benefit will increase or decrease, the Department must act as described in Sections 617 and 618 of these rules when:~~ (4-11-06)

- ~~a. The household requests closure; (4-6-05)~~
- ~~b. The TAFI or AABD grant amount changes; (4-6-05)~~
- ~~c. An individual is sanctioned or disqualified; (4-6-05)~~
- ~~d. The change would cause prohibited participation, see Section 219 of these rules; (4-11-06)~~
- ~~e. Information is received from a source the Department has defined as verified upon receipt in Section 012 of these rules; (4-11-06)~~
- ~~f. The change is required to be reported and the change is expected to continue into the next month; (4-6-05)~~
- ~~g. The Food Stamp benefit will increase and the change is not a change in expenses; (4-11-06)~~
- ~~h. The household reports that all members of the household moved out of the state of Idaho; or (4-7-11)~~
- ~~i. The U.S. Post Office returns mail to the Department because the household moved and left no forwarding address as provided in Section 735 of these rules. (4-7-11)~~

~~02. **Changes Resulting in an Increase in the Food Stamp Benefit.** The Department must also act on changes that have been reported that would increase the household's Food Stamp amount as described in Section 617 of these rules. (6-11-06)~~

~~03. **Documentation.** Changes must be documented in the case record, even if there is no change in the Food Stamp amount. (6-1-94)~~

~~04. **Change Report Form.** A new Change Report Form (HW 0594 or HW 0586) must be given or sent to the household when a change is reported. (6-1-94)~~

~~05. **Receipt of Report Notice.** The Department must notify the household when the report is received. A Notice of Decision meets this requirement, when notifying the household of a benefit determination. (6-1-94)~~

~~06. **Proof.** Give the household a written request for proof. The household must be told failure to provide the proof will result in decreased or stopped benefits. The Department must document how the request for proof was made. (3-15-02)~~

~~07. **Unclear Information.** If the Department is unable to readily determine the effect of a change on the household's benefit amount, the Department will issue a written request advising the household of proof it must provide or actions it must take, to clarify its circumstances. The household has ten (10) days in which to respond to the Department's request, either by telephone or correspondence. (4-6-05)~~

~~614. (RESERVED)~~

~~615. **CHANGES IN SHELTER, DEPENDENT CARE, CHILD SUPPORT, OR MEDICAL EXPENSES.**~~

~~A household reporting a change in shelter, utility, dependent care, child support, or medical expenses will be not required to provide proof of the change until recertification and the six-month or twelve-month contact. The Department will not adjust the Food Stamp benefit during the certification period regardless of whether the change in expenses would cause the Food Stamp benefit to increase or decrease. (3-29-12)~~

~~614 -- 616. (RESERVED)~~

617. INCREASES IN FOOD STAMP BENEFITS.

01. Household Reports a Change. If a household reports a change, ~~other than a change to expenses~~, that results in an increase in Food Stamps and the proof cannot be obtained through interfaces or data brokers, the Department must allow the household ten (10) days to provide proof. (3-29-10)()

02. Failure to Provide Proof of Change. If the household fails to provide proof of a change that would increase the benefit level, the Food Stamp benefit remains at the amount already established. (3-29-10)

03. Proof Provided Within Ten Days. If the household provides proof within ten (10)

days of reporting the change, the Department will increase the Food Stamp benefits beginning the month immediately following the month in which the change was reported. For changes reported after the 20th of the month, a supplement is issued for the next month no later than the 10th of the next month. If the change is reported and verified after the final date to adjust Food Stamp benefits for the following month in the Department's automated eligibility system, the change to the Food Stamp benefits must be made by the following month, even if a supplement must be issued. (4-11-06)

04. Proof Not Provided Within Ten Days. If the household fails to provide proof within ten (10) days of reporting the change, but provides proof later, benefits are increased the month after the proof of the change is provided. (3-29-10)

618. DECREASES IN FOOD STAMP BENEFITS.

~~If a change that is required to be acted upon~~ **If the Department acts on a change that** results in a decrease in Food Stamp benefits, the Department ~~must take action and~~ must give timely notice, if required. The notice must explain the reason for the action. (~~3-29-10~~)()

~~**619. CHANGES NOT REQUIRED TO BE REPORTED.**~~

~~If the household reports a change not required to be reported that would result in a decrease in Food Stamp benefits, the Department will not request proof and will not take action until recertification and the six-month or twelve-month contact. The household must be notified that no action will be taken on the reported change.~~ (3-29-12)

619 -- 620. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
**16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED,
BLIND, AND DISABLED (AABD)**

DOCKET NO. 16-0305-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the temporary rule is **January 1, 2014**. The pending rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and is also adopting a temporary rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-209, 56-236 through 56-240, 56-242, 56-250 through 56-257, 56-260 through 56-266, Idaho Code; and 42 CFR, 45 CFR, and 26 USC Part 36B.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule:

In accordance with Section 67-5226, Idaho Code, the full text of the temporary rule is being published in this Bulletin following this notice. Changes to the pending rule and included in the temporary rule are being made because of input from patient providers concerning patient liability issues. The text for the proposed rule was published in the October 2, 2013, Idaho Administrative Bulletin, **Vol. 13-10, pages 186 through 201**. The temporary rule is being adopted because of changes to federal laws that require implementation on January 1, 2014.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b) and (c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate in order to comply with deadlines in amendments to governing law or federal programs, effective January 1, 2014, and to confer a benefit.

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

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

The fiscal impact for this rulemaking is anticipated to be cost neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending and temporary rule, contact Lori Wolff at (208) 334-5815.

DATED this 26th day of November, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
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THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-209, 56-236 through 56-240, 56-242, 56-250 through 56-257, 56-260 through 56-266, Idaho Code; and 42 CFR, 45 CFR, and 26 USC Part 36B.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 16, 2013.

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

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

This rulemaking is being initiated because of changes in federal laws that must be implemented by January 1, 2014. These rules are being aligned with changes in the eligibility criteria for medical assistance rules and with federal law.

These changes simplify and streamline verification requirements for proof of citizenship and lawful alien status. Residency requirements are being updated to reflect federal law, requirements around child support that do not meet federal requirements are being removed while retaining policies to cooperate with obtaining medical support. Updates are being made to reflect the end of "Aid to Families with Dependent Children" (AFDC), and prior changes to AABD cash.

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

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

The fiscal impact for this rulemaking is anticipated to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because federal laws require the Department to make changes to these rules and have them in place by January 1, 2014, in order to be in compliance with that law. The changes required by federal law are non-negotiable.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Shannon Epperley at (208) 334-5969.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 23, 2013.

DATED this 29th day of August, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0305-1301

005. DEFINITIONS.

~~These definitions~~ For purposes of this chapter, the following terms apply ~~to IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)":~~ (7-1-99)(____)

01. AABD Cash. An EBT payment to a participant, a participant's guardian, or a holder of a limited power of attorney for EBT payments. AABD Cash is a payment of a supplemental cash amount to an individual who meets the program requirements. This payment may be made through direct deposit or an electronic benefits card. (5-3-03)(____)

02. Applicant. A person applying for public assistance from the Department, ~~and whose application is not fully processed~~ including individuals referred to the Department from a health insurance exchange or marketplace. (7-1-99)(____)

03. Annuity. A right to receive periodic payments, either for life, a term of years, or

other interval of time, whether or not the initial payment or investment has been annuitized. It includes contracts for single payments where the single payment represents an initial payment or investment together with increases or deductions for interest or fees rather than an actuarially-based payment from an insurance pool. (3-30-07)

04. Asset. Includes all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to, but does not receive because of action by: (3-30-07)

a. The individual or such individual's spouse; (3-30-07)

b. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or (3-30-07)

c. A person, including any court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse. (3-30-07)

05. Asset Transfer for Sole Benefit. An asset transfer is considered to be for the sole benefit of a spouse, blind or disabled child, or disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of transfer or at any time in the future. (5-3-03)

06. Child. ~~A child is under age eighteen (18), or under twenty one (21) and attending school, college, university, or vocational or technical training designed to prepare him for gainful employment. A child is not married. A child is not the head of a household.~~ Any individual from birth through the end of the month of his nineteenth birthday. (7-1-99)()

07. Citizen. A person having status as a "national of the United States" defined in 8 U.S.C. 1101(a)(22) that includes both citizens of the United States and non-citizen nationals of the United States. ()

078. Department. The Department of Health and Welfare. (7-1-99)

089. Direct Deposit. The electronic deposit of a participant's AABD cash to the participant's personal account with a financial institution. (7-1-99)

0910. Electronic Benefits Transfer (EBT). A method of issuing AABD cash to a participant, a participant's guardian or a holder of a limited power of attorney for EBT payments for a participant. EBT rules are in IDAPA 16.03.20, "Rules Governing Electronic Payments of Public Assistance, Food Stamps and Child Support." (7-1-99)

101. Essential Person. A person of the participant's choice whose presence in the household is essential to the participant's well-being. The essential person provides the services a participant needs to live at home. (5-3-03)

112. Fair Market Value. The fair market value of an asset is the price for which the asset can be reasonably expected to sell on the open market, in the geographic area involved.

(5-3-03)

123. Long-Term Care. Long-term care services are services provided to an institutionalized individual as defined in 42 U.S.C. 1396p(c)(1)(C). (3-30-07)

134. Medicaid. ~~The Federally funded program for medical care~~ Idaho's Medical Assistance Program administered by the Department and funded with federal and state funds according to (Title XIX, Social Security Act) that provides medical care for eligible individuals. ~~(5-3-03)()~~

145. Medical Assistance Rules. Idaho Department of Health and Welfare Rules, IDAPA 16.03.09, "Medicaid Basic Plan Benefits," ~~and~~ IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," and IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits." ~~(3-30-07)()~~

156. Medicaid for Families With Children Rules. Idaho Department of Health and Welfare Rules, IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children." (7-1-99)

167. Needy. A person is considered needy for AABD cash payments if the person meets the nonfinancial requirements of Title XVI of the Social Security Act and the criteria in Section 514 of these rules. (4-7-11)

18. Non-Citizen. Same as "alien" defined in Section 101(a)(3) of the Immigration and Nationality Act (INA) (8 U.S.C. 1101 (a)(3)), and includes any individual who is not a citizen or national of the United States. ()

179. Participant. An individual ~~applying for or receiving assistance~~ who is eligible for, and enrolled in, a Health Care Assistance Program or Medicaid. ~~(7-1-99)()~~

1820. Partnership Policy. A partnership policy is a qualified long-term care insurance policy as defined in Section 7702B(b) of the Internal Revenue Code of 1986, which meets the requirements of the long-term care insurance model regulation and long-term care insurance model act promulgated by the National Association of Insurance Commissioners (NAIC), as incorporated in 42 USC 1396p(b)(5)(A). (4-2-08)

21. Premium. A regular, periodic charge or payment for health coverage. ()

22. Reasonable Opportunity Period. A period of time allowed for an individual to provide requested proof of citizenship or identity. A reasonable opportunity period extends for ninety (90) days beginning on the 5th day after the notice requesting the proof has been mailed to the applicant. This period may be extended if the Department determines that the individual is making a "good faith" effort to obtain necessary documentation. ()

1923. Pension Funds. Pension funds are retirement funds held in individual retirement accounts (IRAs), as described by the Internal Revenue Code, or in work-related pension plans, including plans for self-employed individuals sometimes referred to as Keogh plans. (4-2-08)

204. Sole Beneficiary. The only beneficiary of a trust, including a beneficiary during the grantor's life, a beneficiary with a future interest, and a beneficiary by the grantor's will. (7-1-99)

215. TAFI Rules. Idaho Department of Health and Welfare Rules, IDAPA 16.03.08, "Rules Governing Temporary Assistance for Families in Idaho." (7-1-99)

226. Title XVI. Title XVI of the Social Security Act, known as "Grants to States for Aid to the Aged, Blind, or Disabled," is a program for financial assistance to needy individuals who are sixty-five (65) years of age or over, are blind, or are eighteen (18) years of age or over and permanently and totally disabled. (4-7-11)

237. Title XIX. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. ~~This program pays for medical assistance for certain individuals and families with low income and limited resources.~~ (3-30-07)()

248. Title XXI. Title XXI of the Social Security Act, known as the *State* Children's Health Insurance Program (SCHIP); ~~This is a program that primarily pays for medical assistance for federal and state partnership that provides health insurance to targeted,~~ low-income children. (3-30-07)()

259. Treasury Rate. The five (5) year security note rate listed in the "Daily Treasury Yield Curve Rate" by the U.S. Treasury on January 1 of each year. The January 1 rate is used for the entire calendar year. (4-2-08)

2630. Working Day. A calendar day when regular office hours are observed by the state of Idaho. Weekends and state holidays are not considered working days. (7-1-99)()

(BREAK IN CONTINUITY OF SECTIONS)

072. REQUIRED VERIFICATION.

Applicants must prove their eligibility for aid. The participant is allowed ten (10) calendar days to provide requested proof. The application is denied if the applicant does not provide proof in ten (10) calendar days of the written request and does not have good cause for not providing proof. The Department may also use electronic verification sources when they are available. (7-1-99)()

(BREAK IN CONTINUITY OF SECTIONS)

092. CONCURRENT BENEFIT PROHIBITION.

If a person is potentially eligible for *either* AABD cash, TAFI, or foster care, only one (1)

program may be chosen.

(7-1-99)()

093. -- 099. (RESERVED)

100. RESIDENCY.

The participant must be *voluntarily* living in Idaho and have no immediate intention of leaving. For Medicaid, other persons are Idaho residents if they meet a criteria in Subsections 100.01 through 100.05 of this rule.

(7-1-99)()

01. Foster Child. A participant living in Idaho and receiving child foster care payments from another state. (7-1-99)

02. Incapable Participant. A participant ~~in an Idaho institution~~, who *became is* incapable of indicating his state of residency after age twenty-one (21). ~~The participant is a resident of the state where~~, is considered a resident of Idaho when: ()

a. ~~His~~ His parent or guardian lives ~~in Idaho; or~~ ()

b. ~~A participant~~ He resides in an Idaho institution, ~~who became incapable of indicating his state of residency after age twenty-one (21), is a resident of Idaho.~~ (7-1-99)()

03. Placed in Another State by Idaho. A participant placed by the state of Idaho in an institution in another state. (7-1-99)

04. Homeless. A participant not maintaining a permanent home or having a fixed address who intends to remain in Idaho. (7-1-99)

05. Migrant. A migrant working and living in Idaho. (7-1-99)

(BREAK IN CONTINUITY OF SECTIONS)

102. ~~(RESERVED)~~ U.S. CITIZENSHIP VERIFICATION REQUIREMENTS.

Any individual who participates in AABD cash, Health Care Assistance, or Medicaid benefits must provide proof of U.S. citizenship unless he has otherwise met the requirements under Subsection 104.06 of these rules. ()

01. Citizenship Verified. Citizenship must be verified by electronic means when available. If an electronic verification is not immediately obtainable, the Department may request documentation from the applicant The Department will not deny the application until the applicant has had a reasonable opportunity period to obtain and provide the necessary proof of U.S. citizenship. ()

02. Benefits During Reasonable Opportunity Period. Benefits are provided during the reasonable opportunity period that is provided to allow the applicant time to obtain and provide documentation to verify U.S. citizenship. No overpayment will exist for the reasonable

opportunity period if the applicant does not provide necessary documentation during the reasonable opportunity period so that the application results in denial. ()

03. Electronic Verification. Electronic interfaces initiated by the Department with agencies that maintain citizenship and identity information are the primary sources of verification of U.S. Citizenship and Identity. ()

04. Documents. When verification is not available through an electronic interface, the individual must provide the Department with the most reliable document that is available. Documents can be: ()

a. Originals; ()

b. Photocopies; ()

c. Facsimiles; ()

d. Scanned; or ()

e. Other type of copy of a document. ()

05. Accepted Documentation. Other forms of documentation are accepted to the same extent as an original document, unless information on the submitted document is: ()

a. Inconsistent with other information available to the Department; or ()

b. The Department has good cause to question the validity of the document or the information on it. ()

06. Submission of Documents. The Department accepts documents that are submitted: ()

a. In person; ()

b. By mail or parcel service; ()

c. Through an electronic submission; or ()

d. Through a guardian or authorized representative. ()

103. SOCIAL SECURITY NUMBER (SSN) REQUIREMENT.

01. SSN Required. The applicant must provide his social security number (SSN), or proof he has applied for an SSN, to the Department before approval of eligibility. If the applicant has more than one (1) SSN, all numbers must be provided. ()

a. The SSN must be verified by the Social Security Administration (SSA)

electronically. An applicant with an unverified SSN is not eligible for AABD cash, Health Care Assistance, or Medicaid benefits. ()

b. The Department must notify the applicant in writing if eligibility is denied or lost for failure to meet the SSN requirement. (3-20-04)()

012. **Application for SSN.** To be eligible, the applicant must apply for an SSN, or a duplicate SSN when he cannot provide his SSN to the Department. If the SSN has been applied for but not issued by the SSA, the Department cannot deny, delay, or stop benefits. The Department will help an applicant with required documentation when the applicant applies for an SSN. (3-20-04)

023. **Failure to Apply for SSN.** The applicant may be granted a good cause exception for failure to apply for an SSN if they have a well-established religious objection to applying for an SSN. A well-established religious objection means the applicant: (3-20-04)

a. Is a member of a recognized religious sect or division of the sect; and (3-20-04)

b. Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number. (3-20-04)

034. **SSN Requirement Waived.** An applicant may have the SSN requirement waived when he is: (3-20-04)

a. Only eligible for emergency medical services as described in Section 801 of these rules; or (3-20-04)

b. A newborn child deemed eligible as described in Section 800 of these rules. (4-2-08)

104. U.S. CITIZENSHIP AND IDENTITY DOCUMENTATION REQUIREMENTS.

To be eligible for AABD cash and Medicaid, an individual must provide documentation proof of U.S. citizenship and identity unless he has otherwise met the requirements under Subsection 104.096 of this rule. The individual must provide the Department with the most reliable document that is available. Documents must be originals or copies certified by the issuing agency. Copies of originals or notarized copies cannot be accepted. The Department will accept original documents in person, by mail, or through a guardian or authorized representative as described in Section 102 of these rules. (3-29-10)()

01. **Documents Accepted as Primary Level Proof of Both U.S. Citizenship and Identity.** The following documents are accepted as the primary level of proof of both U.S. citizenship and identity: (3-30-07)()

a. A U.S. passport, including a U.S. Passport card, without regard to expiration date as long as the passport or passport card was issued without limitation; (3-30-07)()

b. A Certificate of Naturalization, DHS Forms N-550 or N-570; or (3-30-07)()

- c. A Certificate of U.S. Citizenship, ~~DHS Forms N-560 or N-561.~~ (3-30-07)()
- d. ~~A~~ **Documentary evidence** issued by a federally recognized Indian tribe ~~evidencing membership, enrollment in, or affiliation with such tribe.~~ **Such documents include:**
(3-29-10)()
 - i. **A tribal enrollment card;** ()
 - ii. **A certificate of Degree of Indian Blood;** ()
 - iii. **A tribal census document; or** ()
 - iv. **Documents on tribal letterhead, issued under the signature of the appropriate tribal official.** ()

02. Documents Accepted as ~~Secondary Level Proof~~ **Evidence of U.S. Citizenship ~~but Not Identity~~.** The following documents are accepted as proof of U.S. citizenship if the proof in Subsection 104.01 of this rule is not available. These documents are not proof of identity and must be used in combination with a least one (1) document listed in Subsections 104.053 ~~through~~ **and** 104.074 of this rule to establish both citizenship and identity. **If the applicant does not have one (1) of the documents listed below, he may submit an affidavit signed by another individual under penalty of perjury who can reasonably attest to the applicant's citizenship, and that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.**
(3-29-10)()

- a. A U.S. birth certificate that shows the individual was born in one (1) of the following: (3-30-07)
 - i. United States fifty (50) states; (3-30-07)
 - ii. District of Columbia; (3-30-07)
 - iii. Puerto Rico, on or after January 13, 1941; (3-30-07)
 - iv. Guam, ~~on or after April 10, 1899;~~ (3-30-07)()
 - v. U.S. Virgin Islands, on or after January 17, 1917; (3-30-07)
 - vi. America Samoa; (3-30-07)
 - vii. Swain's Island; or (3-30-07)
 - viii. Northern Mariana Islands, after November 4, 1986; (3-30-07)
- b. A certification of report of birth issued by the Department of State, Forms DS-1350 or FS-545; (3-30-07)

- c.** A report of birth abroad of a U.S. Citizen, Form FS-240; (3-30-07)
- d.** A U.S. Citizen I.D. card, DHS Form I-197; (3-30-07)
- e.** A Northern Mariana Identification Card, ~~Form I-873~~; (~~3-30-07~~)()
- ~~f.~~** ~~An American Indian Card issued by the Department of Homeland Security with the classification code "KIC," Form I-873;~~ (~~3-30-07~~)()
- ~~g.~~** A final adoption decree showing the child's name and U.S. place of birth, or if the adoption is not final, a statement from the state-approved adoption agency that shows the child's name and U.S. place of birth; (~~3-30-07~~)()
- ~~h.~~** Evidence of U.S. Civil Service employment before June 1, 1976; (4-2-08)
- ~~i.~~** An official U.S. Military record showing a U.S. place of birth; (4-2-08)
- ~~j.~~** A certification of birth abroad, FS-545; (4-2-08)
- ~~k.~~** ~~A~~vVerification with the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) database;~~or~~ (~~4-2-08~~)()
- ~~l.~~** Evidence of meeting the automatic criteria for U.S. citizenship outlined in the Child Citizenship Act of 2000;~~;~~ (~~4-2-08~~)()
- ~~l.~~** Medical records, including, hospital, clinic, or doctor records, or admission papers from a nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth; ()
- ~~m.~~** Life, health, or other insurance record that indicates a U.S. place of birth; ()
- ~~n.~~** Official religious record recorded in the U.S. showing that the birth occurred in the U.S.; ()
- ~~o.~~** School records, including pre-school, Head Start, and daycare, showing the child's name and U.S. place of birth; or ()
- ~~p.~~** Federal or state census record showing U.S. citizenship or a U.S. place of birth. ()
- ~~03.~~** ~~Documents Accepted as Third Level Proof of U.S. Citizenship but Not Identity. The following documents are accepted as proof of U.S. citizenship if a primary or secondary level of proof is not available. These documents are not proof of identity and must be used in combination with a least one (1) document listed in Subsections 104.05 through 104.07 of this rule to establish both citizenship and identity.~~ (~~3-29-10~~)
- ~~a.~~** ~~A written hospital record on hospital letterhead established at the time of the person's birth that was created five (5) years before the initial application date that indicates a~~

~~U.S. place of birth;~~ (4-2-08)

~~b. A life, health, or other insurance record that was created at least five (5) years before the initial application date and that indicates a U.S. place of birth;~~ (4-2-08)

~~e. A religious record recorded in the U.S. within three (3) months of birth showing the birth occurred in the U.S. and showing either the date of the birth or the individual's age at the time the record was made. The record must be an official record recorded with the religious organization;~~ or (4-2-08)

~~d. An early school record showing a U.S. place of birth. The school record must show the name of the child, the date of admission to the school, the date of birth, a U.S. place of birth, and the names and places of the birth of the child's parents.~~ (4-2-08)

~~04. Documents Accepted as Fourth Level Proof of U.S. Citizenship but Not Identity. The following documents are accepted as proof of U.S. citizenship only if documents in Subsections 104.01 through 104.03 of this rule do not exist and cannot be obtained for a person who claims U.S. citizenship. These documents are not proof of identity and must be used in combination with a least one (1) document listed in Subsections 104.05 through 104.07 of this rule to establish both citizenship and identity.~~ (3-29-10)

~~a. Federal or state census record that shows the individual has U.S. citizenship or a U.S. place of birth;~~ (3-30-07)

~~b. One (1) of the following documents that shows a U.S. place of birth and for a participant who is sixteen (16) years of age or older was created at least five (5) years before the application for Medicaid. For a child under sixteen (16) years or age, the document must have been created near the time of birth;~~ (4-2-08)

~~i. Bureau of Indian Affairs tribal census records of the Navajo Indians;~~ (3-30-07)

~~ii. U.S. State vital Statistics official notification of birth registration;~~ (3-30-07)

~~iii. A delayed U.S. public birth record that was recorded more than five (5) years after the person's birth;~~ (4-2-08)

~~iv. Statement signed by the physician or midwife who was in attendance at the time of birth;~~ (3-30-07)

~~v. Medical (clinic, doctor, or hospital) record;~~ (3-30-07)

~~vi. Institutional admission papers from a nursing facility, skilled care facility or other institution;~~ (4-2-08)

~~vii. Bureau of Indian Affairs (BIA) roll of Alaska Natives;~~ or (4-2-08)

~~e. A written declaration, signed and dated, which states, "I declare under penalty of perjury that the foregoing is true and correct." A declaration is accepted for proof of U.S.~~

~~citizenship or naturalization if no other documentation is available and complies with the following:~~ (4-2-08)

~~i. Declarations must be made by two (2) persons who have personal knowledge of the events establishing the individual's claim of U.S. citizenship;~~ (3-30-07)

~~ii. One (1) of the persons making a declaration cannot be related to the individual claiming U.S. citizenship;~~ (3-30-07)

~~iii. The persons making the declaration must provide proof of their own U.S. citizenship and identity; and~~ (3-30-07)

~~iv. A declaration must be obtained from the individual applying for Medicaid, a guardian, or representative that explains why the documentation does not exist or cannot be obtained.~~ (3-30-07)

053. Documents Accepted for Proof Evidence of Identity but Not Citizenship. The following documents are accepted as proof of identity, **provided the document has a photograph or other identifying information including: name, age, sex, race, height, weight, eye color, or address.** ~~They are not proof of citizenship and must be used in combination with at least one (1) document listed in Subsection 104.02 through 104.04 of this rule to establish both citizenship and identity.~~ (3-29-10)()

a. A state- **or territory-**issued driver's license, ~~bearing the individual's picture or other identifying information such as name, age, gender, race, height, weight, or eye color~~ **A driver's license issued by a Canadian government authority is not a valid indicator of identity in the U. S.;** (3-30-07)()

b. A federal, state, or local government-issued identity card ~~with the same identifying information that is included on driver's licenses as described in Subsection 104.05.a. of this rule;~~ (3-29-10)()

c. School identification card ~~with a photograph of the individual;~~ (3-30-07)()

d. U.S. Military card or draft record; (3-30-07)

e. Military dependent's identification card; (3-30-07)

f. U. S. Coast guard Merchant Mariner card; (3-30-07)

g. A cross-match with a federal or state governmental, public assistance, law enforcement, or corrections agency's data system; ~~or~~ (4-2-08)()

h. ~~A declaration signed under the penalty of perjury by the facility director or administrator of a residential care facility where a disabled participant resides may be accepted as proof of identity when the individual does not have or cannot get any document in Subsections 104.05.a. through 104.05.i. of this rule.~~ (3-29-10)

h. A finding of identity from a federal or state governmental agency, when the agency has verified and certified the identity of the individual, including public assistance, law enforcement, internal revenue or tax bureau, or corrections agency; ()

i. A finding of identity from another state benefits agency or program provided that it obtained verification of identity as a criterion of participation; ()

j. Verification of citizenship by a federal agency or another state. If the Department finds that a federal agency or an agency in another state verified citizenship on or after July 1, 2006, no further documentation of citizenship or identity is required; ()

k. Two (2) documents containing consistent information that corroborates the applicant's identity including: employer identification cards, high school or high school equivalency diplomas, college diplomas, marriage certificates, divorce decrees, property deeds or titles; or ()

l. When the applicant does not have any documentation as specified in Subsections 104.03.a. through k. of this rule, the applicant may submit an affidavit signed by another individual under penalty of perjury, who can reasonably attest to the applicant's identity. The affidavit must contain the applicant's name and other identifying information to establish identity stated in Subsection 104.03 of this rule. The affidavit does not have to be notarized. ()

~~06. Additional Documents Accepted for Proof of Identity. If the participant provides citizenship documentation as described in Subsections 104.02 or 104.03 of this rule, three (3) or more corroborating documents may be used to prove identity. (3-29-10)~~

074. Identity Rules for Children. ~~The following documentation of identity f~~For children under ~~sixteen~~ age ~~nineteen~~ (169), clinic, doctor, or hospital records, including pre-school or daycare records, may be used: as additional sources of documentation of identity. (3-30-07)()

~~a. School records may be used to establish identity. Such records also include nursery or daycare records. (3-30-07)~~

~~b. Clinic, doctor, or hospital records. (4-2-08)~~

~~e. A written declaration, signed and dated, which states, "I declare under penalty of perjury that the foregoing is true and correct," if documents listed in Subsection 104.02 of this rule are not available. A declaration may be used if it meets the following conditions: (3-29-10)~~

~~i. It states the date and place of the child's birth; and (3-30-07)~~

~~ii. It is signed by a parent or guardian. (3-30-07)~~

~~d. A declaration can be used for a child up to the age of eighteen (18) when documents listed in Subsection 104.05.a. through 104.05.c. of this rule are not available. (3-29-10)~~

~~e. A declaration cannot be used for identity if a declaration for citizenship documentation was provided for the child. (3-30-07)~~

085. Eligibility for Medicaid ~~Participants~~ Applicants Who Do Not Provide U.S. Citizenship and Identity Documentation. ~~Medicaid participants have~~ If verification of U.S. citizenship and identity is not obtained through electronic means, or if the applicant is unable to provide documentation at the time of application, the applicant has ninety (90) days to provide proof of U.S. citizenship and identity ~~documentation~~. The ninety (90) days begins five (5) days after the date the notice is mailed requesting the documentation of citizenship and identity. Medicaid benefits will be approved pending verification if the ~~participant~~ applicant meets all other eligibility requirements. Medicaid will be denied if the ~~participant~~ applicant refuses to obtain documentation. (4-7-11)()

096. Individuals Considered as Meeting the U.S. Citizenship and Identity Documentation Requirements. The following individuals are considered to have met the U.S. citizenship and identity documentation requirements, regardless of whether documentation required in Subsections 104.01 through 104.085 of this rule is provided: (3-29-10)()

- a. Supplemental Security Income (SSI) recipients; (4-2-08)
- b. Individuals determined by the SSA to be entitled to or ~~are receiving~~ enrolled in any part of Medicare; (4-2-08)()
- c. Social Security Disability Income (SSDI) recipients; (4-7-11)
- d. Adoptive or foster care children receiving assistance under Title IV-B or Title IV-E of the Social Security Act; (4-7-11)
- e. Individuals deemed eligible for Medicaid as a newborn under Section 800 of these rules; and (4-7-11)
- f. Individuals whose name and social security number are validated by the Social Security Administration data match as meeting U.S. citizenship status. (4-7-11)

107. Assistance in Obtaining Documentation. The Department will provide assistance to individuals who ~~are mentally or physically incapacitated and who lack a representative to assist them in obtaining such documentation~~ need assistance in securing satisfactory documentary evidence of citizenship. (3-30-07)()

108. Provide ~~Documentation~~ Verification of U.S. Citizenship and Identity One Time. When an individual's ~~has provided~~ U.S. citizenship and identity documents have been verified, whether through electronic data matches or provision of documentation, changes in eligibility will not require an individual to provide ~~such documentation~~ the verification again, ~~unless~~ If later verification of the documents provideds the Department with good cause to raises a question of the validity of the individual's citizenship or identity, the individual may be requested to provide further verification. (3-30-07)()

105. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.

To be eligible for AABD cash and Medicaid, an individual must be a member of one (1) of the groups listed in Subsections 105.01 through 105.176 of this rule. An individual must also provide proof of identity as provided in Section 104 of these rules. (3-29-10)()

01. U.S. Citizen. A U.S. Citizen or a “national of the United States.” (3-30-07)()

~~**02. U.S. National, National of American Samoa or Swain’s Island.** A U. S. National, National of American Samoa or Swain’s Island. (3-30-07)~~

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

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

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

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

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

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

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

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

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

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

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

b. Is an asylee granted asylum into the U.S. under 8 U.S.C. 1158, and can be eligible

for seven (7) years from the date their asylee status is assigned; (3-30-07)

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

d. Is an Amerasian immigrant admitted into the U.S. under 8 U.S.C. 1612(b)(2)(A)(i)(V), and can be eligible for seven (7) years from the date of entry; (4-7-11)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15. Individuals Not Meeting the Citizenship or Qualified Non-Citizen Requirements. An ~~f~~individuals who does not meet the citizenship or qualified non-citizen requirements in Subsections 105.01 through 105.14 of this rule, may be eligible for emergency medical services if ~~they~~ he meets all other conditions of eligibility. (~~4-7-11~~)()

(BREAK IN CONTINUITY OF SECTIONS)

502. SPECIAL NEEDS ALLOWANCES.

Special needs allowances are a restaurant meals allowance and a service animal food allowance. (4-11-06)

01. Restaurant Meals. The restaurant meals allowance is fifty dollars (\$50) monthly. A physician must state the participant is physically unable to prepare food in his home. A participant able to prepare his food, but living in a place where cooking is not permitted, may be budgeted the restaurant meals allowance for up to three (3) months. (7-1-99)

02. Service Animal Food. The service animal food allowance is seventeen dollars (\$17) monthly. The allowance is budgeted for a blind or disabled participant, using a trained service animal ~~trained by a recognized school~~. (~~4-11-06~~)()

(BREAK IN CONTINUITY OF SECTIONS)

515. RESIDENTIAL AND ASSISTED LIVING FACILITY CARE AND CERTIFIED FAMILY HOME ASSESSMENT AND LEVEL OF CARE.

The participant's need for care, level of care, plan of care, and the licensed facility's ability to provide care is assessed by the ~~Regional Medicaid Services (RMS)~~ Bureau of Long-Term Care Services (BLTCS) when a participant is admitted. The RMS BLTCS must approve the placement before Medicaid can be approved. (~~4-7-11~~)()

516. CHANGE IN LEVEL OF CARE.

A change in the participant's level of care affects eligibility as described in Subsections 516.01 and 516.02 of this rule. (4-7-11)

01. Increase in Level of Care. An increase in level of care is effective the month the RMS BLTCS reassesses the level of care. (~~5-3-03~~)()

02. Decrease in Level of Care. When the RMS BLTCS verifies the participant has a decrease in his level of care, and his income exceeds his new level of care, his Medicaid must be stopped after timely notice. When the RMS BLTCS determines the participant no longer meets any level of care, his eligibility and allowances are based on the Room and Board rate in Section 512 of these rules. (4-7-11)()

(BREAK IN CONTINUITY OF SECTIONS)

618. CONTINUED BENEFITS PENDING A HEARING DECISION.

The participant may continue to receive benefits upon request, pending the hearing decision. The Department must receive the participant's request for continued benefits before the effective date of the Department's action stated in the notice of decision. An applicant cannot receive continued benefits when appealing a denial for failure to provide citizenship and identity verification after the expiration of a reasonable opportunity period. (4-2-08)()

01. Amount of Assistance. The Department will continue the participant's assistance at the current month's level while the hearing decision is pending, unless another change affecting assistance occurs. (3-15-02)

02. Continued Eligibility. The participant must continue to meet all eligibility requirements not related to the hearing issue. (3-15-02)

03. Overpayment. When the hearing decision is in the Department's favor, the participant must repay assistance received while the hearing decision was pending. (3-15-02)

(BREAK IN CONTINUITY OF SECTIONS)

621. ~~COLLECTING UNDERPAID~~ CHANGES IN PATIENT LIABILITY.

~~An overpayment due to underpaid patient liability or client participation is collected by withholding funds from the nursing home or HCBS provider. Adjust the underpaid patient liability or client participation adjusted retroactively for each underpaid month. Funds are not withheld if the participant repays the Department.~~ (7-1-99)

01. Increase in Patient Liability. If the patient liability is increased for the current or a past month, the Department will collect the patient liability directly from the client. ()

02. Decrease in Patient Liability. If the patient liability is decreased for a current or past month, the funds will be paid to the provider and the provider must reimburse the client for the portion of the costs the client paid in excess of their patient liability. ()

(BREAK IN CONTINUITY OF SECTIONS)

701. MEDICAID APPLICATION.

An adult participant, a legal guardian or a representative of the participant must sign the application ~~form~~. The participant must submit the application ~~form~~ to the Department. A Medicaid application may be made for a deceased person. (7-1-99)()

(BREAK IN CONTINUITY OF SECTIONS)

703. CHILD SUPPORT COOPERATION.

The participant must cooperate to identify and locate the noncustodial parent, establish paternity, and establish, modify and enforce a child **medical** support order, to be eligible for Medicaid. ~~After CSS establishes a case, the participant must forward all support payments to CSS for distribution.~~ This includes support payments received directly from the noncustodial parent. The cooperation requirement is waived for poverty level pregnant women exempt from cooperating in establishing paternity and obtaining medical support ~~and payments~~ from, or derived from, the father of a child born out of wedlock. A participant who cannot legally assign his own rights must not be denied Medicaid if the legally responsible person does not cooperate. (4-5-00)()

(BREAK IN CONTINUITY OF SECTIONS)

723. PATIENT LIABILITY FOR PERSON WITH NO COMMUNITY SPOUSE.

For a participant with no community spouse, patient liability is computed as described in Subsections 723.01 through 723.03 of this rule. (5-3-03)

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

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

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

- a.** AABD Income Exclusions. Subtract income excluded in determining eligibility for AABD cash. (7-1-99)
- b.** Aid and Attendance and UME Allowances. Subtract a VA Aid and Attendance allowance and Unusual Medical Expense (UME) allowance for a veteran or surviving spouse, unless the veteran lives in a state operated veterans' home. (3-30-01)
- c.** SSI Payment Two (2) Months. Subtract the SSI payment for a participant entitled to receive SSI at his at-home rate for up to two (2) months, while temporarily in a long-term care facility. (7-1-99)
- d.** AABD Payment. Subtract the AABD payment, and income used to compute the AABD payment, for a participant paid continued AABD payments up to three (3) months in long-term care. (7-1-99)
- e.** First Ninety (\$90) Dollars of VA Pension. Subtract the first ninety (\$90) dollars of a VA pension for a veteran in a private long-term care facility or a State Veterans Nursing Home. (5-3-03)
- f.** Personal Needs. Subtract forty dollars (\$40) for the participant's personal needs. For a veteran or surviving spouse in a private long-term care facility or a State Veterans Nursing Home the first ninety (\$90) dollars of VA pension substitutes for the forty dollar (\$40) personal needs deduction. (5-3-03)
- g.** Employed and Sheltered Workshop Activity Personal Needs. For an employed participant or participant engaged in sheltered workshop or work activity center activities, subtract the lower of the personal needs deduction of two hundred dollars (\$200) or his gross earned income. The participant's total personal needs allowance must not exceed two hundred and thirty dollars (\$230). For a veteran or surviving spouse with sheltered workshop or earned income, and a protected VA pension, the total must not exceed two hundred dollars (\$200). This is a deduction only. No actual payment can be made to provide for personal needs. (3-30-01)
- h.** Home Maintenance. Subtract two hundred and twelve dollars (\$212) for home maintenance cost if the participant had an independent living situation, before his admission for long-term care. His physician must certify in writing the participant is likely to return home within six (6) months, after the month of admission to a long-term care facility. This is a deduction only. No actual payment can be made to maintain the participant's home. (7-1-99)
- i.** Maintenance Need. Subtract a maintenance need deduction for a family member, living in the long-term care participant's home. A family member is claimed, or could be claimed, as a dependent on the Federal Income Tax return of the long-term care participant. The family member must be a minor or dependent child, dependent parent, or dependent sibling of the long-term care participant. The maintenance need deduction is the AFDC payment standard for the dependents, computed according to the AFDC State Plan in effect before July 16, 1996. (7-1-99)
- j.** Medicare and Health Insurance Premiums. Subtract expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, not subject to payment

by a third party. Deduction of Medicare Part B premiums is limited to the first two (2) months of Medicaid eligibility. Medicare Part B premiums must not be subtracted, if the participant got SSI or AABD cash the month prior to the month for which patient liability is being computed.

(7-1-99)

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

(7-1-99)

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

~~(7-1-99)~~()

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

(7-1-99)

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

~~(7-1-99)~~()

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

(3-30-01)

(BREAK IN CONTINUITY OF SECTIONS)

800. NEWBORN CHILD OF MEDICAID MOTHER.

A child is deemed eligible for Medicaid without an application if born to a woman receiving Medicaid on the date of the child's birth, including during a period of retroactive eligibility for the mother. The child remains eligible for Medicaid for up to one (1) year without an application. An application for Medicaid must be filed on behalf of the child no later than his first birthday. He must qualify for Medicaid in his own right after the month of his first birthday.

~~(3-29-10)~~()

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.06 - REFUGEE MEDICAL ASSISTANCE

DOCKET NO. 16-0306-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the temporary rule is **January 1, 2014**. The pending rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and is also adopting a temporary rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-209, 56-236 through 56-240, 56-242, 56-250 through 56-257, 56-260 through 56-266, Idaho Code; and 42 CFR, 45 CFR, and 26 USC Part 36B.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule:

In accordance with Section 67-5226, Idaho Code, the temporary rule is being published in this Bulletin. There are no changes to the pending rule and it is being adopted as originally proposed. The notice of the proposed rule was published in the October 2, 2013, Idaho Administrative Bulletin, **Vol. 13-10, pages 202 through 206**. This temporary rule is being adopted because of changes to federal laws that require implementation on January 1, 2014.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b) and (c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate in order to comply with deadlines in amendments to governing law or federal programs, effective January 1, 2014, and to confer a benefit.

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

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

The fiscal impact for this rulemaking is anticipated to be cost neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending and temporary rule, contact Lori Wolff at (208) 334-5815.

DATED this 26th day of November, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, and 56-203, 56-209, 56-236 through 56-240, 56-242, 56-250 through 56-257, 56-260 through 56-266, Idaho Code; and 42 CFR, 45 CFR, and 26 USC Part 36B.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 16, 2013.

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

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

This rulemaking is being done because of changes in federal laws that must be implemented by January 1, 2014. The proposed amendments to these rules are required for compliance with federal laws. Changes are being made to definitions and for eligibility determination.

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

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

The fiscal impact for this rulemaking is anticipated to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated

rulemaking was not conducted because federal laws require the Department to make changes to these rules and have them in place by January 1, 2014, in order to be in compliance with that law. The changes required by federal law makes these rules non-negotiable.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Shannon Epperley at (208) 334-5969.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 23, 2013.

DATED this 29th day of August, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0306-1301

010. DEFINITION OF TERMS AND ABBREVIATIONS.

For the purposes of these rules, the following terms and abbreviations *are used as defined below* apply: (4-2-08)(____)

~~**01.** *AFDC.* Aid to Families with Dependent Children. AFDC is the family assistance program in effect on June 30, 1997. It was replaced by Temporary Assistance for Families in Idaho (TAFI).~~ (4-2-08)

021. Caretaker. A person related by blood or marriage who holds legal responsibility for the care and support of a minor child or otherwise dependent individual and who is needed in the home to care for such dependent. (4-2-08)

032. Department. The Idaho Department of Health and Welfare or a person authorized to act on behalf of the Department. (4-2-08)

043. Eligible Amerasian. A citizen of Vietnam born between January 1, 1962, and January 1, 1976, who has one (1) American parent. (4-2-08)

054. Entrant. A person from Cuba or Haiti who has been granted special immigration status by USCIS. (4-2-08)

065. Federal Poverty Guidelines (FPG). The federal poverty guidelines issued annually by the Department of Health and Human Services (HHS). (4-2-08)

076. HHS. United States Department of Health and Human Services. (4-2-08)

087. INA. Immigration and Nationality Act, 8 USC Sections 1101-1537. (4-2-08)

098. IRSP. Idaho Refugee Service Program. (4-2-08)

109. I-94. A white three by five (3x5) inch alien identification card issued to refugees prior to their release to a sponsor. This card gives the refugee's name, United States address, and other identifying data. The refugee status will be printed in the lower right hand corner. If a refugee does not have this card, he should be referred to USCIS to obtain one. The dependent of a repatriated United States citizen may also have an I-94 card. (4-2-08)

110. Medical Assistance Program. Services funded by Titles XIX or XXI of the federal Social Security Act, as amended. (4-2-08)

121. Refugee. An alien who: (4-2-08)

a. Because of persecution or fear of persecution on account of race, religion, or political opinion fled from his homeland; and (4-2-08)

b. Cannot return there because of fear of persecution on account of race, religion or political opinion. (4-2-08)

132. State Children's Health Insurance Program (SCHIP). SCHIP is Title XXI of the Social Security Act. It is a federal and state partnership similar to Medicaid, that expands health insurance to targeted, low- income children. (4-2-08)()

143. TAFI. Temporary Assistance for Families in Idaho. TAFI is Idaho's family assistance program whose purpose is to provide temporary cash assistance for Idaho families who meet the eligibility requirements under IDAPA 16.03.08, "Rules Governing the Temporary Assistance for Families in Idaho (TAFI)" program. ~~TAFI replaced the Aid to Families With Dependent Children (AFDC) program.~~ (4-2-08)()

14. Third Party. Includes a person, institution, corporation, public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a medical assistance participant. ()

15. USCIS. United States Citizenship and Immigration Services, ~~formerly known as Immigration and Naturalization Services (INS).~~ (4-2-08)()

(BREAK IN CONTINUITY OF SECTIONS)

135. PRECEDENCE OF CATEGORICAL ASSISTANCE PROGRAMS.

01. New Applicants. An applicant for medical assistance must first have his eligibility determined for Medicaid or SCHIP. To be eligible for Medicaid or SCHIP, the refugee must meet all the eligibility criteria for the applicable category of assistance. If the applicant is determined ineligible for Medicaid or SCHIP, then the Department will determine his eligibility for the Refugee Medical Assistance Program. (4-2-08)()

02. Transfer of Cases. At the end of the eight (8) month time limit for Refugee Medical Assistance, a refugee who is determined Medicaid-eligible in accordance with IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children" or IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)," will be transitioned to Medicaid without the need to submit an additional application. (4-2-08)

136. -- 149. (RESERVED)

150. REFUGEE MEDICAL ASSISTANCE PROGRAM.

01. Time Limitation. Medical assistance under the Refugee Medical Assistance Program will be limited to eight (8) consecutive months beginning with the month the refugee enters the United States. The eligibility period for a child born in the United States to parents receiving Refugee Medical Assistance expires when both of his parents with whom he is living are no longer eligible. (4-2-08)

02. Medical Only. A refugee is not required to apply for or receive Cash Assistance as a condition of eligibility for Refugee Medical Assistance. Denial or closure of Refugee Cash Assistance is not a reason to deny or close Refugee Medical Assistance. (4-2-08)

03. Refugee Cash Assistance Excluded. Refugee Cash Assistance is excluded from income ~~and resources~~ when determining eligibility for Refugee Medical Assistance. (4-2-08)()

04. Automatic Eligibility. Refugees whose countable income does not exceed one hundred fifty percent (150%) of the Federal Poverty Guidelines are automatically eligible for Refugee Medical Assistance. (4-2-08)

05. Refugee Medical Assistance with "Spend Down." An applicant for Refugee Medical Assistance whose countable income exceeds one hundred fifty percent (150%) FPG for his family size may become eligible for Refugee Medical Assistance under certain conditions. A special provision, for refugees only, will allow those refugees whose income exceeds one hundred fifty percent (150%) FPG for his family size to subtract his medical costs from his income and thus "spend down" to the FPG limit for his family size. This "spend down" will be determined on a quarterly basis; the quarter begins with the month of application. The amount by which the refugee's income exceeds one hundred fifty percent (150%) FPG for his family size on a monthly basis is determined by: (4-2-08)

a. Using the best estimate of income to be received during the quarter; and (4-2-08)

b. Multiplying the monthly excess by three (3) to determine the quarterly “spend down.” (4-2-08)

06. Counting Income ~~and Resources~~ for Refugee Medical Assistance with a “Spend Down.” (4-2-08)()

a. Income ~~and resources are~~ **is** counted or excluded in accordance with IDAPA 16.03.01, “Eligibility for Health Care Assistance for Families and Children.” The sole exception is that Refugee Cash Assistance is excluded from income ~~and resources~~ when determining eligibility for Refugee Medical Assistance. (4-2-08)()

b. The Federal Poverty Guideline applicable for the size of the family determines the amount to which an individual or family must “spend down” to be eligible for Refugee Medical Assistance. (4-2-08)

~~e. Total countable resources for the family must not exceed one thousand dollars (\$1,000).~~ (4-2-08)

~~d. Financial resources that are not available to the refugee, including resources remaining in his homeland, can not be considered in determining eligibility for Refugee Medical Assistance.~~ (4-2-08)

~~ec.~~ The income ~~and resources~~ of sponsors, and the in-kind services and shelter provided to refugees by their sponsors, will not be considered in determining eligibility for Refugee Medical Assistance. A shelter allowance must not be given for any in-kind shelter provided. (4-2-08)()

07. Financially Responsible Relatives. (4-2-08)

a. The Department must consider the income ~~and resources~~ of nonrefugee spouses or parents as available to the refugee whether or not they are actually contributed, if they live in the same household. (4-2-08)()

b. If the nonrefugee spouse or parent does not live with the individual, the Department must consider income ~~and resources~~ that are actually contributed by the spouse or parent as available to the refugee. (4-2-08)()

08. Deduction of Incurred Medical Expenses. If countable income exceeds one hundred fifty percent (150%) of the Federal Poverty Guidelines for the family size, the Department must deduct from income, in the following order, incurred medical expenses that are not subject to payment by a third party: (4-2-08)

a. Medicare premiums, other health insurance premiums, deductibles, or coinsurance charges incurred by the individual, family, or financially responsible relatives. (4-2-08)

b. Expenses incurred by the individual, family, or financially responsible relatives for necessary medical and remedial services not covered under the scope of the Medical Assistance Program. (4-2-08)

c. Expenses incurred by the individual, family, or financially responsible relatives for necessary medical and remedial services covered in the scope of the Medical Assistance Program. (4-2-08)

d. On a case by case basis, the Department may set reasonable limits on expenses to be deducted from income under Subsections 150.08.a. and 150.08.b. of this rule. (4-2-08)

09. Determining Eligibility for Refugee Medical Assistance for Refugees Who Must Meet a “Spend Down.” The refugee applicant must provide verification of expenses incurred pursuant to Subsection 150.08 of this rule. If the applicant has medical coverage from a third party, he must verify that charges will not be paid by this third party by providing an Explanation of Benefits or other written statement from the third party. (4-2-08)

a. As the applicant submits medical expenses, the charges should be added in the order listed in Subsection 150.08 of this rule. The expenses that come under Subsection 150.08.c. must be put in chronological order by the date of service. (4-2-08)

b. When the charges equal or exceed the amount of the “spend down,” the applicant becomes eligible for Refugee Medical Assistance. (4-2-08)

c. The date of eligibility is the date of service on the last bill which is covered under the scope of the Medical Assistance Program. (4-2-08)

d. It is the responsibility of the Department caseworker who is determining the applicant’s eligibility to determine when the “spend down” has been met. (4-2-08)

10. Issuing a Medical Card to a Refugee Who Must Meet a “Spend Down.” A Medical Card will not be issued until the applicant has met the “spend down.” The dates on the Medical Card under “Valid Only During” will be the date the applicant becomes eligible for Medicaid benefits “to” the last day of the last month in the quarter for which the “spend down” has been determined. (4-2-08)

11. Continued Coverage. If a refugee who is receiving Refugee Medical Assistance receives earnings from employment, the earnings do not affect the refugee’s continued eligibility for Refugee Medical Assistance. Once a refugee begins receiving Refugee Medical Assistance, he continues to receive it through his eighth month in the United States. (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

400. INCOME ~~AND RESOURCES~~ ON DATE OF APPLICATION.

Eligibility is determined using income ~~and resources~~ on the date of application. Income is not averaged over the application processing period. (4-2-08)()

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

Section 56-261, Idaho Code, directs the Department to implement managed care tools to develop an accountable care system to improve health outcomes. In order to comply, the State has implemented a federal 1915(b) Managed Care Waiver that requires Medicaid participants to enroll in the **Idaho Behavioral Health Plan (IBHP)**. This plan is structured as a statewide prepaid ambulatory health plan (PAHP) under 42 CFR 438.2. This allows the Department to make a prepaid capitated payment for each participant enrolled with the behavioral health managed care entity. These rule changes align this chapter with the managed care waiver.

These rule changes integrate mental health clinic services, psychosocial rehabilitative services, service coordination for adults with serious and persistent mental illness (SPMI), service coordination for children with serious emotional disturbance (SED), and substance use disorder services into behavioral health services.

All rules related to behavioral health services have been removed from IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," and moved into these rules. In addition, specific service limitations have been removed from the rules to allow for behavioral health services to be delivered individualized and evidence-based under a managed care structure, and requirements have been added to describe the responsibilities of the Department and the Department's designee **Optum Idaho**, a managed care contractor, to administer the behavioral health managed care delivery system.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule published in the August 7, 2013, Idaho Administrative Bulletin, **Vol. 13-8, pages 193 through 242**.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal

impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year:

There is no anticipated fiscal impact to the state general fund. The consolidation of mental health clinic services, psychosocial rehabilitative services, mental health service coordination, and substance use disorder service benefits into one program of behavioral health services provided through a managed care delivery system will be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Carolyn Burt at (208) 364-1844.

DATED this 3rd day of October, 2013.

Tamara Prisock P.O. Box 83720, Boise, ID 83720-0036
DHW - Administrative Rules Unit Phone: (208) 334-5500; Fax: (208) 334-6558
450 W. State Street - 10th Floor E-mail: dhwrules@dhw.idaho.gov

**THE FOLLOWING NOTICE WAS PUBLISHED WITH
THE TEMPORARY AND PROPOSED RULE**

EFFECTIVE DATE: The effective date of the temporary rule is **September 1, 2013**.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

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

Tuesday, August 20, 2013 6:00 p.m. P.D.T.	Wednesday, August 21, 2013 1:00 p.m. M.D.T.	Wednesday, August 21, 2013 6:00 p.m. M.D.T.
IDHW Region I Office (lrg. conf. room, lower level) 1120 Ironwood Dr., Suite 102 Coeur d'Alene, ID 83814	Medicaid Central Office (conf. rooms D-East & West) 3232 Elder Street Boise, ID 83705	IDHW Region VII Office (2nd flr., large conf. room) 150 Shoup Ave. Idaho Falls, ID 83402

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

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

and purpose of the proposed rulemaking:

Section 56-261, Idaho Code, directs the Department to implement managed care tools to develop an accountable care system to improve health outcomes. In order to comply, the State will implement a 1915(b) Waiver that will require Medicaid participants to enroll in a statewide prepaid ambulatory health plan (PAHP). Rule changes are being made to incorporate the managed care waiver changes into these rules.

Rule changes will integrate mental health clinic services, psychosocial rehabilitative services, service coordination for adults with severe and persistent mental illness (SPMI), service coordination for children with severe emotional disturbance (SED), and substance use disorder services into behavioral health services.

All rules related to behavioral health services are being removed from IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits" and moved into these rules. In addition, specific service limitations are being removed from the rule to allow for behavioral health services to be delivered individualized and evidence-based under a managed care structure, and requirements are being added to describe the responsibilities of the Department and the Department's designee (a managed care contractor) to administer the behavioral health managed care delivery system.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate because it confers a benefit. In compliance with Section 56-261, Idaho Code, that requires the Department to implement managed care systems whenever possible, these rule changes are necessary in order for the Department to confer the Idaho Medicaid Behavioral Health benefits under the applicable authority.

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: NA

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

There is no anticipated fiscal impact to the state general fund. The consolidation of mental health clinic services, psychosocial rehabilitative services, mental health service coordination, and substance use disorder service benefits into one program of behavioral health services provided through a managed care delivery system will be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this is a temporary rule being done to comply with the requirements in Section 56-261, Idaho Code.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-V) is being incorporated by reference into these rules to give it the force and effect of law. The document is not being reprinted in this chapter of rules due to its length and format and because of the cost for republication.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Carolyn Burt at (208) 364-1844.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 28, 2013.

DATED this 9th day of July, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1301

004. INCORPORATION BY REFERENCE.

The following are incorporated by reference in this chapter of rules: (3-30-07)

01. 42 CFR Part 447. 42 CFR Part 447, “Payment for Services,” revised as of October 1, 2001, is available from CMS, 7500 Security Blvd, Baltimore, M.D., 21244-1850 or on the Code of Federal Regulations internet site at <http://practice.aap.org/content.aspx?aid=1599>. (3-30-07)

02. American Academy of Pediatrics (AAP) Periodicity Schedule. This document is available on the internet at <http://practice.aap.org/content.aspx?aid=1599>. The schedule is also available at the Division of Medicaid, 3232 Elder Street, Boise, ID 83705. (3-30-07)

03. American Speech-Language-Hearing Association (ASHA): Medicaid Guidance for Speech-Language Pathology Services. The American Speech-Language-Hearing Association (2004) Medicaid Guidance for Speech-Language Pathology Services: Addressing the “Under the Direction of” Rule technical report is available on the internet at: <http://www.asha.org/docs/html/TR2004-00142.html>. The report may also be obtained at the ASHA National Office, 2200 Research Boulevard, Rockville, MD 20850-3289, telephone (301) 296-5700. (3-29-10)

04. CDC Child and Teen BMI Calculator. The Centers for Disease Control (CDC) Child and Teen Body Mass Index (BMI) Calculator is available on the internet at <http://www.cdc.gov/nccdphp/dnpa/bmi/index.htm>. The Calculator is also available through the Division of Medicaid, 3232 Elder Street, Boise, ID 83705. (3-30-07)

05. DSM-~~IV-TR~~. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, *Fourth Fifth* Edition, *Text Revision* (DSM-~~IV-TR~~) *Washington Arlington, DC VA*, American Psychiatric Association, 2000~~13~~. *Copies of the manual are*

~~available from the American Psychiatric Association, 1400 K Street, N.W., Washington, DC, 20005.~~ A copy of the manual is *also* available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702. (3-30-07)()

06. Estimated Useful Lives of Depreciable Hospital Assets, 2004 Revised Edition, Guidelines Lives. This document may be obtained from American Hospital Publishing, Inc., 211 East Chicago Avenue, Chicago, IL, 60611. (3-30-07)

07. Idaho Infant Toddler Program Implementation Manual (Revised September 1999). The full text of the "Idaho Infant Toddler Program Implementation Manual," revised September 1999, is available at <http://www.infanttoddler.idaho.gov>. (7-1-13)

08. Idaho Special Education Manual, September 2001. The full text of the "Idaho Special Education Manual, September 2001" is available on the Internet at http://www.sde.idaho.gov/site/special_edu/. A copy is also available at the Idaho Department of Education, 650 West State Street, P.O. Box 83720, Boise, Idaho 83720-0027. (3-30-07)

09. Medicare Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Jurisdiction D Supplier Manual 2007, As Amended. Since the supplier manual is amended on a quarterly basis by CMS, the current year's manual is being incorporated by reference, as amended, to allow for the incorporation of the most recent amendments to the manual. The full text of the Medicare. DME MAC Jurisdiction D Supplier Manual is available via the Internet at <https://www.noridianmedicare.com/dme/news/manual/index.html%3f>. (3-30-07)

10. Physician's Current Procedural Terminology (CPT® Manual). This document may be obtained from the American Medical Association, P.O. Box 10950, Chicago, Illinois 60610, or online at <http://www.ama-assn.org/ama/pub/category/3113.html>. (3-30-07)

11. Provider Reimbursement Manual (PRM). The Provider Reimbursement Manual (PRM), Part I and Part II (CMS Publication 15-1 and 15-2), is available on the CMS website at <http://www.cms.gov/Manuals/PBM/list.asp>. (3-30-07)

12. SIB-R Comprehensive Manual. Scales of Independent Behavior - Revised Comprehensive Manual, 1996, Riverside Publishing Co, 425 Spring Lake Drive, Itasca, IL 60143-2079. A copy is available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho 83702. (3-30-07)

13. Travel Policies and Procedures of the Idaho State Board of Examiners. The text of "Idaho State Travel Policies and Procedures of the Idaho State Board of Examiners," Appendices A and B, June 13, 2000, is available at the Office of the State Controller, 700 W. State St., 5th Fl., Box 83720, Boise, Idaho 83720-0011 or on the Internet at <http://www.sco.idaho.gov>. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Criminal History Check. Criminal history checks are required for certain types of providers under these rules. Providers who are required to have a criminal history check must comply with IDAPA 16.05.06, “Criminal History and Background Checks.” (3-30-07)

02. Availability to Work or Provide Service. (3-30-07)

a. The employer, at its discretion, may allow an individual to provide care or services on a provisional basis once the application for a criminal history and background check is completed and notarized, and the employer has reviewed the application for any disqualifying crimes or relevant records. The employer determines whether the individual could pose a health and safety risk to the vulnerable participants it serves. The individual is not allowed to provide care or services when the employer determines the individual has disclosed a disqualifying crime or relevant records. (3-30-07)

b. Those individuals licensed or certified by the Department are not available to provide services or receive licensure or certification until the criminal history and background check is completed and a clearance issued by the Department. (3-30-07)

03. 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. (3-30-07)

04. Providers Subject to Criminal History Check Requirements. The following providers must receive a criminal history clearance: (3-30-07)

~~**a.** *Mental Health Clinics. The criminal history check requirements applicable to mental health clinic staff are found in Subsection 714.05 of these rules.* (3-30-07)~~

ba. Contracted Non-Emergency Medical Transportation Providers. All staff of transportation providers having contact with participants must comply with IDAPA 16.05.06, “Criminal History and Background Checks,” with the exception of individual contracted transportation providers defined in Subsection 870.05 of these rules. (4-7-11)

~~**e.** *Substance Abuse Treatment Providers. The criminal history check requirements applicable to substance abuse treatment providers are found in Section 694 of these rules.* (5-8-09)~~

b. Provider types deemed by the Department to be at high risk for fraud, waste, and abuse under Subsection 200.02 of these rules must consent to comply with criminal background checks, including fingerprinting, in accordance with 42 CFR 455.434. ()

(BREAK IN CONTINUITY OF SECTIONS)

011. DEFINITIONS: I THROUGH O.

For the purposes of these rules, the following terms are used as defined below: (3-30-07)

01. ICF/ID. Intermediate Care Facility for People with Intellectual Disabilities. An ICF/ID is an entity licensed as an ICF/ID and federally certified to provide care to Medicaid and Medicare participants with developmental disabilities. (3-30-07)

02. Idaho Behavioral Health Plan (IBHP). The Idaho Behavioral Health Plan is a prepaid ambulatory health plan (PAHP) that provides outpatient behavioral health coverage for Medicaid-eligible children and adults. Outpatient behavioral health services include mental health and substance use disorder treatment as well as case management services. The coordination and provision of behavioral health services as authorized through the IBHP contract are provided to qualified, enrolled participants by a statewide network of professionally licensed and certified behavioral health providers. ()

023. Idaho Infant Toddler Program. The Idaho Infant Toddler Program serves children from birth up to three (3) years of age (36 months), and must meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. (7-1-13)

- a.** These requirements for the Idaho Infant Toddler Program include: (7-1-13)
- i. Adherence to procedural safeguards and time lines; (7-1-13)
 - ii. Use of multi-disciplinary assessments and Individualized Family Service Plans (IFSPs); (7-1-13)
 - iii. Provision of early intervention services in the natural environment; (7-1-13)
 - iv. Transition planning; and (7-1-13)
 - v. Program enrollment and reporting requirements. (7-1-13)
- b.** The Idaho Infant Toddler Program may provide the following services for Medicaid reimbursement: (7-1-13)
- i. Occupational therapy; (7-1-13)
 - ii. Physical therapy; (7-1-13)
 - iii. Speech-language pathology; (7-1-13)
 - iv. Audiology; and (7-1-13)

v. Children's developmental disabilities services defined under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-13)

034. In-Patient Hospital Services. Services that are ordinarily furnished in a hospital for the care and treatment of an in-patient under the direction of a physician or dentist except for those services provided in mental hospitals. (3-30-07)

045. Intermediary. Any organization that administers Title XIX or Title XXI; in this case the Department of Health and Welfare. (3-30-07)

056. Intermediate Care Facility Services. Those services furnished in an intermediate care facility as defined in 42 CFR 440.150, but excluding services provided in a Christian Science Sanatorium. (3-30-07)

067. Legal Representative. A parent with custody of a minor child, one who holds a legally-executed and effective power of attorney for health decisions, or a court-appointed guardian whose powers include the power to make health care decisions. (3-30-07)

078. Legend Drug. A drug that requires, by federal regulation or state rule, the order of a licensed medical practitioner before dispensing or administration to the patient. (3-30-07)

089. Level of Care. The classification in which a participant is placed, based on severity of need for institutional care. (3-30-07)

109. Licensed, Qualified Professionals. Individuals licensed, registered, or certified by national certification standards in their respective discipline, or otherwise qualified within the state of Idaho. (3-30-07)

101. Lock-In Program. An administrative sanction, required of a participant found to have misused the services provided by the Medical Assistance Program. The participant is required to select one (1) provider in the identified area(s) of misuse to serve as the primary provider. (3-30-07)

112. Locum Tenens/Reciprocal Billing. The practice of a physician to retain a substitute physician when the regular physician is absent for reasons such as illness, pregnancy, vacation, or continuing medical education. The substitute physician is called the "Locum Tenens" physician. Reimbursement to a Locum Tenens physician will be limited to a period of ninety (90) continuous days. Reciprocal billing occurs when a substitute physician covers the regular physician during an absence or on an on-call basis a period of fourteen (14) continuous days or less. (3-30-07)

123. Medical Assistance. Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act, as amended. (3-30-07)

134. Medicaid. Idaho's Medical Assistance Program. (3-30-07)

145. Medicaid-Related Ancillary Costs. For the purpose of these rules, those services

considered to be ancillary by Medicare cost reporting principles. Medicaid-related ancillary costs will be determined by apportioning direct and indirect costs associated with each ancillary service to Medicaid participants by dividing Medicaid charges into total charges for that service. The resulting percentage, when multiplied by the ancillary service cost, will be considered Medicaid-related ancillaries. (3-30-07)

156. Medical Necessity (Medically Necessary). A service is medically necessary if: (3-30-07)

a. It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; and (3-30-07)

b. There is no other equally effective course of treatment available or suitable for the participant requesting the service which is more conservative or substantially less costly. (3-30-07)

c. Medical services must be of a quality that meets professionally-recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the Department upon request. (3-30-07)

167. Medical Supplies. Items excluding drugs, biologicals, and equipment furnished incident to a physician's professional services commonly furnished in a physician's office or items ordered by a physician for the treatment of a specific medical condition. These items are generally not useful to an individual in the absence of an illness and are consumable, nonreusable, disposable, and generally have no salvage value. Surgical dressings, ace bandages, splints and casts, and other devices used for reduction of fractures or dislocations are considered supplies. (3-30-07)

178. Midwife. An individual qualified as one of the following: (3-29-12)

a. Licensed Midwife. A person who is licensed by the Idaho Board of Midwifery under Title 54, Chapter 55, Idaho Code, and IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery." (3-29-12)

b. Nurse Midwife (NM). An advanced practice professional nurse who is licensed by the Idaho Board of nursing and who meets all the applicable requirements to practice as a nurse midwife under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (3-29-12)

189. Nominal Charges. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the services provided. (3-30-07)

1920. Nonambulatory. Unable to walk without assistance. (3-30-07)

201. Non-Legend Drug. Any drug the distribution of which is not subject to the

ordering, dispensing, or administering by a licensed medical practitioner. (3-30-07)

242. Nurse Practitioner (NP). A registered nurse or licensed professional nurse (RN) who meets all the applicable requirements to practice as nurse practitioner under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, “Rules of the Idaho Board of Nursing.” (7-1-13)

243. Nursing Facility (NF). An institution, or distinct part of an institution, that is primarily engaged in providing skilled nursing care and related services for participants. It is an entity licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare participants. Participants must require medical or nursing care, or rehabilitation services for injuries, disabilities, or sickness. (3-30-07)

244. Orthotic. Pertaining to or promoting the support of an impaired joint or limb. (3-30-07)

245. Outpatient Hospital Services. Preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to a patient not in need of inpatient hospital care. (3-30-07)

256. Out-of-State Care. Medical service that is not provided in Idaho or bordering counties is considered out-of-state. Bordering counties outside Idaho are considered out-of-state for the purpose of authorizing long term care. (3-30-07)

267. Oxygen-Related Equipment. Equipment which is utilized or acquired for the routine administration of oxygen in the home. This includes oxygen tanks, regulators, humidification nebulizers, oxygen concentrators, and related equipment. Equipment which is used solely for the administration of medication into the lungs is excluded from this definition. (3-30-07)

012. DEFINITIONS: P THROUGH Z.

For the purposes of these rules, the following terms are used as defined below: (3-30-07)

01. Participant. A person eligible for and enrolled in the Idaho Medical Assistance Program. (3-30-07)

02. Patient. The person undergoing treatment or receiving services from a provider. (3-30-07)

03. Physician. A person possessing a Doctorate of Medicine degree or a Doctor of Osteopathy degree and licensed to practice medicine by a State or United States territory. (3-30-07)

04. Physician Assistant (PA). A person who meets all the applicable requirements to practice as licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, “Rules for the Licensure of Physician Assistants.” (3-30-07)

05. Plan of Care. A written description of medical, remedial, or rehabilitative services to be provided to a participant, developed by or under the direction and written approval of a

physician. Medications, services and treatments are identified specifically as to amount, type and duration of service. (3-30-07)

06. Prepaid Ambulatory Health Plan (PAHP). As defined in 42 CFR 438.2, a PAHP is an entity that provides medical services to enrollees under contract with the Department on the basis of prepaid capitation payments, or other arrangements that do not use State Plan payment rates. The PAHP does not provide or arrange for, and is not responsible for the provision of any inpatient hospital or institutional services for its enrollees, and does not have a comprehensive risk contract. ()

067. Private Rate. Rate most frequently charged to private patients for a service or item. (3-30-07)

078. PRM. Provider Reimbursement Manual. (3-30-07)

089. Property. The homestead and all personal and real property in which the participant has a legal interest. (3-30-07)

109. Prosthetic Device. Replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts profession within the scope of his practice as defined by state law to: (3-30-07)

- a. Artificially replace a missing portion of the body; or (3-30-07)
- b. Prevent or correct physical deformities or malfunctions; or (3-30-07)
- c. Support a weak or deformed portion of the body. (3-30-07)
- d. Computerized communication devices are not included in this definition of a prosthetic device. (3-30-07)

101. Provider. Any individual, partnership, association, corporation or organization, public or private, that furnishes medical goods or services in compliance with these rules and who has applied for and received a Medicaid provider number and who has entered into a written provider agreement with the Department in accordance with Section 205 of these rules. (3-30-07)

112. Provider Agreement. A written agreement between the provider and the Department, entered into in accordance with Section 205 of these rules. (3-30-07)

123. Provider Reimbursement Manual (PRM). A federal publication that specifies accounting treatments and standards for the Medicare program, CMS Publications 15-1 and 15-2, that are incorporated by reference in Section 004 of these rules. (3-30-07)

134. Prudent Layperson. A person who possesses an average knowledge of health and medicine. (3-30-07)

145. Psychologist, Licensed. A person licensed to practice psychology in Idaho under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State

Board of Psychologist Examiners.” (3-30-07)

156. Psychologist Extender. A person who practices psychology under the supervision of a licensed psychologist as required under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, “Rules of the Idaho State Board of Psychologist Examiners,” and who is registered with the Bureau of Occupational Licenses. (3-30-07)

167. Public Provider. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (3-30-07)

178. Quality Improvement Organization (QIO). An organization that performs utilization and quality control review of health care furnished to Medicare and Medicaid participants. A QIO is formerly known as a Peer Review Organization (PRO). (3-30-07)

189. Related Entity. An organization with which the provider is associated or affiliated to a significant extent, or has control of, or is controlled by, that furnishes the services, facilities, or supplies for the provider. (3-30-07)

1920. R.N. Registered Nurse, which in the State of Idaho is known as a Licensed Professional Nurse. (3-30-07)

201. Rural Health Clinic (RHC). An outpatient entity that meets the requirements of 42 USC Section 1395x(aa)(2). It is primarily engaged in furnishing physicians and other medical and health services in rural, federally-defined, medically underserved areas, or designated health professional shortage areas. (3-30-07)

242. Rural Hospital-Based Nursing Facilities. Hospital-based nursing facilities not located within a metropolitan statistical area (MSA) as defined by the United States Bureau of Census. (3-30-07)

223. Social Security Act. 42 USC 101 et seq., authorizing, in part, federal grants to the states for medical assistance to low-income persons who meet certain criteria. (3-30-07)

234. State Plan. The contract between the state and federal government under 42 USC Section 1396a(a). (3-30-07)

245. Supervision. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (3-30-07)

256. Title XVIII. Title XVIII of the Social Security Act, known as Medicare, for aged, blind, and disabled individuals administered by the federal government. (3-30-07)

267. Title XIX. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources. (3-30-07)

278. Title XXI. Title XXI of the Social Security Act, known as the State Children's

Health Insurance Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children. (3-30-07)

289. Third Party. Includes a person, institution, corporation, public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a medical assistance participant. (3-30-07)

2930. Transportation. The physical movement of a participant to and from a medical appointment or service by the participant, another person, taxi or common carrier. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

150. CHOICE OF PROVIDERS.

01. Service Selection. Each participant may obtain any services available from any participating institution, agency, pharmacy, or practitioner of his choice, unless enrolled in Healthy Connections or a Prepaid Ambulatory Health Plan (PAHP) that limits provider choice. This, however, does not prohibit the Department from establishing the fees which will be paid to providers for furnishing medical and remedial care available under the Medical Assistance Program, or from setting standards relating to the qualifications of providers of such care.

(3-30-07)()

02. Lock-In Option. (3-30-07)

a. The Department may implement a total or partial lock-in program for any participant found to be misusing the Medical Assistance Program according to provisions in Sections 910 through 918 of these rules. (3-30-07)

b. In situations where the participant has been restricted to a participant lock-in program, that participant may choose the physician and pharmacy of his choice. The providers chosen by the lock-in participant will be identified in the Department's Eligibility Verification System (EVS). This information will be available to any Medicaid provider who accesses the EVS. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

230. GENERAL PAYMENT PROCEDURES.

01. Provided Services. (3-30-07)

a. Each participant may consult a participating physician or provider of his choice for care and receive covered services by presenting his identification card to the provider, subject to

restrictions imposed by ~~a~~ participation in Healthy Connections or enrollment in a Prepaid Ambulatory Health Plan (PAHP). ~~(3-30-07)~~()

b. The provider must obtain the required information by using the Medicaid number on the identification card from the Electronic Verification System and transfer the required information onto the appropriate claim form. Where the Electronic Verification System (EVS) indicates that a participant is enrolled in Healthy Connections, the provider must obtain a referral from the primary care provider. Claims for services provided to participant designated as participating in Healthy Connections by other than the primary care provider, without proper referral, will not be paid. (3-30-07)

c. Upon providing the care and services to a participant, the provider or his agent must submit a properly completed claim to the Department. (3-30-07)

d. The Department is to process each claim received and make payment directly to the provider. (3-30-07)

e. The Department will not supply claim forms. Forms needed to comply with the Department's unique billing requirements are included in Appendix D of the Idaho Medicaid Provider Handbook. (3-30-07)

02. Individual Provider Reimbursement. The Department will not pay the individual provider more than the lowest of: (3-30-07)

a. The provider's actual charge for service; or (3-30-07)

b. The maximum allowable charge for the service as established by the Department on its pricing file, if the service or item does not have a specific price on file, the provider must submit documentation to the Department and reimbursement will be based on the documentation; or (3-30-07)

c. The Medicaid-allowed amount minus the Medicare payment or the Medicare co-insurance and deductible amounts added together when a participant has both Medicare and Medicaid. (3-30-07)

03. Services Normally Billed Directly to the Patient. If a provider delivers services and it is customary for the provider to bill patients directly for such services, the provider must complete the appropriate claim form and submit it to the Department. (3-30-07)

04. Reimbursement for Other Noninstitutional Services. The Department will reimburse for all noninstitutional services which are not included in other Idaho Department of Health and Welfare Rules, but allowed under Idaho's Medical Assistance Program according to the provisions of 42 CFR Section 447.325. (3-30-07)

05. Review of Records. (3-30-07)

a. The Department, or its duly authorized agent, the U.S. Department of Health and Human Services, and the Bureau of Audits and Investigations have the right to review pertinent

records of providers receiving Medicaid reimbursement for covered services. (3-30-07)

b. The review of participants' medical and financial records must be conducted for the purposes of determining: (3-30-07)

- i. The necessity for the care; or (3-30-07)
- ii. That treatment was rendered in accordance with accepted medical standards of practice; or (3-30-07)
- iii. That charges were not in excess of the provider's usual and customary rates; or (3-30-07)
- iv. That fraudulent or abusive treatment and billing practices are not taking place. (3-30-07)

c. Refusal of a provider to permit the Department to review records pertinent to medical assistance will constitute grounds for: (3-30-07)

- i. Withholding payments to the provider until access to the requested information is granted; or (3-30-07)
- ii. Suspending the provider's number. (3-30-07)

06. Lower of Cost or Charges. Payment to providers, other than public providers furnishing such services free of charge or at nominal charges to the public, is the lesser of the reasonable cost of such services or the customary charges with respect to such services. Public providers that furnish services free of charge or at a nominal charge are reimbursed fair compensation which is the same as reasonable cost. (3-30-07)

07. Procedures for Medicare Cross-Over Claims. (3-30-07)

a. If a medical assistance participant is eligible for Medicare, the provider must first bill Medicare for the services rendered to the participant. (3-30-07)

b. If a provider accepts a Medicare assignment, the Department will pay the provider for the services, up to the Medicaid allowable amount minus the Medicare payment, and forward the payment to the provider automatically based upon the Medicare Summary Notice (MSN) information on the computer tape which is received from the Medicare Part B Carrier on a weekly basis. (3-30-07)

c. If a provider does not accept a Medicare assignment, a MSN must be attached to the appropriate claim form and submitted to the Department. The Department will pay the provider for the services, up to the Medicaid allowable amount minus the Medicare payment. (3-30-07)

d. For all other services, a MSN must be attached to the appropriate claim form and submitted to the Department. The Department will pay the provider for the services up to the

Medicaid allowable amount minus the Medicare payment. (3-30-07)

08. Services Reimbursable After the Appeals Process. Reimbursement for services originally identified by the Department as not medically necessary will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

399. COVERED SERVICES UNDER BASIC PLAN BENEFITS.

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

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

- a. Inpatient Hospital Services are described in Sections 400 through 406. (3-30-07)
- b. Outpatient Hospital Services are described in Sections 410 through 416. (3-30-07)
- c. Reconstructive Surgery services are described in Sections 420 through 426. (3-30-07)
- d. Surgical procedures for weight loss are described in Sections 430 through 436. (3-30-07)
- e. Investigational procedures or treatments are described in Sections 440 through 446. (3-30-07)

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

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

- a. Physician services are described in Sections 500 through 506. (3-30-07)
- b. Abortion procedures are described in Sections 510 through 516. (3-30-07)

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

- a. Midlevel practitioner services are described in Sections 520 through 526.

- (3-30-07)
- b.** Chiropractic services are described in Sections 530 through 536. (3-30-07)
 - c.** Podiatrist services are described in Sections 540 through 545. (3-29-12)
 - d.** Licensed midwife (LM) services are described in Sections 546 through 552. (3-29-12)
 - e.** Optometrist services are described in Sections 553 through 556. (3-29-12)
- 05. Primary Care Case Management.** Primary care case management services are described in Sections 560 through 579 of these rules. (5-8-09)
- a.** Healthy Connections services are described in Sections 560 through 566. (4-4-13)
 - b.** Health Home services are described in Sections 570 through 576. (4-4-13)
- 06. Prevention Services.** The range of prevention services covered is described in Sections 580 through 649 of these rules. (4-4-13)
- a.** Child Wellness Services are described in Sections 580 through 586. (3-30-07)
 - b.** Adult Physical Services are described in Sections 590 through 596. (3-30-07)
 - c.** Screening mammography services are described in Sections 600 through 606. (3-30-07)
 - d.** Diagnostic Screening Clinic services are described in Sections 610 through 614. (4-4-13)
 - e.** Additional Assessment and Evaluation services are described in Section 615. (4-4-13)
 - f.** Health Questionnaire Assessment is described in Section 618. (4-4-13)
 - g.** Preventive Health Assistance benefits are described in Sections 620 through 626. (5-8-09)
 - h.** Nutritional services are described in Sections 630 through 636. (3-30-07)
 - i.** Diabetes Education and Training services are described in Sections 640 through 646. (3-30-07)
- 07. Laboratory and Radiology Services.** Laboratory and radiology services are described in Sections 650 through 659 of these rules. (5-8-09)
- 08. Prescription Drugs.** Prescription drug services are described in Sections 660

through 679 of these rules. (5-8-09)

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

10. ~~Substance Abuse Treatment Services.~~ Services for substance abuse treatment are described in Sections 690 through 699 of these rules. Outpatient Behavioral Health Services. Community-based outpatient services for behavioral health treatment are described in Sections 707 through 711 of these rules. (5-8-09)()

~~11. Mental Health Services.~~ The range of covered Mental Health services are described in Sections 700 through 719 of these rules. (5-8-09)

~~11.~~ Inpatient Psychiatric Hospital Services. Inpatient Psychiatric Hospital services are described in Sections 700 through 706. (3-30-07)()

~~b. Mental Health Clinic services are described in Sections 707 through 719. (4-4-13)~~

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

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

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

15. Durable Medical Equipment and Supplies. The range of covered durable medical equipment and supplies is described in Sections 750 through 779 of these rules. (5-8-09)

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

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

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

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

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

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

- a. Rural health clinic services are described in Sections 820 through 826. (3-30-07)
 - b. Federally Qualified Health Center services are described in Sections 830 through 836. (3-30-07)
 - c. Indian Health Services Clinic services are described in Sections 840 through 846. (3-30-07)
 - d. School-Based services are described in Sections 850 through 856~~7~~. ~~(3-30-07)~~()
- 19. Transportation.** The range of covered transportation services is described in Sections 860 through 879 of these rules. (5-8-09)
- a. Emergency transportation services are described in Sections 860 through 866. (3-30-07)
 - b. Non-emergency medical transportation services are described in Sections 870 through 876. (4-4-13)
- 20. EPSDT Services.** EPSDT services are described in Sections 880 through 889 of these rules. (5-8-09)
- 21. Specific Pregnancy-Related Services.** Specific pregnancy-related services are described in Sections 890 through 899 of these rules. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

500. PHYSICIAN SERVICES: DEFINITIONS.

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

02. Psychiatric Telehealth. Psychiatric Telehealth is an electronic real time synchronous audio-visual contact between a physician and participant related to the treatment of the participant. The participant is in one (1) location, called the hub site, with specialized equipment including a video camera and monitor, and with the hosting provider. The physician is at another location, called the spoke site, with specialized equipment. The physician and participant interact as if they were having a face-to-face service. This rule does not apply to outpatient behavioral health services provided through the Idaho Behavioral Health Plan (IBHP) that are delivered via telehealth methods. ~~(5-8-09)~~()

501. (RESERVED)

502. PHYSICIAN SERVICES: COVERAGE AND LIMITATIONS.

01. Outpatient Psychiatric Mental Health Services. Physician services not provided through the IBHP as ~~o~~ outpatient psychiatric mental health services are limited to twelve (12) hours of psychiatric evaluations per eligible participant in any twelve (12) month period; and any combination of individual or group psychotherapy services provided by a physician up to a maximum of forty-five (45) hours of service in the consecutive twelve (12) months period beginning with the first such service. ~~(3-30-07)~~()

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

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

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

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

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

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

08. Psychiatric Telehealth. Payment for psychiatric telehealth services not provided through the IBHP is limited to psychiatric services for diagnostic assessments, pharmacological management, and psychotherapy with evaluation and management services twenty (20) to thirty (30) minutes in duration. Reimbursement is not available for a telephone conversation, electronic mail message (e-mail), or facsimile transmission (fax) between a physician and a participant. Service will not be reimbursed when provided via a videophone or webcam. ~~(5-8-09)~~()

(BREAK IN CONTINUITY OF SECTIONS)

611. -- 614~~5~~. (RESERVED)

~~615. ADDITIONAL ASSESSMENT AND EVALUATION SERVICES.~~

~~In addition to evaluations for services as defined in this Chapter, the Department will reimburse for the following evaluations if needed to determine eligibility for Medicaid Enhanced Plan Benefits. (3-30-07)~~

~~**01. Enhanced Mental Health Services.** Enhanced mental health services are not covered under the Basic Plan with the exception of assessment services. The assessment for determination of need for enhanced mental health services is subject to the requirements for comprehensive assessments at IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 114, and provider qualifications under Section 715 of these rules and under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 130 and 131. (3-29-12)~~

~~**02. Service Coordination Services.** Service coordination services are not covered under the Basic Plan, with the exception of assessment services. The assessment for the need for service coordination services is subject to the requirements for service coordination under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 727.03, as applicable to the service being requested, and provider qualifications under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 729. (3-30-07)~~

(BREAK IN CONTINUITY OF SECTIONS)

686. -- 689. (RESERVED)

**~~SUB AREA: SUBSTANCE ABUSE TREATMENT SERVICES
(Sections 690 Through 699)~~**

~~690. SUBSTANCE ABUSE TREATMENT SERVICES: DEFINITIONS.~~

~~The following definitions apply to Sections 690 through 696 of these rules. (5-8-09)~~

~~**01. Assessment Services.** Assessment services include annual assessment, interviewing, and treatment plan building. (5-8-09)~~

~~**02. Case Management Services.** Case management services consist of the following: (5-8-09)~~

~~**a.** Finding, arranging, and assisting the participant to gain access to and maintain appropriate services, supports, and community resources. (5-8-09)~~

~~**b.** Monitoring participant's progress to verify that services are received and are satisfactory to the participant, ascertaining that services meet the participant's needs, documenting progress and any revisions in services needed, and making alternative arrangements if services become unavailable to the participant. (5-8-09)~~

- ~~e. Planning services with the participant that include both community reintegration planning and exit planning. (5-8-09)~~
- ~~03. **Drug Testing.** A urinalysis test used to detect the presence of alcohol or drugs. (5-8-09)~~
- ~~04. **Family Therapy.** Service provided jointly to a participant and the participant's family. The desired outcome is the elimination or reduction of alcohol and drug use and arresting, reversing, or retarding of problems associated with alcohol or drug abuse, or both. Family therapy sessions are for the exclusive benefit of the participant. (5-8-09)~~
- ~~05. **Group Counseling.** Service provided to participants in a peer group setting. The desired outcome is the elimination or reduction of alcohol and drug use and arresting, reversing, or retarding of problems associated with alcohol or drug abuse, or both. (5-8-09)~~
- ~~06. **Individual Counseling.** Service provided to a participant in a one-on-one setting with one (1) participant and one (1) counselor. The desired outcome is the elimination or reduction of alcohol and drug use and arresting, reversing, or retarding of problems associated with alcohol or drug abuse, or both. (5-8-09)~~
- ~~07. **Qualified Substance Abuse Treatment Professional.** A person who has one thousand forty (1,040) hours of supervised experience providing substance abuse treatment and meets one (1) of the criteria listed in Subsection 690.07.a. through 690.07.g. of this rule. (5-8-09)~~
- ~~a. Alcohol and drug counselor certified by the Idaho Board of Alcohol/Drug Counselor's Certification, Inc. (CADC or Advanced CADC); (5-8-09)~~
- ~~b. Licensed professional counselor or licensed clinical professional counselor; (5-8-09)~~
- ~~c. Licensed physician; (5-8-09)~~
- ~~d. Licensed psychologist; (5-8-09)~~
- ~~e. Mid-level practitioner including licensed physician assistant, nurse practitioner or clinical nurse specialist; (5-8-09)~~
- ~~f. Licensed clinical social worker or licensed master social worker; (5-8-09)~~
- ~~g. Licensed marriage and family therapist; or (5-8-09)~~
- ~~h. Qualified substance abuse treatment professional. (5-8-09)~~
- ~~08. **Unit.** An increment of fifteen (15) minutes of time. (5-8-09)~~

~~691. **SUBSTANCE ABUSE TREATMENT SERVICES: PARTICIPANT ELIGIBILITY.** Each participant must meet the intake eligibility screening criteria described in IDAPA 16.07.17,~~

~~“Alcohol and Substance Use Disorders Services.” (5-8-09)~~

~~**692. SUBSTANCE ABUSE TREATMENT SERVICES: COVERAGE AND LIMITATIONS.**~~

~~**01. Inclusion Services.** The services listed in Subsections 692.01.a. through 692.01.f. of this rule are covered including any limitation on the service for substance abuse treatment. (5-8-09)~~

~~**a.** Assessment services are limited to thirty-two (32) units annually. Each assessment is valid for six (6) months and must meet the requirements in IDAPA 16.07.17, “Alcohol and Substance Use Disorders Services.” (5-8-09)~~

~~**b.** Case management services are limited to two hundred and twenty (220) units annually and must not exceed sixteen (16) units per week. Case management services for substance abuse treatment are not covered when the participant is enrolled in any service coordination services described in IDAPA 16.03.10, “Medicaid Enhanced Plan Benefits.” Case management is only provided on an outpatient basis to participants who are at risk of being institutionalized. (5-8-09)~~

~~**c.** Drug testing is limited to three (3) tests per week. (5-8-09)~~

~~**d.** Family therapy services are limited to eight (8) units per week. (5-8-09)~~

~~**e.** Group counseling services are limited to forty-eight (48) units per week. (5-8-09)~~

~~**f.** Individual counseling services are limited to forty-eight (48) units per week. (5-8-09)~~

~~**02. Lifetime Cap.** Substance abuse treatment services provided under this chapter of rules are limited to a lifetime cap of five (5) years. The five-year period begins on the date of the initial assessment, regardless of the source of payment for that assessment. This lifetime cap applies only to participants twenty-two (22) years of age or older. (5-8-09)~~

~~**03. Excluded Services.** Services specifically excluded are described in IDAPA 16.07.17, “Alcohol and Substance Use Disorders Services,” residential services, and life skills training services. (5-8-09)~~

~~**693. SUBSTANCE ABUSE TREATMENT SERVICES: PROCEDURAL REQUIREMENTS.**~~

~~**01. Assessment.** Each participant must receive a biopsychosocial assessment of the participant's alcohol or substance abuse treatment needs. This assessment must meet the requirements in IDAPA 16.07.20, “Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs,” and IDAPA 16.07.17, “Alcohol and Substance Use Disorders Services,” and utilize a Department approved standardized assessment tool. (5-8-09)~~

~~**02. Treatment Plan.** The assessment must be used to develop an individualized~~

~~treatment plan for each participant. The development and content of the treatment plan must meet the requirements in IDAPA 16.07.20, "Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs," and IDAPA 16.07.17, "Alcohol and Substance Use Disorders Services."~~ (5-8-09)

~~**03. Treatment Services.** Substance abuse treatment services necessary to meet participant needs must be identified in the individualized treatment plan. The treatment services must meet the requirements in IDAPA 16.07.17, "Alcohol and Substance Use Disorders Services."~~ (5-8-09)

~~**04. Records.** Each treatment provider must maintain a written record for each participant. The record must meet the standards required for client records in IDAPA 16.07.20, "Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs."~~ (5-8-09)

~~**05. Prior Authorization.** Substance abuse treatment services must be prior authorized by the Department or its designee as required in IDAPA 16.07.20, "Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs."~~ (5-8-09)

~~**06. Healthy Connections Referral.** A referral from the participant's Healthy Connections provider is required for substance abuse treatment services when the participant is enrolled in Healthy Connections.~~ (5-8-09)

~~**604. SUBSTANCE ABUSE TREATMENT SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.**~~

~~**01. Provider Network.** Each provider of substance abuse treatment services must maintain a network of approved programs and treatment facilities that meet the requirements in IDAPA 16.07.20, "Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs."~~ (5-8-09)

~~**02. Certificate of Approval for Programs and Facilities.** Each program and facility providing substance abuse treatment services must meet the applicable approval and certification requirements described in IDAPA 16.07.20, "Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs." An agency must have a certificate of approval issued by the Department prior to staff providing substance abuse treatment services.~~ (5-8-09)

~~**03. Criminal History Check.** Agency staff providing services to participants must have a criminal history check as provided in Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks."~~ (5-8-09)

~~**04. Assessment.** Assessment must be conducted by a qualified substance abuse treatment professional who is certified to administer the standardized assessment tool being used.~~ (5-8-09)

~~**05. Therapy and Counseling Services.** Therapy and counseling services must be provided by a qualified substance abuse treatment professional.~~ (5-8-09)

~~06. Case Management. Case management services must be provided by a qualified substance abuse treatment professional. (5-8-09)~~

~~695. SUBSTANCE ABUSE TREATMENT SERVICES: PROVIDER REIMBURSEMENT. Each covered substance abuse treatment service, except drug testing, is reimbursed by units. Each unit is equal to fifteen (15) minutes of service provided. (5-8-09)~~

~~696. SUBSTANCE ABUSE TREATMENT SERVICES: QUALITY ASSURANCE.~~

~~01. Quality Assurance. Alcohol and drug programs are subject to the quality assurance provisions described in IDAPA 16.07.20, "Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs." (5-8-09)~~

~~02. Department Performance Measurements. The Department will establish performance measurements to evaluate the effectiveness of substance abuse treatment services. The measurements will be reviewed at least annually and adjusted as necessary to provide effective outcomes and quality services. (5-8-09)~~

~~697.—699. (RESERVED)~~

SUB AREA: ~~MENTAL~~ **BEHAVIORAL** Health Services
(Sections 700 -- 719)

(BREAK IN CONTINUITY OF SECTIONS)

~~707. MENTAL HEALTH CLINIC SERVICES: DEFINITIONS~~ **OUTPATIENT BEHAVIORAL HEALTH SERVICES.**

Outpatient behavioral health services are contained in the "Idaho Behavioral Health Plan" (IBHP) that is authorized by a 1915(b) waiver authority and delivered under a PAHP contract. The IBHP allows for the contractor to provide the administration of community-based outpatient behavioral health services for individuals, based on medical necessity, that include therapeutic and rehabilitative treatment intended to minimize symptoms of mental illness, emotional disturbance, and substance use disorders. These services also help restore independent functioning to the greatest extent possible. For more information, please visit the IBHP website at: <http://www.optumidaho.com/>. ()

~~01. Adult. An adult is an individual who is eighteen (18) years of age or older for the purposes of Mental Health Clinic and other outpatient mental health services. (3-30-07)~~

~~02. Comprehensive Diagnostic Assessment. A thorough assessment of the participant's current condition and complete medical and psychiatric history. (5-8-09)~~

~~03. Comprehensive Diagnostic Assessment Addendum. A supplement to the~~

~~comprehensive diagnostic assessment that contains updated information relevant to the formulation of a participant's diagnosis and disposition for treatment. (3-29-12)~~

~~**04. Interdisciplinary Team.** Group that consists of two (2) or more individuals in addition to the participant, the participant's parent or legal guardian, and the participant's natural supports. This may include professionals from several fields or professions. Team members combine their skills and resources to provide guidance and assistance in the creation of the participant's treatment plan. Professionals working with the participant to fulfill the goals and objectives on the treatment plan are members of the participant's interdisciplinary team whether they attend treatment plan meetings or not. At a minimum, professional members of the team include the medical professional authorizing the treatment plan and the specific agency staff member who is working with the participant. (5-8-09)~~

~~**05. Level of Care.** Clinical treatment decisions that determine service site, modality, urgency, and specific interventions needed to address the key presenting signs, symptoms, and environmental factors that indicate the severity of illness and the intensity of service needed by the participant. It also takes into account relevant external factors affecting clinical treatment decisions. (5-8-09)~~

~~**06. Licensed Practitioner of the Healing Arts.** A licensed physician, physician assistant, nurse practitioner, or clinical nurse specialist. The nurse practitioner and clinical nurse specialist must have experience prescribing medications for psychiatric disorders. (5-8-09)~~

~~**07. Mental Health Clinic.** A mental health clinic, also referred to as "agency," must be a proprietorship, partnership, corporation, or other entity, in a distinct location, employing at least two (2) staff qualified to deliver clinic services under this rule and operating under the direction of a physician. (3-30-07)~~

~~**08. Neuropsychological Testing.** Assessment of brain functioning through structured and systematic behavioral observation. Neuropsychological tests are designed to examine a variety of cognitive abilities, including speed of information processing, attention, memory, language, and executive functions, which are necessary for goal-directed behavior. These data can provide information leading to the diagnosis of a cognitive deficit or to the confirmation of a diagnosis, as well as to the localization of organic abnormalities in the central nervous system; the data can also guide effective treatment methods for the rehabilitation of impaired participants. (5-8-09)~~

~~**09. New Participant.** A participant is considered "new" if he has not received Medicaid-reimbursable mental health clinic or psychosocial rehabilitation services (PSR) in the twelve (12) months prior to the current treatment episode. (3-29-12)~~

~~**10. Objective.** A milestone toward meeting the goal that is concrete, measurable, time-limited, and identifies specific behavior changes. (5-8-09)~~

~~**11. Occupational Therapy.** For the purposes of mental health treatment, the use of purposeful, goal-oriented activity to achieve optimum functional performance and independence, prevent further disability, and maintain health with individuals who are limited by the symptoms of their mental illness. (5-8-09)~~

~~12. **Pharmacological Management.** The in-depth management of medications for psychiatric disorders for relief of a participant's signs and symptoms of mental illness, provided by a licensed practitioner of the healing arts. (5-8-09)~~

~~13. **Psychiatric Nurse, Licensed Master's Level.** A certified psychiatric nurse, Clinical Nurse Specialist or Psychiatric Nurse Practitioner, must be licensed in accordance with Title 54, Chapter 14, Idaho Code, or certified by a recognized national certification organization, and have a minimum of a master's degree. (3-30-07)~~

~~14. **Psychological Testing.** Psychological testing refers to any measurement procedure for assessing psychological characteristics in which a sample of an examinee's behavior is obtained and subsequently evaluated and scored using a standardized process. This does not refer to assessments that are otherwise conducted by a professional within the scope of his license for the purposes of determining a participant's mental status, diagnoses or functional impairments. (3-30-07)~~

~~15. **Psychotherapy.** A method of treating and managing psychiatric disorders through the use of evidenced-based psychological treatment modalities that match the participant's ability to benefit from the service. The focus of the service is on behavioral, emotional, and cognitive aspects of a participant's functioning. (5-8-09)~~

~~16. **Restraints.** Restraints include the use of physical, mechanical, or chemical interventions, or other means to temporarily subdue or modify participant behavior. (5-8-09)~~

~~a. A restraint includes: (5-8-09)~~

~~i. Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a participant to move his arms, legs, body, or head freely; or (5-8-09)~~

~~ii. A drug or medication when it is used as a restriction to manage the participant's behavior or restrict the participant's freedom of movement and is not a standard treatment or dosage for the participant's condition; (5-8-09)~~

~~b. A restraint does not include physical escorts or devices, such as orthopedically prescribed devices, to permit the participant to engage in activities without the risk of physical harm. (5-8-09)~~

~~17. **Seclusion.** Seclusion is the involuntary confinement of a participant alone in a room or area from which the participant is prevented from leaving. (5-8-09)~~

~~18. **Serious Emotional Disturbance (SED).** In accordance with the Children's Mental Health Services Act, Section 16-2403, Idaho Code, SED is: (5-8-09)~~

~~a. An emotional or behavioral disorder according to the DSM-IV-TR, which results in a serious disability; and (5-8-09)~~

- ~~**b.** Requires sustained treatment interventions; and (5-8-09)~~
- ~~**e.** Causes the child's functioning to be impaired in thought, perception, affect, or behavior. (5-8-09)~~
- ~~**d.** A substance abuse disorder, or conduct disorder, or developmental disorder, alone, does not constitute a serious emotional disturbance, although one (1) or more of these conditions may co-exist with serious emotional disturbance. (5-8-09)~~
- ~~**19. Serious Mental Illness (SMI).** In accordance with 42 CFR 483.102(b)(1), a person with SMI: (5-8-09)~~
- ~~**a.** Currently or at any time during the year, must have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified in the DSM-IV-TR; and (5-8-09)~~
- ~~**b.** Must have a functional impairment which substantially interferes with or limits one (1) or more major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning with an individual's basic daily living skills, instrumental living skills, and functioning in social, family, vocational or educational contexts. Instrumental living skills include maintaining a household, managing money, getting around the community, and taking prescribed medication. An adult who met the functional impairment criteria during the past year without the benefit of treatment or other support services is considered to have a serious mental illness. (5-8-09)~~
- ~~**20. Serious and Persistent Mental Illness (SPMI).** Participants must meet the criteria for SMI, have at least one (1) additional functional impairment, and have a diagnosis under DSM-IV-TR with one (1) of the following: Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a conclusive diagnosis. (5-8-09)~~
- ~~**21. Treatment Plan Review.** The practice of obtaining input from members of a participant's interdisciplinary team that is focused on evaluating the programs, progress, and future plans of a participant. This review should provide feedback and suggestions intended to help team members and the participant to accomplish the goals identified on the participant's individualized treatment plan. (5-8-09)~~

708. MENTAL OUTPATIENT BEHAVIORAL HEALTH CLINIC SERVICES: PARTICIPANT ELIGIBILITY.

~~Eligibility must be established through the assessment services described under Subsections 709.03.a. and 709.03.b. of these rules. The following are requirements for establishing eligibility for mental health clinic services: All participants who are eligible for Medicaid Basic or Enhanced Benchmark State Plan services, except for participants enrolled in the Idaho Medicare-Medicaid Coordinated Plan (MMCP), are automatically enrolled in the Idaho Behavioral Health Plan and may access behavioral health services that are determined to be medically necessary. (5-8-09)()~~

~~01. **History and Physical Examination.** The participant must have documented evidence of a history and physical examination that has been completed by his primary care physician. This examination must be within the last twelve (12) months immediately preceding the initiation of mental health clinic services and annually thereafter. Providers must refer those participants who have not had a history and physical examination to their primary care provider for this service prior to the delivery of mental health services. A participant who is in crisis may receive mental health services as described under Subsection 709.06 of these rules prior to obtaining a history and physical examination.~~ (5-8-09)

~~02. **Healthy Connections Referral.** A participant who belongs to the Healthy Connections program must be referred to the mental health clinic by his Healthy Connections physician.~~ (5-8-09)

~~03. **Establishment of Service Needs.** The initial assessment of the participant must establish that the services requested by the participant or his legal guardian are therapeutically appropriate and can be provided by the clinic.~~ (5-8-09)

~~04. **Conditions That Require New Assessment and Individualized Treatment Plan.** If an individual who is not eligible for Medicaid receives assessment services from any staff who does not have the qualifications required under Subsection 715.03 of these rules, and later becomes eligible for Medicaid, a new comprehensive diagnostic assessment and individualized treatment plan are required, which must be developed by a professional listed under Subsection 715.03 of these rules.~~ (3-29-12)

709. MENTAL OUTPATIENT BEHAVIORAL HEALTH CLINIC SERVICES: COVERAGE AND LIMITATIONS.

~~All mental health clinic services must be provided at the clinic unless provided to an eligible homeless individual.~~ (3-30-07)

~~01. **Clinic Services — Mental Health Clinics (MHC).** Under 42 CFR 440.90, the Department will pay for preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services provided by a mental health clinic to a participant who is not an inpatient in a hospital or nursing home or correctional facility except as specified under IDAPA 16.03.10, “Medicaid Enhanced Plan Benefits,” Section 229.~~ (3-30-07)

~~02. **Services or Supplies in Mental Health Clinics That Are Not Reimbursed.** Any service or supplies not included as part of the allowable scope of Medicaid.~~ (5-8-09)

~~03. **Evaluation and Diagnostic Services in Mental Health Clinics.** Participants must obtain a comprehensive diagnostic assessment as the initial evaluation in mental health clinics.~~ (3-29-12)

~~**a.** The comprehensive diagnostic assessment must include a current mental status examination, a description of the participant’s readiness and motivation to engage in treatment, participate in the development of his treatment plan and adhere to his treatment plan. The assessment must include the five (5) axes diagnoses under DSM-IV-TR with recommendations for level of care, intensity, and expected duration of treatment services. A comprehensive diagnostic~~

~~assessment is a reimbursable service when: (3-29-12)~~

~~i. A comprehensive diagnostic assessment is medically necessary in order to provide Basic Plan mental health services; (3-29-12)~~

~~ii. The participant is seeking Enhanced Plan services; and (3-29-12)~~

~~iii. When the assessment is performed by qualified staff identified under Subsection 715.02 of these rules. (5-8-09)~~

~~b. Psychological testing may be provided as a reimbursable service when provided in direct response to a specific evaluation question. The psychological report must contain the reason for the performance of this service. Agency staff may deliver this service if they meet one (1) of the following qualifications: (5-8-09)~~

~~i. Licensed Psychologist; (3-30-07)~~

~~ii. Psychologist extenders as described in IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners"; or (3-30-07)~~

~~iii. A qualified therapist listed in Subsection 715.03 of these rules who has documented evidence of education or training qualifying him to administer, score, interpret, and report findings for the psychological test he will be performing. (3-30-07)~~

~~e. Neuropsychological testing may be provided as a reimbursable service when provided in direct response to a specific evaluation question for participants whose clinical presentation indicates possible neurological involvement or central nervous system compromise from either a congenital or acquired etiology impacting the individual's functional capacities. The neuropsychological evaluation report must contain the reason for the performance of this service. Agency staff may deliver this service if they are a licensed psychologist or psychologist extender with specific competencies in neuropsychological testing. (5-8-09)~~

~~d. Occupational therapy assessment may be provided as a reimbursable service when recommended by the treatment team. This service may include the administration of standardized and non-standardized assessments and must be provided by an occupational therapist licensed in accordance with IDAPA 22.01.09, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants." (5-8-09)~~

~~04. Psychotherapy Treatment Services in Mental Health Clinics. Individual and group psychotherapy must be provided in accordance with the goals specified in the individualized treatment plan as described in Section 710 of these rules. (5-8-09)~~

~~05. Family Psychotherapy. Family psychotherapy services must be delivered in accordance with the goals of treatment as specified in the individualized treatment plan. The focus of family psychotherapy is on the dynamics within the family structure as it relates to the participant. (5-8-09)~~

~~a. Family psychotherapy services with the participant present must: (5-8-09)~~

- ~~i. Be face-to-face with at least one (1) family member present in addition to the participant; (5-8-09)~~
- ~~ii. Focus the treatment services on goals identified in the participant's individualized treatment plan; and (5-8-09)~~
- ~~iii. Utilize an evidence-based treatment model. (5-8-09)~~
- ~~**b.** Family psychotherapy without the participant present must: (5-8-09)~~
 - ~~i. Be face-to-face with at least one (1) family member present; (5-8-09)~~
 - ~~ii. Focus the services on the participant; and (5-8-09)~~
 - ~~iii. Utilize an evidence-based treatment model. (5-8-09)~~
- ~~**06. Emergency Psychotherapy Services.** Individual emergency psychotherapy services can be provided by qualified clinic staff at any time. (5-8-09)~~
 - ~~**a.** Emergency services provided to an eligible participant prior to the completion of a comprehensive diagnostic assessment must be fully documented in the participant's medical record; and (3-29-12)~~
 - ~~**b.** Each emergency service will be counted as a unit of service and part of the allowable limit per participant unless the contact results in hospitalization. Provider agencies may submit claims for the provision of psychotherapy in emergency situations even when contact does not result in the hospitalization of the participant. (3-30-07)~~
- ~~**07. Pharmacological Management.** Pharmacological management is a reimbursable service when consultations are provided by a physician or other practitioner of the healing arts within the scope of practice defined in their license in direct contact with the participant. (5-8-09)~~
 - ~~**a.** Consultation must be for the purpose of prescribing, monitoring, and/or administering medication as part of the participant's individualized treatment plan; and (5-8-09)~~
 - ~~**b.** Pharmacological management, if provided, must be specified on the participant's individualized treatment plan and must include the frequency and duration of the treatment. (5-8-09)~~
- ~~**08. Nursing Services.** Nursing services are reimbursable when physician ordered and supervised, and included as part of the participant's individualized treatment plan. (5-8-09)~~
 - ~~**a.** Licensed and qualified nursing personnel can supervise, monitor, and administer medication within the limits of the Nursing Practice Act, Section 54-1402, Idaho Code; and (3-30-07)~~
 - ~~**b.** The frequency and duration of the treatment must be specified on the participant's~~

~~individualized treatment plan. (3-30-07)~~

~~**09. Limits on Mental Health Clinic Services.** Services provided by Mental Health Clinics are limited to twenty-six (26) services per calendar year. This is for any combination of evaluation, diagnosis and treatment services. A total of four (4) hours per year is the maximum time allowed for diagnostic assessment services. Psychological and neuropsychological testing services are limited to two (2) computer administered testing sessions and four (4) assessment hours per year. Additional testing must be prior authorized by the Department. Testing services are not included in the annual assessment limitation described at Subsection 124.01. The duration of psychological and neuropsychological testing is determined by the participant's benefits and the presenting reason for such an assessment. (3-29-12)~~

~~**10. Occupational Therapy Services.** Occupational therapy services are reimbursable when included as part of the participant's individualized treatment plan. Agency staff may deliver these services if they are an occupational therapist licensed in accordance with IDAPA 22.01.09, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants." The practice of occupational therapy encompasses the evaluation, consultation, and treatment of individuals whose abilities to cope with the tasks of daily living are threatened or impaired. It includes a treatment program through the use of specific techniques that enhance functional performance and includes evaluation or assessment of the participant's: (5-8-09)~~

- ~~**a.** Self-care, functional skills, cognition, and perception; (5-8-09)~~
- ~~**b.** Sensory and motor performance; (5-8-09)~~
- ~~**c.** Play skills, vocational, and prevocational capacities; and (5-8-09)~~
- ~~**d.** Need for adaptive equipment. (5-8-09)~~

~~**01. Community-Based Outpatient Behavioral Health Services.** The Community-Based Outpatient Behavioral Health Services included in the Idaho Behavioral Health Plan (IBHP) are medically necessary rehabilitation services that evaluate the need for and provide therapeutic and rehabilitative treatment to minimize symptoms of mental illness and substance use disorders and restore independent functioning. These services include: ()~~

- ~~**a.** Assessments and Planning; ()~~
- ~~**b.** Psychological and Neurological Testing; ()~~
- ~~**c.** Psychotherapy (Individual, Group, and Family); ()~~
- ~~**d.** Pharmacologic Management; ()~~
- ~~**e.** Partial Care Treatment; ()~~
- ~~**f.** Behavioral Health Nursing; ()~~
- ~~**g.** Drug Screening; ()~~

h. Community-Based Rehabilitation; ()

i. Substance Use Disorder Treatment Services; and ()

j. Case Management. ()

02. Prior Authorization. Some behavioral health services may require prior authorization from the IBHP contractor. ()

710. ~~MENTAL OUTPATIENT BEHAVIORAL HEALTH CLINIC SERVICES:~~ WRITTEN INDIVIDUALIZED TREATMENT PLAN PROVIDER QUALIFICATIONS.

~~A written individualized treatment plan is a medically ordered plan of care. An individualized treatment plan must be developed and implemented for each participant receiving mental health clinic services. Treatment planning is reimbursable if conducted by a qualified professional identified in Subsection 715.03 of these rules. The IBHP services are delivered by network providers who are enrolled with the contractor and meet reimbursement, quality, and utilization standards. All community-based outpatient behavioral health service providers are subject to the limitations of practice imposed by state law, federal regulations, and by the various state boards that regulate professional competency requirements, and in accordance with applicable Department rules. The contractor will enter into agreements with enrolled providers to provide the services under the IBHP. These agreements will include the reimbursement methodology agreed upon by the contractor and Department.~~ (3-29-12)()

~~**01. Individualized Treatment Plan Development.** The individualized treatment plan must be developed by the following: (3-30-07)~~

~~**a.** The treatment staff providing the services; and (5-8-09)~~

~~**b.** The participant, if capable, and his parent or legal guardian. The participant and his parent or legal guardian may also choose others to participate in the development of the plan. (5-8-09)~~

~~**02. Individualized Treatment Plan Requirements.** An individualized treatment plan must include, at a minimum, the following: (3-30-07)~~

~~**a.** Statement of the overall goals as identified by the participant or his parent or legal guardian and concrete, measurable treatment objectives to be achieved by the participant, including time frames for completion. The goals and objectives must be individualized, and must reflect the choices of the participant or his parent or legal guardian. The goals and objectives must address the emotional, behavioral, and skill training needs identified by the participant or his parent or legal guardian through the intake and assessment process. The tasks must be specific to the type of modality used and must specify the frequency and anticipated duration of therapeutic services. (5-8-09)~~

~~**b.** Documentation of who participated in the development of the individualized treatment plan. (3-30-07)~~

~~i. The authorizing physician must sign and date the plan within thirty (30) calendar days of the initiation of treatment. (3-30-07)~~

~~ii. The participant, when able, and his parent or legal guardian must sign the treatment plan indicating their agreement with service needs identified and their participation in its development. If these signatures indicating participation in the development of the treatment plan are not obtained, then the agency must document in the participant's record the reason the signatures were not obtained, including the reason for the participant's refusal to sign. A copy of the treatment plan must be given to the participant and his parent or legal guardian. (5-8-09)~~

~~iii. Other individuals who participated in the development of the treatment plan must sign the plan. (3-30-07)~~

~~iv. The author of the treatment plan must sign and date the plan and include his title and credentials. (5-8-09)~~

~~e. The treatment plan must be created in direct response to the findings of the assessment process. (3-29-12)~~

~~d. The treatment plan must include a prioritized list of issues for which treatment is being sought, and the type, frequency, and duration of treatment estimated to achieve all objectives based on the ability of the participant to effectively utilize services. (5-8-09)~~

~~e. Tasks that are specific, time-limited activities and interventions designed to accomplish the objectives in the individualized treatment plan that are recommended by the participant's interdisciplinary team and agreed to by the participant or his parent or legal guardian. Each task description must specify the anticipated place of service, the frequency of services, the type of service, and the person(s) responsible to provide the service. (5-8-09)~~

~~f. Discharge criteria and aftercare plans must also be identified on the treatment plan. (5-8-09)~~

~~**03. Treatment Plan Reviews.** The agency staff must conduct intermittent treatment plan reviews when medically necessary. The intermittent treatment plan reviews must be conducted with the participant or his legal guardian at least every one hundred twenty (120) days. During the reviews, the agency staff providing the services, the participant, and any other members of the participant's interdisciplinary team as identified by the participant or his legal guardian must review the progress the participant has made on objectives and identify objectives that may be added, amended, or deleted from the individualized treatment plan. The attendees of the treatment plan review are determined by the participant or his legal guardian and agency staff providing the services. (5-8-09)~~

~~**04. Physician Review of Treatment Plan.** Each individualized treatment plan must be reviewed, updated, and signed by a physician at least annually. Changes in the types, duration, or amount of services that are determined during treatment plan reviews must be reviewed and signed by a physician. Projected dates for the participant's reevaluation and the revision of the individualized treatment plan must be recorded on the treatment plan. (3-29-12)~~

~~05. Continuation of Services. Continuation of services after the first year must be based on documentation of the following: (3-30-07)~~

~~a. Description of the ways the participant has specifically benefited from mental health services, and why he continues to need additional mental health services; and (5-8-09)~~

~~b. The participant's progress toward the achievement of therapeutic goals that would eliminate the need for the service to continue. (3-30-07)~~

711. MENTAL OUTPATIENT BEHAVIORAL HEALTH CLINIC SERVICES: EXCLUDED SERVICES NOT REIMBURSABLE UNDER MEDICAID PROCEDURAL REQUIREMENTS.

Providers must enroll in the IBHP with the contractor and meet both the credentialing and quality assurance guidelines of the contractor. ()

~~01. Inpatient Medical Facilities. Medicaid will not pay for mental health clinic services rendered to participants residing in inpatient medical facilities, including nursing homes, hospitals, or public institutions defined in 42 CFR 435.1009; or (5-8-09)~~

~~02. Non-Reimbursable. The Department will not reimburse a service unless the participant's medical record includes the signature and credential of the professional staff providing the therapy or participant contact, the length of the session, and the date of the contact. (5-8-09)~~

~~03. Non-Eligible Staff. Any treatment or contact provided as a result of an individualized treatment plan that is performed by any staff other than those qualified to deliver services under Subsection 715.03 of these rules is not eligible for reimbursement by the Department. (5-8-09)~~

~~04. Recoupment. If a record is determined not to meet minimum requirements as set forth herein, any payments made on behalf of the participant are subject to recoupment. (3-30-07)~~

01. Administer IBHP. The contractor is responsible for administering the IBHP, including: eligibility verification, management of behavioral health service provision, behavioral health claims processing, payments to providers, data reporting, utilization management, and customer service. ()

02. Authorization. The contractor is responsible for authorization of covered behavioral health services that require authorization prior to claim payment. ()

03. Complaints, Grievances, and Appeals. Complaints, grievances, and appeals are handled through a process between the contractor and Department that is in compliance with state and federal requirements. Participants must utilize the complaint, grievance, and appeal process required by the contractor prior to initiating an administrative appeal with the Department. ()

~~712. MENTAL HEALTH CLINIC SERVICES: CREDENTIALING RESPONSIBILITIES OF THE DEPARTMENT.~~

~~01. **Reimbursement.** A mental health clinic must be designated as credentialed or provisionally credentialed in order to receive Medicaid reimbursement for services. Any agency that fails to achieve or maintain credentialed status will have its Medicaid provider agreement terminated. (5-8-09)~~

~~02. **Application.** All existing providers and new provider applicants must submit an application for credentialing that will be reviewed in order to proceed with the credentialing process and obtain the required credential by the Department. All initial applications will be responded to within thirty (30) calendar days. If the application is incomplete or is not in substantial compliance with these rules, the applicant must submit the additional information within ten (10) business days of receipt of notice for the application to be considered further. The application will be reviewed up to three (3) times. If the applicant has not provided the required information by the third submittal, then the application will be denied and the application will not be considered again for twelve (12) months. (5-8-09)~~

~~03. **Temporary Credentialed Status.** In order for existing providers to be able to continue to provide services during initial development, the Department will grant a one-time temporary credential to all existing providers. (5-8-09)~~

~~04. **New Providers.** New provider applicants will be required to submit a credentialing application and successfully complete the credentialing application process as a condition for Department approval as a Medicaid provider. If the new provider applicant successfully passes the application portion of credentialing, then a temporary credential will be issued to the provider for up to one hundred eighty (180) days. Within the one hundred eighty (180) days, an on-site review will be conducted. If the provider applicant is deemed to be in substantial compliance with these rules, then the temporary credential will be converted to a full credential. If the provider fails to be in substantial compliance, then the temporary credential will expire, credentialed status will be denied, and the provider applicant will not be considered for credentialing again for twelve (12) months. (5-8-09)~~

~~05. **Elements of Credentialing.** The initial credentialing process consists of the application, self-study, and an on-site review for compliance with the requirements of these rules. (5-8-09)~~

~~a. The application provides documentation the agency has met the criteria set forth in these rules. Elements contained in the application include: (5-8-09)~~

~~i. Ownership and governance; (5-8-09)~~

~~ii. Physician contract for medical and clinical oversight and supervision; (5-8-09)~~

~~iii. Proof of appropriate insurance; (5-8-09)~~

~~iv. Appropriate employment and contract documentation; and (5-8-09)~~

~~v. Copies of relevant licenses and transcripts. (5-8-09)~~

~~b. The self-study provides the agency the opportunity to formally document policies~~

~~and procedures that demonstrate compliance with Sections 713 and 714 of these rules. (5-8-09)~~

~~e. The on-site review provides the Department the opportunity to observe service delivery and ensure the agency actually implements and complies with their policies and procedures. (5-8-09)~~

~~**06. Deemed Status.** Providers accredited by private accreditation agencies, (i.e., the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or Commission on the Accreditation of Rehabilitation Facilities (CARF)), will be exempt from credentialing processes. Other accrediting agencies may be determined acceptable upon review by the Department. Providers must submit to the Department appropriate documentation of their private accreditation status. (5-8-09)~~

~~**07. Expiration and Renewal of Credentialed Status.** Credentials issued under these rules will be issued for a period up to three (3) years. Unless denied or revoked, the agency's credential will expire on the date designated by the Department. No later than ninety (90) days before expiration, an agency must apply for renewal of credentials. A site review may be conducted by the Department for renewal applications. (5-8-09)~~

~~**08. Provisional Credentialed Status.** If a new or renewal applicant is found deficient in one (1) or more of the requirements for credentialing, but does not have deficiencies that jeopardize the health and safety of the participants or substantially affect the provider's ability to provide services, a provisional credential may be issued. Provisional credentials will be issued for a period not to exceed one hundred eighty (180) days. During that time, the Department will determine whether the deficiencies have been corrected. If so, then the agency will be credentialed. If not, then the credential will be denied or revoked. (3-30-07)~~

~~**09. Denial or Revocation of Credentialed Status.** The Department may deny or revoke credentials when conditions exist that endanger the health, safety, or welfare of any participant or when the agency is not in substantial compliance with these rules. Additional causes for denial or revocation of credentials include the following: (5-8-09)~~

~~a. The provider agency or provider agency applicant has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining credentialed status; (3-30-07)~~

~~b. The provider agency or provider agency applicant has been convicted of fraud, gross negligence, abuse, assault, battery or exploitation; (5-8-09)~~

~~c. The provider agency or provider agency applicant has been convicted of a criminal offense within the past five (5) years other than a minor traffic violation or similar minor offense; (3-30-07)~~

~~d. The provider agency or provider agency applicant has been denied or has had revoked any health facility license or certificate; (3-30-07)~~

~~e. A court has ordered that any provider agency owner or provider agency applicant must not operate a health facility, residential care or assisted living facility, or certified family~~

home; (3-30-07)

~~f. Any owners, employees, or contractors of the provider agency or provider agency applicant are listed on the statewide Child Abuse Registry, Adult Protection Registry, Sexual Offender Registry, or Medicaid exclusion lists; (3-30-07)~~

~~g. The provider agency or provider agency applicant is directly under the control or influence, whether financial or other, of any person who is described in Subsections 712.09.a. through 712.09.f. of this rule. (3-30-07)~~

~~10. **Procedure for Appeal of Denial or Revocation of Credentials.** Immediately upon denial or revocation of credentials, the Department will notify the applicant or provider in writing by certified mail or by personal service of its decision, the reason for its decision, and how to appeal the decision. The appeal is subject to the hearing provisions in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (3-30-07)~~

~~713. **MENTAL HEALTH CLINIC SERVICES: RESPONSIBILITIES OF THE DEPARTMENT.**~~

~~The Department will administer the provider agreement for the provision of mental health clinic services and is responsible for the following tasks: (3-29-12)~~

~~01. **Prior Authorization Process.** Reimbursement for specific services that require prior authorization will be authorized from the date the required documentation is received by the Department. The Department will complete the prior authorization process within ten (10) working days from the date all the required information is received from the provider. The specific documentation that is required for prior authorization is dependent on the request for additional services. The Department must authorize the number of hours and type of services, as specifically required in these rules, which could be reasonably expected to address the participant's needs in relation to those services. (3-29-12)~~

~~02. **Notice of Decision.** At the point the Department makes a decision that a participant is ineligible for specific services, a notice of decision citing the reason(s) the participant is ineligible for those services must be issued by the Department. The notice of decision must be sent to the adult participant and a copy to his legal guardian, if any. When the participant is a minor child, the notice of decision must be sent to the minor child's parent or legal guardian. (3-29-12)~~

~~03. **Responding to Requests for Services.** When the Department receives from a provider a written request for services that must be prior authorized, the Department must review the request and either approve or deny the request within ten (10) working days of receipt. A clear rationale for the increase in hours or change in service type must be included with the request. (3-29-12)~~

~~714. **MENTAL HEALTH CLINIC SERVICES: PROVIDER AGENCY REQUIREMENTS.**~~

~~Each agency that enters into a provider agreement with the Department for the provision of mental health clinic services must meet the following requirements: (3-30-07)~~

~~01. **Healthy Connections Referral.** Provider agencies must obtain a Healthy~~

~~Connections referral if the participant is enrolled in the Healthy Connections program and document the referral in the participant's medical record. Provider agencies must document compliance with the requirements under Subsection 708.01 of these rules. (5-8-09)~~

~~**02. Effectiveness of Services.** Effectiveness of services, as measured by a participant's achievement of his plan objectives, must be monitored by the provider and changes to the individualized treatment plan must be initiated when service needs change or interventions are shown to be ineffective. These measures must be included in the participant's treatment plan review. (5-8-09)~~

~~**03. Staff to Participant Ratio.** The following treatment staff to participant ratios for group treatment services must be observed: (5-8-09)~~

~~**a.** For children under four (4) years of age, the ratio must be 1:1. No group work is allowed. (5-8-09)~~

~~**b.** For children four (4) to twelve (12) years of age, the ratio must be 1:6 for groups. Group size must not exceed twelve (12) participants. (5-8-09)~~

~~**c.** For children over twelve (12) years of age, the ratio must be 1:10 for groups. Group size must not exceed twelve (12) participants. (5-8-09)~~

~~**04. Family Participation Requirement.** The following standards must be observed for services provided to children: (5-8-09)~~

~~**a.** For a child under four (4) years of age, the child's parent or legal guardian should be actively involved by being present on the premises and available for consultation with the staff during the delivery of mental health services. The child's parent or legal guardian does not have to participate in the treatment session or be present in the room in which the service is being conducted; (5-8-09)~~

~~**b.** For a child four (4) to twelve (12) years of age, the child's parent or legal guardian should be actively involved. The child's parent or legal guardian does not have to participate in the treatment session but must be available for consultation with the staff providing the service; (5-8-09)~~

~~**c.** For a child over twelve (12) years of age, the child's parent or legal guardian should be involved, as appropriate. If the interdisciplinary team recommends that the child's parent or legal guardian not be involved in any aspect of the treatment, then the reasons for excluding the child's parent or legal guardian must be documented in the medical record. (5-8-09)~~

~~**d.** For a child whose parent or legal guardian does not participate in the services, the provider must document efforts made to involve the parent or legal guardian and must make appropriate adjustments to the treatment plan to address the parent or legal guardian's lack of involvement. (5-8-09)~~

~~**e.** Nothing in these rules may interfere with compliance to provisions of Section 16-~~

~~2428, Idaho Code, regarding confidentiality and disclosure of children's mental health information. (5-8-09)~~

~~05. **Mental Health Clinic.** Each location of the agency must meet the requirements under this rule. (3-30-07)~~

~~06. **Physician Requirement for Clinic Supervision.** In order to fulfill the requirement that the clinic be under the direction of a physician, the clinic must have a contract with the physician. (3-30-07)~~

~~a. The contract must specifically require that the physician spend as much time in the clinic as is necessary to assure that participants are receiving services in a safe and efficient manner in accordance with accepted standards of medical practice. (3-30-07)~~

~~b. The supervising physician of the clinic may also serve as the supervising physician of a participant's care. (3-30-07)~~

~~07. **Physician Requirement for Supervision of a Participant's Care.** Each participant's care must be under the supervision of a physician directly affiliated with the clinic. Documentation of the affiliation must be kept in the clinic location. The clinic may have as many physician affiliations as is necessary in order to meet the needs of the volume of participants served in that location. The physician who supervises a participant's care does not have to deliver this service at the clinic nor does the physician have to be present at the clinic when the participant receives services at the clinic. In order to fulfill the requirement for physician supervision of a participant's care, the following conditions must also be met: (3-30-07)~~

~~a. The clinic and the physician must enter into a formal arrangement in which the physician must assume professional responsibility for the services provided; (3-30-07)~~

~~b. The physician must see the participant at least once annually to determine the medical necessity and appropriateness of clinic services; (5-8-09)~~

~~c. The physician must review and sign the individualized treatment plan as an indicator that the services are medically necessary and prescribed; and (5-8-09)~~

~~d. The physician must review and sign all updates to the individualized treatment plan that involve changes in the types or amounts of services and must sign all intermittent treatment plan reviews that represent substantial changes in the goals, objectives, or services. (5-8-09)~~

~~08. **Assessment.** All treatment in mental health clinics must be based on one (1) or more assessments of the participant's needs, required under Section 709.03 of these rules and provided under the direction of a licensed physician. (5-8-09)~~

~~09. **Criminal History Checks.** (3-30-07)~~

~~a. The agency must verify that all employees, subcontractors, or agents of the agency providing direct care or clinical services have complied with IDAPA 16.05.06, "Criminal History~~

~~and Background Checks.” (3-30-07)~~

~~**b.** Once an employee, subcontractor, or agent of the agency has met the requirements specified in Subsection 009.02.a. of these rules, he may begin working for the agency on a provisional basis. (3-30-07)~~

~~**e.** Once an employee, subcontractor, or agent of the agency has received a criminal history clearance, any additional criminal convictions must be reported to the Department when the agency learns of the conviction. (3-30-07)~~

~~**10. Agency Employees and Subcontractors.** Employees and subcontractors of the agency are subject to the same conditions, restrictions, qualifications and rules as the agency. (3-30-07)~~

~~**11. Supervision.** The agency must ensure that staff providing clinical services are supervised according to the following guidelines: (3-30-07)~~

~~**a.** Standards and requirements for supervision under the rules of the Idaho Bureau of Occupational Licenses and the Idaho State Board of Medicine must be met; (5-8-09)~~

~~**b.** Case-specific supervisory contact must be made weekly, at a minimum, with staff for whom supervision is a requirement; and (3-30-07)~~

~~**e.** Documentation of supervision must be maintained by the agency and be available for review by the Department. (3-30-07)~~

~~**12. Restraints and Seclusion.** (5-8-09)~~

~~**a.** Restraints and seclusion must not be employed under any circumstances except when an agency staff person employs physical holds as an emergency response to assault or aggression or other immediate safety risks in accordance with the following requirements in Subsections 714.12.a.i. through 714.12.a.iii.: (5-8-09)~~

~~**i.** The agency must have an accompanying policy and procedure that addresses the use of the such holds. (5-8-09)~~

~~**ii.** The physical holds employed must be a part of a nationally recognized non-violent crisis intervention model. (5-8-09)~~

~~**iii.** The staff person who employs the hold technique(s) must have evidence in his personnel record of current certification in the method. (5-8-09)~~

~~**b.** Provider agencies must develop policies that address the agency’s response by staff to emergencies involving assault or aggression or other immediate safety risks. All policies and procedures must be consistent with licensure requirements, federal, state, and local laws, and be in accordance with accepted standards of healthcare practice. (5-8-09)~~

~~**13. Continuing Education.** The agency must ensure that all staff complete twenty (20)~~

~~hours of continuing education annually in the field in which they are licensed. Documentation of the continuing education hours must be maintained by the agency and be available for review by the Department. Nothing in these rules will affect professional licensing continuing education standards and requirements set by the Bureau of Occupational Licenses.~~ (3-30-07)

~~**14. Ethics.**~~ (3-30-07)

~~**a.** The provider must adopt, adhere to and enforce a Code of Ethics on its staff who are providing Medicaid reimbursable services. The Code of Ethics must be similar to or patterned after one (1) of the following:~~ (3-30-07)

~~i. US Psychiatric Rehabilitation Association Code of Ethics found at https://uspra.ipower.com/Certification/Practitioner_Code_of_Ethics.pdf;~~ (3-30-07)

~~ii. National Association of Social Workers Code of Ethics found at <http://www.naswde.org/pubs/code/default.asp>;~~ (3-30-07)

~~iii. American Psychological Association Code of Ethics found at <http://www.apa.org/ethics/code/index.aspx>;~~ (3-30-07)

~~iv. American Counseling Association Code of Ethics found at <http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx>.~~ (3-30-07)

~~v. Marriage and Family Therapists Code of Ethics found at http://www.aamft.org/imis15/content/legal_ethics/code_of_ethics.aspx.~~ (3-30-07)

~~**b.** The Provider must develop a schedule for providing ethics training to its staff.~~ (3-30-07)

~~**e.** The ethics training schedule must provide that new employees receive the training during their first year of employment, and that all staff receive ethics training no less than four (4) hours every four (4) years thereafter.~~ (3-30-07)

~~**d.** Evidence of the Agency's Code of Ethics, the discipline(s) upon which it is modeled, and each staff member's training on the Code must be submitted to the Department upon request.~~ (3-30-07)

~~**15. Building Standards For Mental Health Clinics.**~~ (3-30-07)

~~**a.** Accessibility. Mental health clinic service providers must be responsive to the needs of the service area and persons receiving services and accessible to persons with disabilities as defined in Section 504 of the Federal Rehabilitation Act, the Americans with Disabilities Act, and the uniform federal accessibility standard.~~ (3-30-07)

~~**b.** Environment. Clinics must be designed and equipped to meet the needs of each participant including, but not limited to, factors such as sufficient space, equipment, lighting and noise control.~~ (3-30-07)

- ~~e. Capacity. Clinics must provide qualified staff as listed in Subsection 715.01 of these rules to meet a staff to participant ratio required under Subsection 714.03 of this rule that ensures safe, effective and clinically appropriate interventions. (5-8-09)~~
- ~~d. Fire and Safety Standards. (3-30-07)~~
- ~~i. Clinic facilities must meet all local and state codes concerning fire and life safety. The owner/operator must have the facility inspected at least annually by the local fire authority and successfully pass the inspection. In the absence of a local fire authority, such inspections must be obtained from the Idaho State Fire Marshall's office. A copy of the inspection must be made available upon request and must include documentation of any necessary corrective action taken on violations cited; and (5-8-09)~~
- ~~ii. The clinic facility must be structurally sound and must be maintained and equipped to assure the safety of participants, employees and the public; and (3-30-07)~~
- ~~iii. In clinic facilities where natural or man-made hazards are present, suitable fences, guards or railings must be provided to protect participants; and (3-30-07)~~
- ~~iv. Clinic facilities must be kept free from the accumulation of weeds, trash and rubbish; and (3-30-07)~~
- ~~v. Portable heating devices are prohibited except units that have heating elements that are limited to not more than two hundred twelve (212F) degrees Fahrenheit. The use of unvented, fuel-fired heating devices of any kind are prohibited. All portable space heaters must be U.L. approved as well as approved by the local fire or building authority; and (3-30-07)~~
- ~~vi. Flammable or combustible materials must not be stored in the clinic facility; and (3-30-07)~~
- ~~vii. All hazardous or toxic substances must be properly labeled and stored under lock and key; and (3-30-07)~~
- ~~viii. Water temperatures in areas accessed by participants must not exceed one hundred twenty (120) degrees Fahrenheit; and (3-30-07)~~
- ~~ix. Portable fire extinguishers must be installed throughout the clinic facility. Numbers, types and location must be directed by the applicable fire authority noted in Subsection 714.15.d. of this rule; and (5-8-09)~~
- ~~x. Electrical installations and equipment must comply with all applicable local or state electrical requirements. In addition, equipment designed to be grounded must be maintained in a grounded condition and extension cords and multiple electrical outlet adapters must not be utilized unless U.L. approved and the numbers, location, and use of them are approved in writing by the local fire or building authority. (3-30-07)~~
- ~~xi. There must be a telephone available on the premises for use in the event of an emergency. Emergency telephone numbers must be posted near the telephone or where they can~~

- ~~be easily accessed; and (3-30-07)~~
- ~~xii. Furnishings, decorations or other objects must not obstruct exits or access to exits. (3-30-07)~~
- ~~e. Emergency Plans and Training Requirements. (3-30-07)~~
- ~~i. Evacuation plans must be posted throughout the facility. Plans must indicate point of orientation, location of all fire extinguishers, location of all fire exits, and designated meeting area outside of building. (3-30-07)~~
- ~~ii. There must be written policies and procedures covering the protection of all persons in the event of fire or other emergencies; and (3-30-07)~~
- ~~iii. All employees must participate in fire and safety training upon employment and at least annually thereafter; and (3-30-07)~~
- ~~iv. All employees and partial care participants must engage in quarterly fire drills. At least two (2) of these fire drills must include evacuation of the building; and (3-30-07)~~
- ~~v. A brief summary of the fire drill and the response of the employees and partial care participants must be written and maintained on file. The summary must indicate the date and time the drill occurred, problems encountered and corrective action taken. (3-30-07)~~
- ~~f. Food Preparation and Storage. (3-30-07)~~
- ~~i. If foods are prepared in the clinic facility, they must be stored in such a manner as to prevent contamination and be prepared using sanitary methods. (3-30-07)~~
- ~~ii. Except during actual preparation time, cold perishable foods must be stored and served under forty-five (45F) degrees Fahrenheit and hot perishable foods must be stored and served over one hundred forty (140F) degrees Fahrenheit. (3-30-07)~~
- ~~iii. Refrigerators and freezers used to store participant lunches and other perishable foods used by participants, must be equipped with a reliable, easily readable thermometer. Refrigerators must be maintained at forty-five (45F) degrees Fahrenheit or below. Freezers must be maintained at zero (0F) to ten (10F) degrees Fahrenheit or below. (3-30-07)~~
- ~~iv. When meals are prepared or provided for by the clinic, meals must be nutritional. (3-30-07)~~
- ~~g. Housekeeping and Maintenance Services. (3-30-07)~~
- ~~i. The interior and exterior of the clinic facility must be maintained in a clean, safe and orderly manner and must be kept in good repair; and (3-30-07)~~
- ~~ii. Deodorizers cannot be used to cover odors caused by poor housekeeping or unsanitary conditions; and (3-30-07)~~

- ~~iii. All housekeeping equipment must be in good repair and maintained in a clean, safe and sanitary manner; and (3-30-07)~~
- ~~iv. The clinic facility must be maintained free from infestations of insects, rodents and other pests; and (3-30-07)~~
- ~~v. The clinic facility must maintain the temperature and humidity within a normal comfort range by heating, air conditioning, or other means. (3-30-07)~~
- ~~vi. Garbage will be disposed of in a sanitary manner. It must not be allowed to accumulate and must be placed in leak-proof bags. (3-30-07)~~
- ~~h. Firearms. No firearms are permitted in the clinic facility. (3-30-07)~~
- ~~i. Plumbing. Restroom facilities must be maintained in good working order and available and accessible to participants while at the clinic in accordance with the Americans with Disabilities Act. This includes the presence of running water for operation of the toilet and washing hands. (3-30-07)~~
- ~~j. Lighting. Lighting levels must be maintained throughout the clinic facility which are appropriate to the service being provided. (3-30-07)~~
- ~~k. Drinking Water. Where the source is other than a public water system or commercially bottled, water quality must be tested and approved annually by the district health department. (3-30-07)~~

~~715. MENTAL HEALTH CLINIC SERVICES: AGENCY STAFF QUALIFICATIONS.~~

~~**01. Staff Qualifications.** The mental health clinic must assure that each agency staff person delivering treatment services to Medicaid participants works within the scope of his license and has, at a minimum, one (1) or more of the following credentials: (5-8-09)~~

- ~~**a.** Licensed Psychiatrist; (3-30-07)~~
- ~~**b.** Licensed Physician or Licensed Practitioner of the healing arts; (3-30-07)~~
- ~~**c.** Licensed Psychologist; (3-30-07)~~
- ~~**d.** Psychologist Extender, registered with the Bureau of Occupational Licenses; (3-30-07)~~
- ~~**e.** Licensed Masters Social Worker; (3-30-07)~~
- ~~**f.** Licensed Clinical Social Worker; (3-30-07)~~
- ~~**g.** Licensed Social Worker; (3-30-07)~~

- ~~h.~~ *Licensed Clinical Professional Counselor;* (3-30-07)
- ~~i.~~ *Licensed Professional Counselor;* (3-30-07)
- ~~j.~~ *Licensed Marriage and Family Therapist;* (3-30-07)
- ~~k.~~ *Licensed Associate Marriage and Family Therapist;* (5-8-09)
- ~~l.~~ *Certified Psychiatric Nurse, (RN), as described in Subsection 707.13 of these rules;* (5-8-09)
- ~~m.~~ *Licensed Professional Nurse, R.N.; or* (3-30-07)
- ~~n.~~ *Licensed Occupational Therapist.* (5-8-09)
- ~~02.~~ *Staff Qualified to Deliver a Comprehensive Diagnostic Assessment. A comprehensive diagnostic assessment is a reimbursable service when delivered by one (1) of the following licensed professionals:* (5-8-09)
- ~~a.~~ *Psychiatrist;* (5-8-09)
- ~~b.~~ *Physician;* (5-8-09)
- ~~c.~~ *Practitioner of the healing arts;* (5-8-09)
- ~~d.~~ *Psychologist;* (5-8-09)
- ~~e.~~ *Clinical Social Worker;* (5-8-09)
- ~~f.~~ *Clinical Professional Counselor;* (5-8-09)
- ~~g.~~ *Licensed Marriage and Family Therapist;* (5-8-09)
- ~~h.~~ *Certified Psychiatric Nurse, (RN), as described in Subsection 707.13 of these rules;* (5-8-09)
- ~~i.~~ *Licensed Professional Counselor whose provision of diagnostic services is supervised as described in IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists";* (5-8-09)
- ~~j.~~ *Licensed Masters Social Worker whose provision of diagnostic services is supervised as described in IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners";* (5-8-09)
- ~~k.~~ *Licensed Associate Marriage and Family Therapist whose provision of diagnostic services is supervised as described in IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; or* (5-8-09)

~~l. Psychologist Extender, registered with the Bureau of Occupational Licenses whose provision of diagnostic services is supervised as described in IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners."~~ (5-8-09)

~~03. **Qualified Interdisciplinary Treatment Planning Staff.** The individualized treatment plan development is reimbursable if conducted by a qualified staff person who, at a minimum, has one (1) or more of the following qualifications:~~ (5-8-09)

- ~~a. Licensed Psychologist;~~ (3-30-07)
- ~~b. Psychologist Extender, registered with the Bureau of Occupational Licenses;~~ (3-30-07)
- ~~c. Licensed Masters Social Worker;~~ (5-8-09)
- ~~d. Licensed Clinical Social Worker;~~ (5-8-09)
- ~~e. Certified Psychiatric Nurse, (RN);~~ (3-30-07)
- ~~f. Licensed Clinical Professional Counselor;~~ (5-8-09)
- ~~g. Licensed Professional Counselor;~~ (5-8-09)
- ~~h. Licensed Physician or other licensed practitioner of the healing arts;~~ (5-8-09)
- ~~i. Licensed Psychiatrist;~~ (5-8-09)
- ~~j. Licensed Marriage and Family Therapist;~~ (5-8-09)
- ~~k. Licensed Associate Marriage and Family Therapist; or~~ (5-8-09)
- ~~l. Licensed Professional Nurse, RN.~~ (5-8-09)

~~04. **Non-Qualified Staff.** Any delivery of evaluation, diagnostic service, or treatment designed by any person other than an agency staff person designated as qualified under Sections 709 or 715 of these rules, is not eligible for reimbursement under the Medicaid.~~ (5-8-09)

~~05. **Staff Qualifications for Psychotherapy Services.** Licensed, qualified professionals providing psychotherapy services as set forth in Subsections 709.04 through 709.06 of these rules must have, at a minimum, one (1) or more of the following credentials:~~ (5-8-09)

- ~~a. Licensed Psychiatrist;~~ (3-30-07)
- ~~b. Licensed Physician;~~ (3-30-07)
- ~~c. Licensed Psychologist;~~ (3-30-07)
- ~~d. Licensed Clinical Social Worker;~~ (3-30-07)

- ~~e. Licensed Clinical Professional Counselor; (3-30-07)~~
 - ~~f. Licensed Marriage and Family Therapist; (3-30-07)~~
 - ~~g. Certified Psychiatric Nurse (RN), as described in Subsection 707.09 of these rules; (5-8-09)~~
 - ~~h. Licensed Professional Counselor whose provision of psychotherapy is supervised in compliance with IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; (5-8-09)~~
 - ~~i. Licensed Masters Social Worker whose provision of psychotherapy is supervised as described in IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; (5-8-09)~~
 - ~~j. Licensed Associate Marriage and Family Therapist whose provision of psychotherapy is supervised as described in IDAPA 25.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; or (5-8-09)~~
 - ~~k. A Psychologist Extender, registered with the Bureau of Occupational Licenses whose provision of diagnostic services is supervised in compliance with IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (5-8-09)~~
- ~~06. **Support Staff.** For the purposes of this rule, support staff is any person who is not a professional listed in Subsection 715.01 of this rule. The agency may elect to employ support staff to provide support services to participants. Such support services may include providing transportation, cooking and serving meals, cleaning and maintaining the physical plant, or providing general, non-professional supervision. Support staff must not deliver or assist in the delivery of services that are reimbursable by Medicaid. (5-8-09)~~

~~**716. MENTAL HEALTH CLINIC SERVICES: RECORD REQUIREMENTS FOR PROVIDERS.**~~

- ~~01. **Assessments.** A comprehensive diagnostic assessment must be contained in all participant medical records. (3-29-12)~~
- ~~02. **Informed Consent.** The agency must ensure that participants who receive services through the agency have obtained informed consent from the participant or his legal guardian indicating agreement with all of the elements on the individualized treatment plan including choice of the provider agency, designated services, times, dates, frequencies, objectives, goals, and exit criteria. For a minor child, informed consent must be obtained from the minor's parent or legal guardian. (5-8-09)~~
- ~~03. **Documentation.** All assessments and testing evaluations must be in written form, dated, and fully signed to certify when completed and by whom, and retained in the participant's file for documentation purposes. (3-29-12)~~
- ~~04. **Data.** All data gathered must be directed towards formulation of a written~~

~~diagnosis, problem list, and individualized treatment plan which specifies the type, frequency, and anticipated duration of treatment. (3-30-07)~~

~~**05. Mental Health Clinic Record Keeping Requirements. (3-30-07)**~~

~~**a. Maintenance.** Each mental health clinic will be required to maintain records on all services provided to Medicaid participants. (5-8-09)~~

~~**b. Record Contents.** The records must contain the current individualized treatment plan ordered by a physician and must meet the requirements as set forth in Section 710 of this rule. (5-8-09)~~

~~**e. Requirements.** The records must: (3-30-07)~~

~~i. Specify the exact type of treatment provided; and (3-30-07)~~

~~ii. Who the treatment was provided by; and (3-30-07)~~

~~iii. Specify the duration of the treatment and the time of day delivered; and (3-30-07)~~

~~iv. Contain detailed records which outline exactly what occurred during the therapy session or participant contact documented by the person who delivered the service; and (3-30-07)~~

~~v. Contain the legible, dated signature, with degree credentials listed, of the staff member performing the service. (3-30-07)~~

~~**717. MENTAL HEALTH CLINIC SERVICES: PROVIDER REIMBURSEMENT.**~~

~~**01. Services.** Payment for clinic services will be made directly to the clinic and will be in accordance with rates established by the Department for the specific services. (3-30-07)~~

~~**02. Payment in Full.** Each provider of clinic services must accept the Department's payment for such services as payment in full and must not bill the medical assistance participant for any portion of any charges incurred for the cost of his care. (3-30-07)~~

~~**03. Third Party.** All available third party payment resources, such as Medicare and private insurance, must be exhausted before the Department is billed for services provided to an eligible participant. Proof of billing other third party payers will be required by the Department. (3-30-07)~~

~~**04. Injections.** Payment for the administration of injections must be in accordance with rates established by the Department. (3-30-07)~~

~~**718. MENTAL HEALTH CLINIC SERVICES: QUALITY OF SERVICES.**~~

~~The Department must monitor the quality and outcomes of mental health clinic services provided to participants, in coordination with the Divisions of Medicaid, Management Services, Family and Community Services (FACS), and Behavioral Health. (3-30-07)~~

712 -- 719. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

850. SCHOOL-BASED SERVICE: DEFINITIONS.

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

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

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

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

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

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

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

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

mental illness. ()

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

851. SCHOOL-BASED SERVICE: PARTICIPANT ELIGIBILITY.

To be eligible for medical assistance reimbursement for covered services, school districts and charter schools must ensure the student is: (7-1-13)

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

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

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

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

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

~~**06. Service Specific Eligibility.** Psychosocial Rehabilitation (PSR), Behavioral Intervention, Behavioral Consultation, and Personal Care Services (PCS) have additional eligibility requirements. (7-1-13)~~

~~**a.** Psychosocial Rehabilitation (PSR). To be eligible for PSR, the student must meet the PSR eligibility criteria for children in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 112, or the Department of Education's criteria for emotional disturbance found in the Idaho Special Education Manual available online at the Idaho Department of Education website, http://www.sde.idaho.gov/site/special_edu/. Districts are to coordinate the delivery of services if the student is receiving PSR services authorized by the Department. (7-1-13)~~

~~**b.** Behavioral Intervention and Behavioral Consultation. To be eligible for behavioral intervention and behavioral consultation services, the student must: (7-1-13)~~

~~**i.** Meet the criteria for developmental disabilities as identified in Section 66-402(5), Idaho Code, and have documentation to support eligibility using the standards under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 501; and (7-1-13)~~

~~ii. Exhibit maladaptive behaviors that include frequent disruptive behaviors, aggression, self-injury, criminal or dangerous behavior evidenced by a score of at least one point five (1.5) standard deviations from the mean in at least two (2) behavior domains and by at least two (2) raters familiar with the student, or at least two (2) standard deviations from the mean in one (1) composite score that consists of at least three (3) behavior domains by at least two (2) raters familiar with the student, on a standardized behavioral assessment approved by the Department; and (7-1-13)~~

~~iii. Have maladaptive behaviors that interfere with the student's ability to access an education. (7-1-13)~~

~~e. Personal Care Services. To be eligible for personal care services (PCS) the student must have a completed children's PCS assessment approved by the Department. To determine eligibility for PCS, the assessment results must find the student requires PCS due to a medical condition that impairs the physical or functional abilities of the student. (7-1-13)~~

852. SCHOOL-BASED SERVICE: SERVICE-SPECIFIC PARTICIPANT ELIGIBILITY.

Psychosocial Rehabilitation (PSR), Behavioral Intervention, Behavioral Consultation, and Personal Care Services (PCS) have additional eligibility requirements. ()

01. Psychosocial Rehabilitation (PSR). To be eligible for PSR, the student participant must meet one (1) of the following: ()

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

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

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

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

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

- i. Vocational/educational; ()
- ii. Financial; ()
- iii. Social relationships/support; ()
- iv. Family; ()
- v. Basic living skills; ()
- vi. Housing; ()
- vii. Community/legal; or ()
- viii. Health/medical. ()

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

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

- a.** Meet the criteria for developmental disabilities as identified in Section 66-402(5),

Idaho Code, and have documentation to support eligibility using the standards under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 501; and ()

b. Exhibit maladaptive behaviors that include frequent disruptive behaviors, aggression, self-injury, criminal or dangerous behavior evidenced by a score of at least one point five (1.5) standard deviations from the mean in at least two (2) behavior domains and by at least two (2) raters familiar with the student, or at least two (2) standard deviations from the mean in one (1) composite score that consists of at least three (3) behavior domains by at least two (2) raters familiar with the student, on a standardized behavioral assessment approved by the Department; and ()

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

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

8523. SCHOOL-BASED SERVICE: COVERAGE AND LIMITATIONS.

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

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

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

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

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

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

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

b. Be conducted by qualified professionals for the respective discipline as defined in Section 8545 of these rules; (~~7-1-13~~)()

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

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

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

a. Behavioral Intervention. Behavioral Intervention is used to promote the student's ability to participate in educational services, as defined in Section 850 of these rules, through a consistent, assertive, and continuous intervention process. It includes the development of replacement behaviors with the purpose to prevent or treat behavioral conditions of students who exhibit maladaptive behaviors. Services include individual or group behavioral interventions. The following staff-to-participant ratios apply: (7-1-13)

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

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

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

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

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

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

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

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

c. Medical Equipment and Supplies. Medical equipment and supplies that are covered by Medicaid must be ordered by a physician and prior authorized, based on medical

necessity, in order to be billed. Authorized items must be used at school at the location where the service is provided. Equipment that is too large or unsanitary to transport from home to school may be covered if prior authorized. The equipment and supplies must be used for the student's exclusive use and transfer with the student if the student changes schools. Equipment no longer usable by the student, may be donated to the school by the student. (7-1-13)

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

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

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

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

ii. Assistance with bladder or bowel requirements that may include helping the student to and from the bathroom or assisting the student with bedpan routines; (7-1-13)

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

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

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

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

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

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

i. Psychotherapy. (3-30-07)

j. Psychosocial Rehabilitation (PSR) Services and Evaluation. Psychosocial rehabilitation (PSR) services and evaluation services to assist the student in gaining and utilizing

skills necessary to participate in school. Training in behavior control, social skills, communication skills, appropriate interpersonal behavior, symptom management, activities of daily living, study skills, and coping skills are types of interventions that may be reimbursed. This service is to prevent placement of the student into a more restrictive educational situation. ~~See IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 123 for a description of PSR services.~~ (3-29-10)()

- k.** Speech/Audiological Therapy and Evaluation. (3-30-07)
- l.** Social History and Evaluation. (3-30-07)
- m.** Transportation Services. School districts and charter schools can receive reimbursement for mileage for transporting a student to and from home, school, or location of services when: (7-1-13)

 - i. The student requires special transportation assistance such as a wheelchair lift, an attendant, or both, when medically necessary for the health and safety of the student and ordered by a physician; (3-30-07)
 - ii. The transportation occurs in a vehicle specifically adapted to meet the needs of a student with a disability; (3-30-07)
 - iii. The student requires and receives another Medicaid reimbursable service billed by the school-based services provider, other than transportation, on the day that transportation is being provided; (3-30-07)
 - iv. Both the Medicaid-covered service and the need for the special transportation are included on the student's plan; and (3-30-07)
 - v. The mileage, as well as the services performed by the attendant, are documented. See Section 85~~4~~⁵ of these rules for documentation requirements. (3-30-07)()
- n.** Interpretive Services. Interpretive services needed by a student who is deaf or does not adequately speak or understand English and requires an interpreter to communicate with the professional or paraprofessional providing the student with a health-related service may be billed with the following limitations: (7-1-13)

 - i. Payment for interpretive services is limited to the specific time that the student is receiving the health-related service; (3-30-07)
 - ii. Both the Medicaid-covered service and the need for interpretive services must be included on the student's plan; and (3-30-07)
 - iii. Interpretive services are not covered if the professional or paraprofessional providing services is able to communicate in the student's primary language. (3-30-07)

8534. SCHOOL-BASED SERVICE: PROCEDURAL REQUIREMENTS.

The following documentation must be maintained by the provider and retained for a period of six

(6) years: (7-1-13)

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

- i. Type, frequency, and duration of the service(s) provided; (7-1-13)
- ii. Title of the provider(s), including the direct care staff delivering services under the supervision of the professional; (7-1-13)
- iii. Measurable goals, when goals are required for the service; and (7-1-13)
- iv. Specific place of service. (7-1-13)

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

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

- a. Name of student; (7-1-13)
- b. Name and title of the person providing the service; (7-1-13)
- c. Date, time, and duration of service; (7-1-13)
- d. Place of service, if provided in a location other than school; (7-1-13)
- e. Category of service and brief description of the specific areas addressed; and (7-1-13)
- f. Student's response to the service when required for the service. (7-1-13)

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

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

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

referrals and recommendations. (7-1-13)

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

b. A recommendation or referral must be obtained prior to the provision of services for which the school district or charter school is seeking reimbursement. (7-1-13)

07. Parental Notification. School districts and charter schools must document that parents were notified of the health-related services and equipment for which they will bill Medicaid. Notification must comply with the requirements in Subsection 85~~34~~.08 of this rule. ~~(7-1-13)~~()

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

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

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

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

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

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

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

8545. SCHOOL-BASED SERVICE: PROVIDER QUALIFICATIONS AND DUTIES.

Medicaid will only reimburse for services provided by qualified staff. The following are the minimum qualifications for providers of covered services: (7-1-13)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

03. Medical Equipment and Supplies. See Subsection 85~~2~~³.03 of these rules. (7-1-13)()

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

05. Occupational Therapy and Evaluation. Occupation therapy and evaluation must be provided by or under the supervision of an individual qualified and registered to practice in Idaho. (7-1-13)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

07. Physical Therapy and Evaluation. Physical therapy and evaluation must be provided by an individual qualified and licensed as a physical therapist to practice in Idaho. (7-1-13)

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

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

- b.** Licensed physician; (7-1-13)
 - c.** Licensed psychologist; (7-1-13)
 - d.** Psychologist extender registered with the Bureau of Occupational Licenses; or (7-1-13)
 - e.** Certified school psychologist. (7-1-13)
- 09. Psychotherapy.** Provision of psychotherapy services must have, at a minimum, one (1) or more of the following credentials: (7-1-13)
- a.** Psychiatrist, M.D.; (7-1-13)
 - b.** Physician, M.D.; (7-1-13)
 - c.** Licensed psychologist; (7-1-13)
 - d.** Licensed clinical social worker; (7-1-13)
 - e.** Licensed clinical professional counselor; (7-1-13)
 - f.** Licensed marriage and family therapist; (7-1-13)
 - g.** Certified psychiatric nurse (R.N.), as described in Subsection 707.13 of these rules; (7-1-13)
 - h.** Licensed professional counselor whose provision of psychotherapy is supervised in compliance with IDAPA 24.15.01, “Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists”; (7-1-13)
 - i.** Licensed masters social worker whose provision of psychotherapy is supervised as described in IDAPA 24.14.01, “Rules of the State Board of Social Work Examiners”; (7-1-13)
 - j.** Licensed associate marriage and family therapist whose provision of psychotherapy is supervised as described in IDAPA 24.15.01, “Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists”; or (7-1-13)
 - k.** Psychologist extender, registered with the Bureau of Occupational Licenses, whose provision of diagnostic services is supervised in compliance with IDAPA 24.12.01, “Rules of the Idaho State Board of Psychologist Examiners.” (7-1-13)
- 10. Psychosocial Rehabilitation (PSR).** Psychosocial rehabilitation must be provided by a: (7-1-13)
- a.** Licensed physician, licensed practitioner of the healing arts, or licensed psychiatrist; (7-1-13)

- b. Licensed master's level psychiatric nurse; (7-1-13)
- c. Licensed psychologist; (7-1-13)
- d. Licensed clinical professional counselor or professional counselor; (7-1-13)
- e. Licensed marriage and family therapist or associate marriage and family therapist; (7-1-13)
- f. Licensed masters social worker, licensed clinical social worker, or licensed social worker; (7-1-13)
- g. Psychologist extender registered with the Bureau of Occupational Licenses; (7-1-13)
- h. Licensed professional or registered nurse (RN); (7-1-13)
- ~~i. Psychosocial rehabilitation specialist as defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 131; (7-1-13)~~
- ~~ji. Licensed occupational therapist; (7-1-13)~~
- ~~kj. Certified school psychologist; ~~or~~ (7-1-13)()~~
- ~~lk. Certified school social worker; ~~or~~ (7-1-13)()~~
- l. Psychosocial rehabilitation (PSR) specialist. A PSR specialist is: ()
 - i. An individual who has a Bachelor's degree and holds a current PRA credential; or ()
 - ii. An individual who has a Bachelor's degree or higher and was hired on or after November 1, 2010, to work as a PSR specialist to deliver Medicaid-reimbursable mental health services. This individual may continue to do so for a period not to exceed thirty (30) months from the initial date of hire. In order to continue as a PSR specialist beyond a total period of thirty (30) months from the date of hire, the worker must have completed a certificate program or earned a certification in psychiatric rehabilitation based upon the primary population with whom he works in accordance with the requirements set by the PRA. ()
 - iii. Credential required for PSR specialists working primarily with adults. ()
- (1) Applicants who intend to work primarily with adults, age eighteen (18) or older, must become a Certified Psychiatric Rehabilitation Practitioner in accordance with the PRA requirements. ()
- (2) Applicants who work primarily with adults, but also intend to work with participants under the age of eighteen (18), must have training addressing children's developmental milestones, or have evidence of classroom hours in equivalent courses. The

worker's supervisor must determine the scope and amount of training the worker needs in order to work competently with children assigned to the worker's caseload. ()

iv. Credential required for PSR specialists working primarily with children. ()

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

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

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

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

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

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

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

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

b. Physical Therapy. Refer to IDAPA 24.13.01, "Rules Governing the Physical

Therapy Licensure Board,” for qualifications, supervision and service requirements. (7-1-13)

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

8556. SCHOOL-BASED SERVICE: PROVIDER REIMBURSEMENT.

Payment for health-related services provided by school districts and charter schools must be in accordance with rates established by the Department. (7-1-13)

01. Payment in Full. Providers of services must accept as payment in full the school district or charter school payment for such services and must not bill Medicaid or Medicaid participants for any portion of any charges. (7-1-13)

02. Third Party. For requirements regarding third party billing, see Section 215 of these rules. (3-30-07)

03. Recoupment of Federal Share. Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of the Federal share of payments for services, sanctions, or both. (3-30-07)

04. Matching Funds. Federal funds cannot be used as the State's portion of match for Medicaid service reimbursement. School districts and charter schools must, for their own internal record keeping, calculate and document the non-federal funds (maintenance of effort assurance) that have been designated as their certified match. This documentation needs to include the source of all funds that have been submitted to the State and the original source of those dollars. The appropriate matching funds will be handled in the following manner: (3-30-07)

a. Schools will estimate the amount needed to meet match requirements based on their anticipated monthly billings. (3-30-07)

b. School districts and charter schools will send the Department the matching funds, either by check or automated clearing house (ACH) electronic funds transfers. (3-30-07)

c. The Department will hold matching funds in an interest bearing trust account. The average daily balance during a month must exceed one hundred dollars (\$100) in order to receive interest for that month. (3-30-07)

d. The payments to the districts will include both the federal and non-federal share (matching funds). (3-30-07)

e. Matching fund payments must be received and posted in advance of the weekly Medicaid payment cycle. (3-30-07)

f. If sufficient matching funds are not received in advance, all Medicaid payments to the school district will be suspended and the school district will be notified of the shortage. Once

sufficient matching funds are received, suspended payments will be processed and reimbursement will be made during the next payment cycle. (3-30-07)

g. The Department will provide the school districts a monthly statement which will show the matching amounts received, interest earned, total claims paid, the matching funds used for the paid claims, and the balance of their funds in the trust account. (3-30-07)

h. The school districts will estimate the amount of their next billing and the amount of matching funds needed to pay the Department. (3-30-07)

i. The estimated match requirement may be adjusted up or down based on the remaining balance held in the trust account. (3-30-07)

8567. SCHOOL-BASED SERVICE: QUALITY ASSURANCE.

The provider will grant the Department immediate access to all information required to review compliance with these rules. (3-30-07)

8578. -- 859. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1302

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice, the pending rule will become final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code; also 42 CFR 447.90 - Credible allegations of fraud; 42 CFR 455 - Provider Screening and Enrollment; and 42 CFR 498 - Appeal rights; and Subtitle E, Section 6401 of the Patient Protection and Affordable Care Act (Affordable Care Act).

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The proposed rule changes are being done to align with changes in federal regulations and to comply with CMS requirements related to missed appointments.

The proposed rule changes align state rules with federal regulations in 42 CFR 447.90, 42 CFR 455, and 42 CFR 498 that require the Medicaid agency to:

1. Re-validate all provider enrollment information no less frequently than every five (5) years;
2. Ensure all providers prescribing drugs or ordering services for Medicaid participants are enrolled with the agency;
3. Ensure that all providers complete a screening process involving site visits and payment of fees for certain types of providers, either through the Medicaid agency itself or through Medicare; and
4. Align the appeals process for providers denied enrollment with federal requirements.

This rule change also clarifies language about provider charges for missed appointments in accordance with federal requirements.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule published in the October 2, 2013, Idaho Administrative Bulletin, [Vol. 13-10, pages 207 through 213](#).

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

These changes will be accomplished with existing resources and modifications to existing operational processes and are expected to be cost neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jeanne Siroky at (208) 364-1897.

DATED this 19th day of November, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720

Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code; also 42 CFR 447.90 - Credible allegations of fraud; 42 CFR 455 - Provider Screening and Enrollment; and 42 CFR 498 - Appeal rights; and Subtitle E, Section 6401 of the Patient Protection and Affordable Care Act (Affordable Care Act).

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

Tuesday, October 15, 2013 at 2:00 p.m. MDT
Medicaid Central Office Conference Room D-East 3232 Elder St, Boise, ID
You may also participate in this hearing via conference call: Call-in Number: 1-888-706-6468 When prompted, enter Participant ID: 8617015

Thursday, October 17, 2013 at 2:00 p.m. MDT
--

**IDHW Region VI Office
2nd Floor Conf. Room
1070 Hiline Road
Pocatello, ID**

Friday, October 18, 2013 at 2:00 p.m. PDT

**IDHW Region I Office
Suite 102, (lower level large conference room)
1120 Ironwood Drive
Coeur d'Alene, ID**

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

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

The proposed rule changes are being done to align with changes in federal regulations and to comply with CMS requirements related to missed appointments.

The proposed rule changes will align state rules with federal regulations in 42 CFR 447.90, 42 CFR 455, and 42 CFR 498 that require the Medicaid agency to:

1. Re-validate all provider enrollment information no less frequently than every five (5) years;
2. Ensure all providers prescribing drugs or ordering services for Medicaid participants are enrolled with the agency;
3. Ensure that all providers complete a screening process involving site visits and payment of fees for certain types of providers, either through the Medicaid agency itself or through Medicare; and
4. Align the appeals process for providers denied enrollment with federal requirements.

This rule change will also clarify language about provider charges for missed appointments in accordance with federal requirements.

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: NA

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

These changes will be accomplished with existing resources and modifications to existing operational processes and are expected to be cost neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because it was not feasible due to the fact that these rule changes are being done to comply with federal requirements under 42 CFR. The Department has selected the means of compliance that are the least burdensome and the least costly to both providers and the state.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Jeanne Siroky at (208) 364-1897.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 23, 2013.

DATED this 30th day of August, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1302

160. RESPONSIBILITY FOR KEEPING APPOINTMENTS.

The participant is solely responsible for making and keeping an appointment with the provider. ~~If a participant makes an appointment and subsequently does not keep it, the participant may be required to pay the provider an amount established by the provider's missed appointment policy that is applicable to all patients of the provider.~~ The Department will not reimburse providers when participants do not attend scheduled appointments. Providers may not bill participants for missed appointments. (4-2-08)()

(BREAK IN CONTINUITY OF SECTIONS)

200. PROVIDER APPLICATION PROCESS.

01. **Provider Application.** ~~Providers may apply for provider numbers with the Department. Those in-state providers who have previously been assigned a Medicare number may retain that same number. The Department will confirm the status for all applicants with the appropriate licensing board and assign Medicaid provider numbers.~~ Providers who meet

Medicaid enrollment requirements may apply for Idaho Medicaid provider status with the Department. All healthcare providers who are eligible for a National Provider Identifier (NPI) must apply using that identifying number. For providers not eligible for a NPI, the Department will assign a provider number upon approval of the application. (3-30-07)()

02. ~~Denial of Provider Application~~ Screening Levels. ~~The Department must not accept the application of a provider who is suspended from Medicare or Medicaid in another state.~~ In accordance with 42 CFR 455.450, the Department will assign risk levels of “limited,” “moderate,” or “high” to defined groups of providers. These assignments and definitions will be published in the provider handbook. (3-30-07)()

03. Medicare Enrollment Requirement for Specified Providers. The following providers must enroll as Medicare providers prior to enrollment or revalidation as a Medicaid provider. ()

a. Any providers classified in the “moderate” or “high” categorical risk level, as defined in the provider handbook. ()

b. Any provider type classified as an institutional provider by Medicare. ()

04. Disclosure of Information by Providers and Fiscal Agents. All enrolling providers and their fiscal agents must comply with the disclosure requirements as stated in 42 CFR 455, Subpart B, “Disclosure of Information by Providers and Fiscal Agents.” ()

05. Denial of Provider Agreement. The Department may deny provider status by refusing a request to enter into a provider agreement, refusing to extend an existing agreement, or refusing to enter into additional agreements with any individual or entity. Reasons for denying provider status include those described in IDAPA 16.05.07, “The Investigation and Enforcement of Fraud, Abuse, and Misconduct,” Section 265. ()

06. Mandatory Denial of Provider Agreement. The Department will deny a request for a provider agreement when: ()

a. The provider fails to meet the qualifications required by rule or by any applicable licensing board; ()

b. The provider was a managing employee, or had an ownership interest, as defined in 42 CFR Section 455.101, in any entity that was previously found by the Department to have engaged in fraudulent conduct, or abusive conduct related to the Medicaid program, or has demonstrated an inability to comply with the requirements related to the provider status for which application is made, including submitting false claims or violating provisions of any provider agreement; ()

c. The provider was a managing employee, or had an ownership interest, as defined in 42 CFR Section 455.101, in any entity that failed to repay the Department for any overpayments, or to repay claims previously found by the Department to have been paid improperly, whether the failure resulted from refusal, bankruptcy, or otherwise, unless prohibited by law; ()

d. The provider employs as a managing employee, contracts for any management services, shares any ownership interests, or would be considered a related party to any individual or entity identified in Subsections 200.06.a. through 200.06.c. of this rule. ()

e. The provider fails to comply with any applicable requirement under 42 CFR 455. ()

f. The provider is precluded from enrollment due to a temporary moratorium issued by the Secretary of Health and Human Services in accordance with 42 CFR 455.470. ()

g. The provider is currently suspended from Medicare or Medicaid in any state, or has been terminated from Medicare or Medicaid in any state. ()

201. -- 204. (RESERVED)

205. AGREEMENTS WITH PROVIDERS.

01. In General. ~~The Department will enter into written agreements with each provider or group of providers of supplies or services under the Program.~~ **All individuals or organizations must enter into a written provider agreement accepted by the Department prior to receipt of any reimbursement for services.** Agreements may contain any terms or conditions deemed appropriate by the Department. ~~Each agreement will contain, among others, the following terms and conditions requiring the provider:~~ **All provider agreements must be signed by the provider or by an owner or officer who has the legal authority to bind the provider in the agreement.** (3-30-07)()

~~**a.** To retain for a minimum of six (6) years any records necessary for a determination of the services the provider furnishes to participants; and~~ (3-30-07)

~~**b.** To furnish to the Department, the U.S. Department of Health and Human Services, the Fraud Investigation Unit, or the Idaho State Police any information requested regarding payments claimed by the provider for services; and~~ (3-30-07)

~~**c.** To furnish to the Department, the U.S. Department of Health and Human Services, the Fraud Investigation Unit, or the Idaho State Police, information requested on business transactions as follows:~~ (3-30-07)

~~**i.** Ownership of any subcontractor with whom the provider has had business transactions of more than twenty-five thousand dollars (\$25,000) during a twelve (12) month period ending on the date of request; and~~ (3-30-07)

~~**ii.** Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor during the five (5) year period ending on the date of request.~~ (3-30-07)

02. Federal Disclosure Requirements. To comply with the disclosure requirements in 42 CFR 455, Subpart B, each provider, other than an individual practitioner or a group of

practitioners, must disclose to the Department: (3-30-07)

a. The full name and address of each individual who has either direct or indirect ownership interest in the disclosing entity or in any subcontractor of five percent (5%) or more prior to entering into an agreement or at the time of survey and certification; and (3-30-07)

b. Whether any person named in the disclosure is related to another person named in the disclosure as a spouse, parent, or sibling. (3-30-07)

03. ~~Termination of Provider Agreements~~ Enforcement Actions and Terminations. Provider agreements may be terminated with or without cause. ~~Terminations for cause may be appealed as a contested case in accordance with the IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings."~~ The Department may, at its discretion, take any of the following actions for cause based on the provider's conduct or the conduct of its employees or agents, or when the provider fails to comply with any term or provision of the provider agreement, or any applicable state or federal regulation: ~~(3-30-07)()~~

a. ~~The Department may, in its discretion, terminate a provider's agreement for cause based on its conduct or the conduct of its employees or agents, when the provider fails to comply with any term or provision of the provider agreement. Other action may also be taken, based on the conduct of the provider as provided in Section 205 of this chapter of rules, and notice of termination must be given as provided therein. Terminations for cause may be appealed as a contested case in accordance with the IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Ruling."~~ Require corrective actions as described in IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct," Section 270. ~~(3-30-07)()~~

b. Require a corrective action plan to be submitted by the provider to address noncompliance with the provider agreement; ()

c. Reduce, limit, or suspend payment of claims pending the submission, acceptance, or completion of a corrective action plan; ()

d. Limit or suspend provision of services to participants who have not previously established services with the provider pending the submission, acceptance, or completion of a corrective action plan; or ()

e. Terminate the provider's agreement. ()

04. Termination of Provider Agreements. Due to the need to respond quickly to state and federal mandates, as well as the changing needs of the State Plan, the Department may terminate provider agreements without cause by giving written notice to the provider as set forth in the agreement. If an agreement does not provide a notice period, the period is twenty-eight (28) days. Terminations without cause may result from, but are not limited to, elimination or change of programs or requirements, or the provider's inability to continue providing services due to the actions of another agency or board. Terminations without cause are not subject to contested case proceedings since the action will either affect a class of providers, or will result from the discretionary act of another regulatory body. ~~(3-30-07)()~~

~~04. Denial of Provider Agreement. The Department may deny provider status by refusing a request to enter into a provider agreement, refusing to extend an existing agreement, or refusing to enter into additional agreements with any individual or entity, that: (3-30-07)~~

~~a. Fails to meet the qualifications required by rule or by any applicable licensing board; (3-30-07)~~

~~b. Has previously been, or was a managing employee, or had an ownership interest, as defined in 42 C.F.R. Section 455.101, in any entity which was previously found by the Department to have engaged in fraudulent conduct, or abusive conduct related to the Medicaid program or has demonstrated an inability to comply with the requirements related to the provider status for which application is made, including, but not limited to submitting false claims or violating provisions of any provider agreement; (3-30-07)~~

~~c. Has failed, or was a managing employee, or had an ownership interest, as defined in 42 C.F.R. Section 455.101, in any entity that failed to repay the Department for any overpayments, or to repay claims previously found by the Department to have been paid improperly, whether the failure resulted from refusal, bankruptcy, or otherwise, unless prohibited by law; or (3-30-07)~~

~~d. Employs as a managing employee, contracts for any management services, shares any ownership interests, or would be considered a related party to any individual or entity identified in Subsections 205.04.a. through 205.04.e., of this rule. (3-30-07)~~

206. -- 209. (RESERVED)

210. CONDITIONS FOR PAYMENT.

01. Participant Eligibility. The Department will reimburse providers for medical care and services, regardless of the current eligibility status of the medical assistance participant in the month of payment, provided that a complete and properly submitted claim for payment has been received and each of the following conditions are met: ~~(3-30-07)()~~

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

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

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

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

02. Time Limits. The time limit set forth in Subsection 210.01.ed. of this rule does not apply with respect to retroactive eligibility adjustment ~~payments~~. When participant eligibility is determined retroactively, the Department will reimburse providers for services within the period of retroactive eligibility if a claim for those services is submitted within twelve (12) months of the date of the participant's eligibility determination. (3-30-07)()

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

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

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

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

(BREAK IN CONTINUITY OF SECTIONS)

~~342. -- 349. (RESERVED)~~

~~350. CRITERIA FOR PARTICIPATION IN THE MEDICAID PROGRAM.~~

~~01. Application for Participation and Reimbursement. Prior to participation in the Medicaid Program, the Department must certify a facility for participation in the Program. Their recommendations are forwarded to the Division of Welfare, Division of Medicaid or its successor organization, for approval. The Division of Medicaid or its successor organization issues a provider number to the facility which becomes the primary provider identification number. The Division of Medicaid or its successor organization will need to establish an interim rate for the new applicant facility. This facility is now authorized to offer services at the level for which the provider agreement was issued.~~ (3-30-07)

~~02. Reimbursement. The reimbursement mechanism for payment to providers that Medicaid reimburses under a cost-based methodology under Sections 300 through 389 of these rules. The Medical Assistance Program will not reimburse a facility until it is certified, has a signed agreement for participation and an established interim per diem rate.~~ (3-30-07)

~~351.~~—359. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

735. THERAPY SERVICES: PROVIDER REIMBURSEMENT.

01. Payment for Therapy Services. The payment for therapy includes the use of therapeutic equipment to provide the modality or therapy. No additional charge may be made to either the Medicaid program or the participant for the use of such equipment. (4-2-08)

02. Payment Procedures. Payment procedures are as follows: (3-30-07)

a. Therapy provided by home health agencies will be paid at a per visit rate as described in Section 725 of these rules and in accordance with IDAPA 16.03.07, “Rules for Home Health Agencies.” (4-2-08)

b. Therapists ~~identified by Medicare~~ **enrolled with Medicaid** as independent practitioners; **and** licensed by the appropriate state licensing board ~~and enrolled as Medicaid providers~~ will be reimbursed on a fee-for-service basis. ~~Exceptions to the requirement for Medicare certification include:~~ (5-8-09)

~~i. Provider types that Medicare does not certify as is the case for speech language pathologists; and~~ (5-8-09)

~~ii. Providers that only treat pediatric participants and do not expect to treat Medicare participants.~~ (5-8-09)

~~iii.~~ Only those independent practitioners who have been enrolled as Medicaid providers can bill the Department directly for their services. A therapy assistant cannot bill Medicaid directly. The maximum fee will be based upon the Department’s fee schedule, available from the central office for the Division of Medicaid, the contact information for which is found in Section 005 of these rules. (5-8-09)()

c. Therapy rendered on-site to hospital inpatients or outpatients will be paid at a rate not to exceed the payment determined as reasonable cost using Title XVIII (Medicare) standards and principles. (4-2-08)

d. Payment for therapy services rendered to participants in long-term care facilities is included in the facility reimbursement as described in IDAPA 16.03.10, “Medicaid Enhanced Plan Benefits.” (7-1-13)

e. Payment for therapy services rendered to participants in school-based services is described in Section 855 of these rules. (4-2-08)

f. Payment for therapy services rendered by the Idaho Infant Toddler Program will be reimbursed on a fee-for-service basis. (7-1-13)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1303

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the temporary rule is **January 1, 2014**. The pending rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is acted on by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and is also adopting this rule as a temporary rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code; also the Patient Protection and Affordable Care Act (Affordable Care Act - P.L. 111-148), Section 2502(a)(2).

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

Changes to federal laws governing Medicaid programs require all states to cover tobacco cessation drug benefits for all Medicaid eligible participants effective January 1, 2014. This rule change adds the federally required tobacco cessation drugs and counseling for all non-pregnant Medicaid eligible adults over the age of 21. These products are already covered for pregnant women and children under age 21.

In accordance with Section 67-5226, Idaho Code, the full text of the temporary rule is being published in this Bulletin following this notice. There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 2, 2013, Idaho Administrative Bulletin, **Vol. 13-10, pages 214 through 219**.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate in order to implement 42 USC 2502(a)(2) that requires states to cover all eligible participants for tobacco cessation drug benefits, effective January 1, 2014.

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

These benefits are already available to Medicaid participants through the Preventive Health Assistance (PHA) program. These rules shift coverage from that program to pharmacy coverage, and the net impact is expected to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions

concerning this pending rule, contact Arlee Coppinger at (208) 364-1958.

DATED this 27th day of November, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code; also the Patient Protection and Affordable Care Act (Affordable Care Act - P.L. 111-148), Section 2502(a)(2).

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Tuesday, October 15, 2013 at 11:00 a.m. MDT
Medicaid Central Office Conference Room D-East 3232 Elder St, Boise, ID

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

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

Changes to federal laws governing Medicaid programs require all states to cover tobacco cessation drug benefits for all Medicaid eligible participants effective January 1, 2014.

This rule change will add the federally required tobacco cessation counseling for all non-

pregnant Medicaid eligible adults over the age of 21. These products are already covered for pregnant women and children under age 21.

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: NA

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

These benefits are already available to Medicaid participants through the Preventive Health Assistance (PHA) program. These rules shift coverage from that program to pharmacy coverage and the net impact is expected to be cost neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because it was not feasible due to the fact that these rule changes will be publishing as Temporary. Note that the Temporary rule will publish with the pending rule in the January 2014, Idaho Administrative Bulletin. The temporary rule is being done to comply with the requirements in the Affordable Care Act that add mandatory coverage for tobacco cessation drug benefits under Medicaid programs, effective January 1, 2014.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Arla Farmer (208) 364-1958.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 23, 2013.

DATED this 30th day of August, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1303

620. PREVENTIVE HEALTH ASSISTANCE (PHA): DEFINITIONS.

01. Behavioral PHA. Benefits available to a participant specifically to support ~~tobacco cessation or~~ weight control. (3-30-07)()

02. Benefit Year. A benefit year is twelve (12) continuous months. A participant's PHA benefit year begins the date his initial points are earned. (3-30-07)

03. PHA Benefit. A mechanism to reward healthy behaviors and good health choices of a participant eligible for preventive health assistance. (3-30-07)

04. Wellness PHA. Benefits available to a participant to support wellness ~~and safety.~~
(3-30-07)()

621. PREVENTIVE HEALTH ASSISTANCE (PHA): PARTICIPANT ELIGIBILITY.

01. Behavioral PHA. The participant must have a Health Questionnaire on file with the Department. The Health Questionnaire is used to determine eligibility for a Behavioral PHA. The participant must indicate on the Health Questionnaire that he wants to change a behavior related to weight management ~~or tobacco cessation.~~ The participant must meet one of the following criteria: (3-30-07)()

a. For an adult, a body mass index (BMI) of thirty (30) or higher or eighteen and one-half (18 1/2) or lower. (3-30-07)

b. For a child, a body mass index (BMI) that falls in either the overweight or the underweight category as calculated using the Centers for Disease Control (CDC) Child and Teen BMI Calculator. (3-30-07)

~~**c.** For either an adult or a child, use of tobacco products.~~ (3-30-07)

02. Wellness PHA. A participant who is required to pay premiums to maintain eligibility under IDAPA 16.03.01, "Eligibility for Health Assistance for Families and Children," is eligible for Wellness PHA. (3-30-07)

622. PREVENTIVE HEALTH ASSISTANCE (PHA): COVERAGE AND LIMITATIONS.

01. Point System. The PHA benefit uses a point system to track points earned and used by a participant. Each point equals one (1) dollar. (3-29-10)

a. Maximum Benefit Points. (3-30-07)

i. The maximum number of points that can be earned for a Behavioral PHA is two hundred (200) points each benefit year. (3-30-07)

ii. The maximum number of points that can be earned for a Wellness PHA benefit is one hundred twenty (120) points each benefit year. (3-30-07)

~~**b.** Each participant is limited to one (1) Behavioral PHA benefit at any point in time.~~
(3-30-07)

eb. Points expire and are removed from a participant's PHA benefit at the end of the participant's benefit year. (3-30-07)

dc. Points earned for a specific participant's PHA benefit cannot be transferred to or combined with points in another participant's PHA benefit. (3-30-07)

~~**02.** Medications and Pharmaceutical Supplies. Medications and pharmaceutical supplies must be purchased from a licensed pharmacy. (3-30-07)~~

~~**a.** Each medication and pharmaceutical supply must have a primary purpose directly related to weight management or tobacco cessation. (3-30-07)~~

~~**b.** Each medication and pharmaceutical supply must be approved by the FDA, or specifically recommended by the participant's PCP, or a referred physician specialist. (3-30-07)~~

032. Weight Management Program. Each program must provide weight management services and must include a curriculum that includes at least one (1) of the three (3) following areas: (3-30-07)

a. Physical fitness; (3-30-07)

b. Balanced diet; or (3-30-07)

c. Personal health education. (3-30-07)

043. Participant Request for Coverage. A participant can request that a previously unidentified ~~product or~~ service be covered. The Department will approve a request if the product or service meets the requirements described in this section of rule and the vendor meets the requirements in Section 624 of these rules. ~~(3-30-07)()~~

054. Premiums. (3-30-07)

a. Wellness PHA benefit points must be used to offset a participant's premiums. (3-29-10)

b. Only premiums that must be paid to maintain eligibility under IDAPA 16.03.01, "Eligibility for Health Assistance for Families and Children" can be offset by PHA benefit points. (3-30-07)

065. Hearing Rights. A participant does not have hearing rights for issues arising between the participant and a chosen vendor. (3-30-07)

623. PREVENTIVE HEALTH ASSISTANCE (PHA): PROCEDURAL REQUIREMENTS.

01. Behavioral PHA. (3-30-07)

a. A PHA benefit will be established for each participant who meets the eligibility

criteria for Behavioral PHA. A participant must complete a PHA Benefit Agreement Form prior to earning any points. (3-30-07)

~~*b. Each participant who chooses a goal of tobacco cessation must enroll in a tobacco cessation program. (3-30-07)*~~

~~*eb.*~~ Each participant who chooses ~~*a goal of*~~ **to enroll in** weight management must participate in a physician approved or monitored weight management program. ~~*(3-30-07)*~~ **()**

~~*dc.*~~ An initial one hundred (100) points are earned when the agreement form is received by the Department and the benefit is established. (3-30-07)

~~*ed.*~~ An additional one hundred (100) points can be earned by a participant who completes his program or reaches a chosen, defined goal. The vendor monitoring the participant's progress must verify that the program was completed or the goal was reached. (3-30-07)

02. Wellness PHA. (3-30-07)

a. A PHA benefit will be established for each participant who meets the eligibility criteria for Wellness PHA. Each participant must demonstrate that he has received recommended wellness visits and immunizations for his age prior to earning any points. (3-30-07)

b. Ten (10) points can be earned each month by a participant who receives all recommended wellness visits and immunizations for his age during the benefit year. (3-29-10)

03. Approved Products and Services. The reimbursable products and services of each vendor must be prior approved by the Department. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

662. PRESCRIPTION DRUGS: COVERAGE AND LIMITATIONS.

01. General Drug Coverage. The Department will pay for those prescription drugs not excluded by Subsection 662.04 of these rules which are legally obtainable by the order of a licensed prescriber whose licensing allows for the prescribing of legend drugs, as defined under Section 54-1705(28), Idaho Code, and which are deemed medically necessary as defined in Section 011 of these rules. (3-30-07)

02. Dispensing Fee. Dispensing Fee is defined as the cost of filling a prescription including direct pharmacy overhead, and is for all services pertaining to the usual practice of pharmacy, including: (4-4-13)

a. Interpretation, evaluation, compounding, and dispensing of prescription drug orders; (3-30-07)

- b.** Participation in drug selection; (3-30-07)
 - c.** Drug administration; (3-30-07)
 - d.** Drug regimen and research reviews; (3-30-07)
 - e.** Proper storage of drugs; (3-30-07)
 - f.** Maintenance of proper records; (3-30-07)
 - g.** Prescriber interaction; and (3-30-07)
 - h.** Patient counseling. (3-30-07)
- 03. Limitations on Payment.** Medicaid payment for prescription drugs will be limited as follows: (3-30-07)
- a.** Days' Supply. Medicaid will not cover any days' supply of prescription drugs that exceeds the quantity or dosage allowed by these rules. (3-30-07)
 - b.** Brand Name Drugs. Medicaid will not pay for a brand name product that is part of the federal upper limit (FUL) or state maximum allowable cost (SMAC) listing when the physician has not specified the brand name drug to be medically necessary. (3-30-07)
 - c.** Medication for Multiple Persons. When the medication dispensed is for more than one (1) person, Medicaid will only pay for the amount prescribed for the person or persons covered by Medicaid. (3-30-07)
 - d.** No Prior Authorization. Medicaid will not pay for a covered drug or pharmacy item that requires, but has not received, prior authorization for Medicaid payment as required in Section 663 of these rules. (3-30-07)
 - e.** Limitations to Discourage Waste. Medicaid may conduct drug utilization reviews and impose limitations for participants whose drug utilization exceeds the standard participant profile or disease management guidelines determined by the Department. (3-30-07)
- 04. Excluded Drug Products.** The following categories and specific products are excluded from coverage by Medicaid: (3-30-07)
- a.** Non-Legend Medications. Federal legend medications that change to non-legend status, as well as their therapeutic equivalents regardless of prescription, status unless: (3-30-07)
 - i.** They are included in Subsection 662.05.b. of these rules; or (3-30-07)
 - ii.** The Director determines that non-legend drug products are covered based upon appropriate criteria including the following: safety, effectiveness, clinical outcomes of the drug in comparison with other therapeutically interchangeable alternative drugs, cost, and the recommendation of the Pharmacy And Therapeutics Committee. Therapeutically interchangeable

is defined in Subsection 663.01.e. of these rules. (3-30-07)

b. Legend Drugs. Any legend drugs for which federal financial participation is not available. (3-30-07)

c. Diet Supplements. Diet supplements and weight loss products, except lipase inhibitors when prior authorized as outlined in Section 663 of these rules. (3-30-07)

d. Amphetamines and Related Products. Amphetamines and related products for cosmetic purposes or weight loss. Amphetamines and related products which are deemed to be medically necessary may be covered if prior authorized as outlined in Section 663 of these rules. (3-30-07)

e. Ovulation/Fertility Drugs. Ovulation stimulants, fertility drugs, and similar products. (3-30-07)

f. Impotency Aids. Impotency aids, either as medication or prosthesis. (3-30-07)

~~**g.** Tobacco Cessation Products. Nicotine chewing gum, sprays, inhalers, transdermal patches and related products, with the exception that both legend and non-legend tobacco cessation products will be covered for children and pregnant women when prescribed by their physician. (4-4-13)~~

h.g. Medications Utilized for Cosmetic Purposes. Medications utilized for cosmetic purposes or hair growth. Prior authorization may be granted for these medications if the Department finds other medically necessary indications. (3-30-07)

h. Vitamins. Vitamins unless included in Subsection 662.05.a. of these rules. (3-30-07)

i. Dual Eligibles. Drug classes covered under Medicare, Part D, for Medicaid participants who are also eligible for Medicare. (3-30-07)

05. Additional Covered Drug Products. Additional drug products will be allowed as follows: (3-30-07)

a. Therapeutic Vitamins. Therapeutic vitamins may include: (3-30-07)

i. Injectable vitamin B12 (cyanocobalamin and analogues); (3-30-07)

ii. Vitamin K and analogues; (3-30-07)

iii. Pediatric legend vitamin-fluoride preparations; (3-30-07)

iv. Legend prenatal vitamins for pregnant or lactating women; (3-30-07)

v. Legend folic acid; (3-30-07)

- vi. Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients; (4-4-13)
 - vii. Legend vitamin D and analogues; and (4-4-13)
 - viii. Legend ~~smoking tobacco~~ cessation products ~~for pregnant women and children.~~
(4-4-13)()
- b.** Prescriptions for Nonlegend Products. Prescriptions for nonlegend products may include: (3-30-07)
- i. Insulin; (3-30-07)
 - ii. Disposable insulin syringes and needles; (3-30-07)
 - iii. Oral iron salts; (4-4-13)
 - iv. Permethrin; and (4-4-13)
 - v. ~~Smoking Tobacco~~ cessation products ~~for pregnant women and children.~~
(4-4-13)()

06. Limitation of Quantities. Medication refills provided before at least seventy-five percent (75%) of the estimated days' supply has been utilized are not covered, unless an increase in dosage is ordered. Days' supply is the number of days a medication is expected to last when used at the dosage prescribed for the participant. No more than a thirty-four (34) days' supply of continuously required medication is to be purchased in a calendar month as a result of a single prescription with the following exceptions: (3-30-07)

- a.** Doses of Medication. Up to one hundred (100) doses of medication may be dispensed, not to exceed a one hundred (100) day supply for: (3-30-07)
- i. Cardiac glycosides; (3-30-07)
 - ii. Thyroid replacement hormones; (3-30-07)
 - iii. Prenatal vitamins; (3-30-07)
 - iv. Nitroglycerin products - oral or sublingual; (3-30-07)
 - v. Fluoride and vitamin/fluoride combination products; and (3-30-07)
 - vi. Nonlegend oral iron salts. (3-30-07)
- b.** Oral Contraceptive Products. Oral contraceptive products may be dispensed in a quantity sufficient for one (1), two (2), or three (3) cycles. (3-30-07)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

Section 56-261, Idaho Code, directs the Department to implement managed care tools to develop an accountable care system to improve health outcomes. In order to comply, the State has implemented a federal 1915(b) Managed Care Waiver that requires Medicaid participants to enroll in the **Idaho Behavioral Health Plan (IBHP)**. This plan is structured as a statewide prepaid ambulatory health plan (PAHP) under 42 CFR 438.2. This allows the Department to make a prepaid capitated payment for each participant enrolled with the behavioral health managed care entity. These rule changes align this chapter with the managed care waiver.

All rules related to behavioral health services have been removed from these rules and moved into IDAPA 16.03.09, "Medicaid Basic Plan Benefits."

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule published in the August 7, 2013, Idaho Administrative Bulletin, **Vol. 13-8, pages 243 through 283**.

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

There is no anticipated fiscal impact to the state general fund. The consolidation of mental health clinic services, psychosocial rehabilitative services, mental health service coordination, and substance use disorder service benefits into one program of behavioral health services provided through a managed care delivery system will be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Carolyn Burt at (208) 364-1844.

DATED this 3rd day of October, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500; fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is **September 1, 2013**.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

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

Tuesday, August 20, 2013 6:00 p.m. P.D.T.	Wednesday, August 21, 2013 1:00 p.m. M.D.T.	Wednesday, August 21, 2013 6:00 p.m. M.D.T.
IDHW Region I Office (lrg. conf. room, lower level) 1120 Ironwood Dr., Suite 102 Coeur d'Alene, ID 83814	Medicaid Central Office (conf. rooms D-East & West) 3232 Elder Street Boise, ID 83705	IDHW Region VII Office (2nd flr., large conf. room) 150 Shoup Ave. Idaho Falls, ID 83402

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

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

Section 56-261, Idaho Code, directs the Department to implement managed care tools to develop an accountable care system to improve health outcomes. In order to comply, the State will implement a 1915(b) Waiver that will require Medicaid participants to enroll in a statewide prepaid ambulatory health plan (PAHP). Rule changes are being made to incorporate the managed care waiver changes into these rules.

All rules related to behavioral health services are being removed from these rules and moved into IDAPA 16.03.09, "Medicaid Basic Plan Benefits."

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate because it confers a benefit. In compliance with Section 56-261, Idaho Code, that requires the Department to implement managed care systems whenever possible, these rule changes are necessary in order for the Department to confer the Idaho Medicaid Behavioral Health benefits under the applicable authority.

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

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

There is no anticipated fiscal impact to the state general fund. The consolidation of mental health clinic services, psychosocial rehabilitative services, mental health service coordination, and substance use disorder service benefits into one program of behavioral health services provided through a managed care delivery system will be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this is a temporary rule being done to comply with the requirements in Section 56-261, Idaho Code.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Carolyn Burt at (208) 364-1844.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 28, 2013.

DATED this 9th day of July, 2013.

[LSO Rules Analysis Memo](#)

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-1301

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.03.10, “Medicaid Enhanced Plan Benefits.” (3-19-07)

02. Scope. These rules establish the Medicaid Enhanced Plan Benefits covered under Title XIX and Title XXI. Participants who are eligible for Enhanced Plan Benefits are also eligible for benefits under IDAPA 16.03.09, “Medicaid Basic Plan Benefits,” with the exception of coverage for dental services. Dental services for the Medicaid Enhanced Plan are covered under Sections 080 through 085 of these rules. Outpatient behavioral health benefits are contained in IDAPA 16.03.09. “Medicaid Basic Plan Benefits.” (~~5-8-09~~)()

03. Scope of Reimbursement System Audits. These rules also provide for the audit of providers’ claimed costs against these rules and Medicare standards. The Department reserves the right to audit financial and other records of the provider, and, when warranted, the records of entities related to the provider. Audits consist of the following types of records: (3-19-07)

- a. Cost verification of actual costs for providing goods and services; (3-19-07)
- b. Evaluation of provider’s compliance with the provider agreement, reporting form instructions, and any applicable law, rule, or regulation; (3-19-07)
- c. Effectiveness of the service to achieve desired results or benefits; and (3-19-07)
- d. Reimbursement rates or settlement calculated under this chapter. (3-19-07)

04. Exception to Scope for Audits and Investigations. Audits as described in these rules do not apply to the audit processes used in conducting investigations of fraud and abuse under IDAPA 16.05.07, “Investigation and Enforcement of Fraud, Abuse, and Misconduct.” (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

004. INCORPORATION BY REFERENCE.

The Department has incorporated by reference the following document: (3-19-07)

01. 42 CFR Part 447. 42 CFR Part 447, “Payment for Services,” revised as of October 1, 2001, is available from CMS, 7500 Security Blvd, Baltimore, M.D., 21244-1850 or on the Code of Federal Regulations website at <http://www.access.gpo.gov/nara/cfr/cfr-table-search.html>. (3-19-07)

02. CDT - 2007/2008 (Current Dental Terminology, Sixth Edition). Current Dental Terminology, Sixth Edition, is available from the American Dental Association, 211 East Chicago Ave., Chicago, IL 60601-9985, or may be ordered online at <http://www.adacatalog.org>. A copy is

available for public review at the Division of Medicaid, 3232 Elder Street, Boise, ID 83705.

(5-8-09)

~~03. **DSM-IV-TR.** American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) Washington, DC, American Psychiatric Association, 2000. Copies of the manual are available from the American Psychiatric Association, 1400 K Street, N.W., Washington, DC, 20005. A copy of the manual is also available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702.~~

~~(3-19-07)~~

043. Estimated Useful Lives of Depreciable Hospital Assets, 2004 Revised Edition, Guidelines Lives. This document may be obtained from American Hospital Publishing, Inc., 211 E. Chicago Ave., Chicago, IL. 60611.

(3-19-07)

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

(3-19-07)

065. Provider Reimbursement Manual (PRM). The Provider Reimbursement Manual (PRM), Part I and Part II CMS Publication 15-1 and 15-2), is available on the CMS website at <http://www.cms.gov/Manuals/PBM/list.asp>.

(3-19-07)

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

(3-19-07)

087. SIB-R Comprehensive Manual. Scales of Independent Behavior - Revised Comprehensive Manual, 1996, Riverside Publishing Co, 425 Spring Lake Drive, Itasca, IL 60143-2079.

(3-19-07)

098. Travel Policies and Procedures of the Idaho State Board of Examiners. The text of "Idaho State Travel Policies and Procedures of the Idaho State Board of Examiners," Appendices A and B, June 13, 2000, is available at the Office of the State Controller, 700 W. State St., 5th Fl., Box 83720, Boise, Idaho 83720-0011 or on the Internet at <http://www.sco.idaho.gov/>.

(3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

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.” (3-19-07)

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. Crisis Intervention Providers. The criminal history and background check requirements applicable to crisis intervention providers as provided in Section 685 of these rules. (7-1-11)

h. 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)

i. 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)

j. 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)

k. 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)

~~**l.** *Mental Health Clinics. The criminal history and background check requirements applicable to mental health clinic staff as provided in IDAPA 16.03.09, “Medicaid Basic Plan Benefits,” Section 714. (3-19-07)*~~

~~**m.** 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)~~

~~**n.** 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)~~

~~**o.** *Psychosocial Rehabilitation Agencies. The criminal history and background check requirements applicable to psychosocial rehabilitation agency employees as provided in Subsection 130.02 of these rules. (3-19-07)*~~

~~**p.** 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)~~

~~**q.** 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)~~

~~**r.** 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)~~

~~**s.** 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)~~

~~**t.** 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)~~

~~**u.** 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)

038. GENERAL REIMBURSEMENT: TYPES OF PARTICIPANT SERVICES.

The following types of services are reimbursed as provided in Section 037 of these rules. (4-4-13)

~~01. Payment for Enhanced Outpatient Mental Health Services. The fees for outpatient mental health services described in Section 110 of these rules. (4-4-13)~~

~~02. Psychosocial Rehabilitative Services (PSR). The fees for psychosocial rehabilitative services (PSR) described in Section 120 of these rules. (4-4-13)~~

031. Personal Care Services. The fees for personal Care Services (PCS) described in Section 300 of these rules. (4-4-13)

042. Aged and Disabled Waiver Services. The fees for personal care services (PCS) described in Section 320 of these rules. (4-4-13)

053. Children's Waiver Services. The fees for children's waiver services described in Section 680 of these rules. (4-4-13)

064. Adults with Developmental Disabilities Waiver Services. The fees for adults with developmental disabilities waiver services described in Section 700 of these rules. (4-4-13)

075. Service Coordination. The fees for service coordination described in Section 720 of these rules. (4-4-13)

086. Therapy Services. The fees for physical therapy, occupational therapy, and speech-language pathology services described in Section 215 of these rules include the use of therapeutic equipment to provide the modality or therapy. No additional charge may be made to either the Medicaid program or the client for the use of such equipment. (4-4-13)

(BREAK IN CONTINUITY OF SECTIONS)

075. ENHANCED PLAN BENEFITS: COVERED SERVICES.

Individuals who are eligible for the Medicaid Enhanced Plan Benefits are eligible for all benefits covered under IDAPA 16.03.09, "Medicaid Basic Plan Benefits," with the exception of coverage for dental services. In addition to those benefits, individuals in the enhanced plan are eligible for the following enhanced benefits as provided for in this chapter of rules. (5-8-09)

01. Dental Services. Dental Services are provided as described under Sections 080 through 089 of these rules. (3-29-12)

02. Enhanced Hospital Benefits. Organ transplants are provided under the Enhanced Hospital services as described in Sections 090 through 099 of these rules. (3-19-07)

03. Enhanced ~~Mental~~ Outpatient Behavioral Health Benefits. Enhanced ~~Mental Outpatient Behavioral~~ Health services are ~~provided under Sections 100 through 147 of these rules.~~ described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." (3-19-07)()

04. Enhanced Home Health Benefits. Private Duty Nursing services are provided under the Enhanced Home Health as described in Sections 200-219 of these rules. (3-19-07)

05. Therapies. Physical, Speech, and Occupational Therapy Providers as described in Section 215 of these rules. (3-19-07)

06. Long Term Care Services. The following services are provided under the Long Term Care Services. (3-30-07)

a. Nursing Facility Services as described in Sections 220 through 299 of these rules. (3-19-07)

b. Personal Care Services as described in Sections 300 through 308 of these rules. (3-30-07)

c. A & D Waiver Services as described in Sections 320 through 330 of these rules. (3-30-07)

07. Hospice. Hospice services as described in Sections 450 through 459 of these rules. (3-19-07)

08. Developmental Disabilities Services. (3-19-07)

a. Developmental Disability Standards as described in Sections 500 through 506 of these rules. (3-19-07)

b. Children's Developmental Disability Services as described in Sections 520 through 528, 660 through 666, and 680 through 686 of these rules. (7-1-13)

c. Adult Developmental Disabilities Services as described in Sections 507 through 520, and 649 through 657 of these rules. (7-1-13)

d. ICF/ID as described in Sections 580 through 649 of these rules. (3-19-07)

e. Developmental Disabilities Agencies as described in Sections 700 through 719 of these rules. (3-19-07)

09. Service Coordination Services. Service coordination as described in 720 through 779 of these rules. (3-19-07)

10. Breast and Cervical Cancer Program. Breast and Cervical Cancer Program is described in Sections 780 through 800 of these rules. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

SUB AREA: ENHANCED ~~MENTAL HEALTH~~
INPATIENT PSYCHIATRIC HOSPITAL SERVICES
(Sections 100 Through 199)

(BREAK IN CONTINUITY OF SECTIONS)

103. --~~109.~~ (~~RESERVED~~)

~~II. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES.~~

~~In addition to mental health services covered under IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Sections 709 through 718, the Medicaid Enhanced Plan Benefits include the following enhanced outpatient mental health benefits.~~

~~(5-8-09)~~

~~01. Community Reintegration. The enhanced services include community reintegration as described in Sections 111 through 146 of these rules.~~

~~(5-8-09)~~

~~02. Partial Care Services. The enhanced services include partial care services in a Mental Health Clinic as described in Subsection 116.01 of these rules.~~

~~(5-8-09)~~

~~03. Psychotherapy. The enhanced services include additional psychotherapy in a Mental Health Clinic as described in Subsection 118.01 of these rules.~~

~~(5-8-09)~~

~~04. Skill Training. The enhanced services include skill training as described in Sections 111 through 146 of these rules.~~

~~(5-8-09)~~

~~III. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES: DEFINITIONS.~~

~~These definitions apply to Sections 100 through 146 of these rules.~~

~~(3-19-07)~~

~~01. Agency. A Medicaid provider who delivers either mental health clinic services or psychosocial rehabilitative services, or both.~~

~~(5-8-09)~~

~~02. Community Reintegration. A psychosocial rehabilitation (PSR) service that provides practical information and direct support to help the participant maintain his current skills, prevent regression, or practice newly-acquired life skills. The intention of this service is to provide the information and support needed by a participant to achieve the highest level of stability and independence that meets his ongoing recovery needs.~~

~~(5-8-09)~~

~~03. Comprehensive Diagnostic Assessment. A thorough assessment of the participant's current condition and complete medical and psychiatric history.~~

~~(5-8-09)~~

~~04. Comprehensive Diagnostic Assessment Addendum. A supplement to the~~

~~comprehensive diagnostic assessment that contains updated information relevant to the formulation of a participant's diagnosis and disposition for treatment. (3-29-12)~~

~~**05. Demographic Information.** Information that identifies participants and is entered into the Department's database collection system. (3-19-07)~~

~~**06. Duration of Services.** Refers to length of time for a specific service to occur in a single encounter. (5-8-09)~~

~~**07. Goal.** The desired outcome related to an identified issue. (3-19-07)~~

~~**08. Initial Contact.** The date a participant, or participant's parent or legal guardian comes in to an agency and requests Enhanced Plan services. (5-8-09)~~

~~**09. Interdisciplinary Team.** Group that consists of two (2) or more individuals in addition to the participant, the participant's legal guardian, and the participant's natural supports. This may include professionals from several fields or professions. Team members combine their skills and resources to provide guidance and assistance in the creation of the participant's treatment plan. Professionals working with the participant to fulfill the goals and objectives on the treatment plan are members of the participant's interdisciplinary team whether they attend treatment plan meetings or not. At a minimum, professional members of the team include the medical professional authorizing the treatment plan and the specific agency staff member who is working with the participant. (5-8-09)~~

~~**10. Issue.** A statement specifically describing the participant's behavior directly relating to the participant's mental illness and functional impairment. (3-19-07)~~

~~**11. Level of Care.** Clinical treatment decisions that determine service site, modality, urgency, and specific interventions needed to address the key presenting signs, symptoms, and environmental factors that indicate the severity of illness and the intensity of service needed by the participant. It also takes into account relevant external factors affecting clinical treatment decisions. (5-8-09)~~

~~**12. Licensed Practitioner of the Healing Arts.** A licensed physician, physician assistant, nurse practitioner, or clinical nurse specialist. The nurse practitioner and clinical nurse specialist must have experience prescribing medications for psychiatric disorders. (5-8-09)~~

~~**13. Neuropsychological Testing.** Assessment of brain functioning through structured and systematic behavioral observation. Neuropsychological tests are designed to examine a variety of cognitive abilities, including speed of information processing, attention, memory, language, and executive functions, which are necessary for goal-directed behavior. These data can provide information leading to the diagnosis of a cognitive deficit or to the confirmation of a diagnosis, as well as to the localization of organic abnormalities in the central nervous system. The data can also guide effective treatment methods for the rehabilitation of impaired participants. (5-8-09)~~

~~**14. New Participant.** A participant is considered "new" if he has not received Medicaid-reimbursable mental health clinic or psychosocial rehabilitation services (PSR) in the~~

~~twelve (12) months prior to the current treatment episode. (3-29-12)~~

~~**15. Objective.** A milestone toward meeting the goal that is concrete, measurable, time-limited, and behaviorally specific. (3-19-07)~~

~~**16. Occupational Therapy.** For the purposes of mental health treatment, the use of purposeful, goal-oriented activity to achieve optimum functional performance and independence, prevent further disability, and maintain health with individuals who are limited by the symptoms of their mental illness. (5-8-09)~~

~~**17. Partial Care.** Partial care is treatment for participants with serious and persistent mental illness (SPMI) whose functioning is sufficiently disrupted to the extent that it interferes with their productive involvement in daily living. Partial care services are a structured program of therapeutic interventions that assist program participants in the stabilization of their behavior and conduct through the application of principles of behavior modification for behavior change and structured, goal-oriented group socialization for skill acquisition. (3-29-12)~~

~~**18. Pharmacological Management.** The in-depth management of medications for psychiatric disorders for relief of a participant's signs and symptoms of mental illness, provided by a licensed practitioner of the healing arts. (5-8-09)~~

~~**19. Psychiatric Nurse, Licensed Master's Level.** A certified psychiatric nurse, Clinical Nurse Specialist or Psychiatric Nurse Practitioner, must be licensed in accordance with Title 54, Chapter 14, Idaho Code, or certified by a recognized national certification organization, and have a minimum of a master's degree. (5-8-09)~~

~~**20. Psychosocial Rehabilitative Services (PSR).** An array of rehabilitative services that emphasize resiliency for children with serious emotional disturbance (SED) and recovery for adults with serious and persistent mental illness (SPMI). Services target skills for children that they would have appropriately developed for their developmental stage had they not developed symptoms of SED. Services target skills for adults that have been lost due to the symptoms of their mental illness. (5-8-09)~~

~~**21. Psychotherapy.** A method of treating and managing psychiatric disorders through the use of evidenced-based psychological treatment modalities that match the participant's ability to benefit from the service. The focus of the service is on behavioral, emotional, and cognitive aspects of a participant's functioning. (5-8-09)~~

~~**22. Psychological Testing.** Psychological testing refers to any measurement procedure for assessing psychological characteristics in which a sample of an examinee's behavior is obtained and subsequently evaluated and scored using a standardized process. This does not refer to assessments that are otherwise conducted by a professional within the scope of his license for the purposes of determining a participant's mental status, diagnoses or functional impairments. (5-8-09)~~

~~**23. Restraints.** Restraints include the use of physical, mechanical, or chemical interventions, or other means to temporarily subdue or modify participant behavior. (5-8-09)~~

- ~~**a.** A restraint includes; (5-8-09)~~
- ~~i. Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a participant to move his arms, legs, body, or head freely; or (5-8-09)~~
- ~~ii. A drug or medication when it is used as a restriction to manage the participant's behavior or restrict the participant's freedom of movement and is not a standard treatment or dosage for the participant's condition; (5-8-09)~~
- ~~**b.** A restraint does not include physical escorts or devices, such as orthopedically prescribed devices, to permit the participant to participate in activities without the risk of physical harm. (5-8-09)~~
- ~~**24. Seclusion.** Seclusion is the involuntary confinement of a participant alone in a room or area from which the participant is prevented from leaving. (5-8-09)~~
- ~~**25. Serious Emotional Disturbance (SED).** In accordance with the Children's Mental Health Services Act, Section 16-2403, Idaho Code, SED is: (5-8-09)~~
- ~~**a.** An emotional or behavioral disorder, according to the DSM-IV-TR which results in a serious disability; and (5-8-09)~~
- ~~**b.** Requires sustained treatment interventions; and (5-8-09)~~
- ~~**c.** Causes the child's functioning to be impaired in thought, perception, affect, or behavior. (5-8-09)~~
- ~~**d.** A substance abuse disorder, or conduct disorder, or developmental disorder, alone, does not constitute a serious emotional disturbance, although one (1) or more of these conditions may co-exist with serious emotional disturbance. (5-8-09)~~
- ~~**26. Serious Mental Illness (SMI).** In accordance with 42 CFR 483.102(b)(1), a person with SMI: (5-8-09)~~
- ~~**a.** Currently or at any time during the year, must have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified in the DSM-IV-TR; and (5-8-09)~~
- ~~**b.** Must have a functional impairment which substantially interferes with or limits one (1) or more major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning with an individual's basic daily living skills, instrumental living skills, and functioning in social, family, vocational or educational contexts. Instrumental living skills include maintaining a household, managing money, getting around the community, and taking prescribed medication. An adult who met the functional impairment criteria during the past year without the benefit of treatment or other support services is considered to have a serious mental illness. (5-8-09)~~

~~27. **Serious and Persistent Mental Illness (SPMI).** Participants must meet the criteria for SMI, have at least one (1) additional functional impairment, and have a diagnosis under DSM-IV-TR with one (1) of the following: Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a conclusive diagnosis. (5-8-09)~~

~~28. **Skill Training.** The service of providing a curriculum-based method of skill building in a custom-tailored approach that meets the needs identified on the person's assessment, focuses on interventions that are necessary to maintain functioning, prevent regression, or achieve a rehabilitation goal, and promotes increased independence in thinking and behavior. Skill training may be delivered individually or in groups. (5-8-09)~~

~~29. **Tasks.** Specific, time-limited activities and interventions designed to accomplish the objectives in the individualized treatment plan. (3-19-07)~~

~~30. **Treatment Plan Review.** The practice of obtaining input from members of a participant's interdisciplinary team that is focused on evaluating the programs, progress, and future plans of a participant. This review should provide feedback and suggestions intended to help team members and the participant to accomplish the participant's goals identified on the participant's individualized treatment plan. (5-8-09)~~

~~31. **USPRA.** The United States Psychiatric Rehabilitation Association is an association that works to improve and promote the practice and outcomes of psychiatric rehabilitation and recovery. USPRA also maintains a certification program to promote the use of qualified staff to work for individuals with mental illness. <http://www.uspra.org> (5-8-09)~~

~~112. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES: PARTICIPANT ELIGIBILITY.~~

~~To qualify for enhanced outpatient mental health services, a participant must obtain a comprehensive diagnostic assessment as described in Section 114 of these rules. The comprehensive diagnostic assessment for enhanced outpatient mental health services must include documentation of the medical necessity for each service to be provided. For partial care services, the comprehensive diagnostic assessment must also contain documentation that shows the participant is currently at risk for an out-of-home placement, further clinical deterioration that would lead to an out-of-home placement, or further clinical deterioration that would interfere with the participant's ability to maintain his current level of functioning. (4-4-13)~~

~~01. **General Participant Eligibility Criteria.** The medical record must have documented evidence of a history and physical examination that has been completed by a participant's primary care physician. This examination must be within the last twelve (12) months immediately preceding the initiation of mental health clinic services and annually thereafter. Providers must refer those participants who have not had a history and physical examination to their primary care provider for this service. Participants who are in crisis as described at Subsection 123.04 of this rule may receive mental health services prior to obtaining a history and physical examination. In order for a participant to be eligible for enhanced outpatient mental health services, the following criteria must be met and documented in the comprehensive~~

~~diagnostic assessment;~~ (5-8-09)

~~a. The service represents the least restrictive setting and other services have failed or are not appropriate for the clinical needs of the participant.~~ (5-8-09)

~~b. The services can reasonably be expected to improve the participant's condition or prevent further regression so that the current level of care is no longer necessary or may be reduced.~~ (4-2-08)

~~c. Participants identified in Subsections 112.01.c.i. through 112.01.c.iii. of this rule cannot participate in enhanced outpatient mental health services;~~ (4-2-08)

~~i. Participants at immediate risk of self-harm or harm to others who cannot be stabilized;~~ (4-2-08)

~~ii. Participants needing more restrictive care or inpatient care; and~~ (4-2-08)

~~iii. Participants who have not fulfilled the requirements of Subsections 112.02 or 112.03 of these rules.~~ (4-2-08)

~~02. **Eligibility Criteria for Children.** To be eligible for services, a participant under the age of eighteen (18) must have a serious emotional disturbance (SED).~~ (5-8-09)

~~03. **Eligibility Criteria for Adults.** To be eligible for services, a participant must be eighteen (18) years or older and have a serious mental illness (SMI).~~ (5-8-09)

~~04. **Level of Care Criteria—Mental Health Clinics.** To be eligible for mental health clinic services, a participant must meet the criteria as described in Subsections 112.04.a. and 112.04.b. of this rule.~~ (4-2-08)

~~a. Children must meet Subsections 112.01 and 112.02 of this rule.~~ (4-2-08)

~~b. Adults must meet Subsections 112.01 and 112.03 of this rule.~~ (4-2-08)

~~05. **Level of Care Criteria—Psychosocial Rehabilitation (PSR) Services for Children.**~~ (4-4-13)

~~a. To be eligible for the PSR services of skill training and community reintegration, a child must meet the criteria of SED and Subsections 112.01 and 112.02 of this rule and must experience a substantial impairment in functioning.~~ (4-4-13)

~~b. The participant's comprehensive diagnostic assessment must clearly identify the participant's need for skill training services that target skill deficits caused by his mental health condition. The participant's record must contain documentation that collaboration has occurred with the participant's other service providers in order to prevent duplication of skill training treatment services.~~ (4-4-13)

~~c. A child's level and type of functional impairment must be documented in the~~

~~medical record. The Child and Adolescent Functional Assessment Scale/Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS) instrument must be used to obtain the child's initial functional impairment score. Subsequent scores must be obtained at regular intervals in order to determine the child's change in functioning that occurs as a result of mental health treatment. (4-4-13)~~

~~d. Items endorsed on the CAFAS/PECFAS must be supported by specific descriptions of the child's observable behavior in the comprehensive diagnostic assessment. Substantial impairment requires that the child score in the moderate range in at least two (2) subscales on the CAFAS/PECFAS. One (1) of the two (2) subscales must be from the following list: self-harmful behavior, moods/emotions, or thinking. (4-4-13)~~

~~06. Level of Care Criteria—Psychosocial Rehabilitation (PSR) Services and Partial Care Services for Adults. (4-4-13)~~

~~a. To be eligible for partial care services or the PSR services of skill training and community reintegration, an adult must meet the criteria of SPMI and Subsection 112.01 of this rule. In addition, the psychiatric disorder must be of sufficient severity to affect the participant's functional skills negatively, causing a substantial disturbance in role performance or coping skills in at least two (2) of the areas in Subsection 112.06.c.i. through 112.06.c.viii. of this rule on either a continuous or an intermittent, at least once per year, basis. (4-4-13)~~

~~b. The participant's comprehensive diagnostic assessment must clearly identify the participant's need for skill training services that target skill deficits caused by his mental health condition. The participant's record must contain documentation that collaboration has occurred with the participant's other service providers in order to prevent duplication of skill training treatment services. (4-4-13)~~

~~e. The skill areas that are targeted must be consistent with the participant's ability to engage and benefit from treatment. The detail of the adult's level and type of functional impairment must be documented in the medical record in the following areas: (4-4-13)~~

- ~~i. Vocational/educational; (4-2-08)~~
- ~~ii. Financial; (4-2-08)~~
- ~~iii. Social relationships/support; (4-2-08)~~
- ~~iv. Family; (4-2-08)~~
- ~~v. Basic living skills; (4-2-08)~~
- ~~vi. Housing; (4-2-08)~~
- ~~vii. Community/legal; or (4-2-08)~~
- ~~viii. Health/medical. (4-2-08)~~

~~07. Criteria Following Discharge For Psychiatric Hospitalization.~~ Children and adults discharged from psychiatric hospitalization and who meet the diagnostic criteria of the target population in these rules are eligible for enhanced outpatient mental health clinic and PSR services. (3-19-07)

~~a. Children and adults discharged from psychiatric hospitalization and who meet the diagnostic criteria of the target population in these rules, described in Subsection 112.02 of this rule for children, and in Subsection 112.03 of this rule for adults, are considered immediately eligible for enhanced outpatient mental health services for a period of at least one hundred and twenty (120) days following discharge from the hospital. The individualized treatment plan must be completed and documented in the medical record within ten (10) days of discharge. (5-8-09)~~

~~i. Up to two (2) hours of plan development hours may be used for coordinating with hospital staff and others the participant chooses. These plan development hours are to be used for the development of an individualized treatment plan based on the participant's hospital records and past history. The provider agency does not have to perform any additional assessment in order to initiate treatment nor does the participant need to qualify as described in Section 114 of these rules. (5-8-09)~~

~~ii. Upon initiation of treatment at the agency, the treatment plan is valid for no more than one hundred twenty (120) days from the date of discharge from the hospital. A comprehensive diagnostic assessment or updated comprehensive diagnostic assessment addendum must be completed within ten (10) days of the initiation of treatment if one is not available from the hospital or if the one from the hospital does not contain the needed clinical information. (3-29-12)~~

~~b. In order for the participant to continue in the services listed on the post-hospitalization treatment plan beyond one hundred twenty (120) days, the plan must be updated and the provider must establish that the participant meets the criteria as described in Subsections 112.01 through 112.06 of this rule as applicable to the services being provided, and that enhanced outpatient mental health services are appropriate for the participant's age, circumstances, and medically necessary level of care. The PSR or mental health clinic provider does not need to submit form H0002 because the participant is already in the Enhanced Plan. (3-29-12)~~

~~113. (RESERVED)~~

~~114. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES: COMPREHENSIVE DIAGNOSTIC ASSESSMENT.~~

~~In order to determine eligibility for enhanced outpatient mental health services, a comprehensive diagnostic assessment must first be completed by one (1) of the licensed professionals listed under IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 715.02. For participants seeking services beyond twelve (12) months, a review of the existing assessment is required to determine whether a full comprehensive diagnostic assessment or an updated assessment is needed to reflect the participant's current status on an annual basis. The treatment staff's determination that the latest assessment accurately represents the status of the participant must be documented in the medical record. In such cases, only an updated assessment that includes a new mental status examination is required. The assessment must be directed toward formulation of a diagnosis and a written individualized treatment plan. The participant, and the participant's parent or guardian~~

~~when appropriate, must take part in the assessment to the fullest extent possible. The comprehensive diagnostic assessment must include a five (5) axes diagnosis under DSM-IV-TR documented in a face-to-face evaluation, a complete psychiatric and medical history, a current mental status examination, a description of the participant's readiness and motivation to engage in treatment, participate in the development of his treatment plan and adhere to his treatment plan, treatment recommendations including level of care, and any other information that contributes to the assessment of the participant's current psychiatric status and need for services.~~
(5-8-09)

~~115. (RESERVED)~~

~~116. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES — WRITTEN INDIVIDUALIZED TREATMENT PLAN.~~

~~A written individualized treatment plan must be developed and implemented for each participant of enhanced outpatient mental health services as a means to address the enhanced service needs of the participant. Each individualized treatment plan must specify the individual staff person responsible for providing each service, and the amount, frequency and expected duration of treatment. The development of the initial treatment plan is reimbursable if conducted by a professional identified in Subsections 131.01 through 131.03 of these rules. When the assessment indicates that the participant would benefit from psychotherapy or additional diagnostic services, the treatment plan must be completed by a qualified professional listed under IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 715.03.~~
(3-29-12)

~~01. Goals. Services identified on the treatment plan must support the goals that are applicable to the participant's identified needs. For adults, their treatment plan must incorporate the need for psychiatric services identified by the comprehensive diagnostic assessment. For children, their treatment plan must incorporate the substantial impairment areas identified by the CAFAS. Participant's goals may include any of the following:~~
(3-29-12)

~~a. Skill Training. The goal is to assist the participant in regaining skills that have been lost due to the symptoms of his mental illness or that would have been otherwise developed except for the interference of his mental health condition. Through skill training, the participant should achieve maximum reduction of symptoms of mental illness or serious emotional disturbance that will allow for the greatest adjustment to living in the community.~~
(5-8-09)

~~b. Community Reintegration. The goal is to provide practical information and support for the participant to be able to be effectively involved in the rehabilitation process.~~
(5-8-09)

~~c. Partial care. The goal is to decrease the severity and acuity of presenting symptoms so that the participant may be maintained in the least restrictive setting and to increase the participant's interpersonal skills in order to obtain the optimal level of interpersonal adjustment.~~
(3-19-07)

~~d. Psychotherapy. The goal is to engage in active treatment that involves psychological strategies for problem resolution to promote optimal functioning and a condition of improved mental health.~~
(5-8-09)

~~e. Pharmacological Management. The goal is to obtain a decrease or remission of symptoms of psychiatric illness and improve quality of life through the use of pharmacological agents without causing adverse effects. (5-8-09)~~

~~02. Plan Content. An individualized treatment plan must meet the requirements listed in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 710. Additionally, at least one (1) objective is required in the areas that are most likely to lead to the greatest level of stabilization. (5-8-09)~~

~~03. Plan Timeframes. An individualized treatment plan must be developed and signed by a licensed physician or other licensed practitioner of the healing arts within thirty (30) calendar days from initial contact. Intermittent treatment plan reviews must occur as needed to incorporate progress, different goals, or change in treatment focus, but must not exceed one hundred twenty (120) days between reviews. An updated treatment plan must be developed for participants who will continue in treatment beyond twelve (12) months. (3-29-12)~~

~~04. Choice of Providers. The participant or his parent or legal guardian must be allowed to choose whether or not he desires to receive enhanced outpatient mental health services and which provider agency or agencies he would like to assist him in accomplishing the objectives stated in his individualized treatment plan. Documentation must be included in the participant's medical record showing that the participant or his parent or legal guardian has been informed of his rights to refuse services and choose provider agencies. (5-8-09)~~

~~05. No Duplication of Services. The provider agency or its designee must monitor, coordinate, and jointly plan with all known providers to a participant to prevent duplication of services provided to enhanced outpatient mental health services participants through other Medicaid reimbursable and non-Medicaid programs. (3-19-07)~~

~~117. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES: MENTAL HEALTH CLINICS (MHC).~~

~~All rules in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 707 through 718 apply to Mental Health Clinic services in this chapter with the enhancements described under Section 118 of these rules. (5-8-09)~~

~~118. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES: DESCRIPTIONS.~~

~~01. Psychotherapy. Under the Medicaid Enhanced Plan, individual, family and group psychotherapy services are limited to forty-five (45) hours per calendar year. (3-19-07)~~

~~02. Partial Care Services. Under the Medicaid Enhanced Plan, partial care services are limited to twelve (12) hours per week per eligible participant. (5-8-09)~~

~~a. In order to be considered a partial care service, the service must: (3-19-07)~~

~~i. Be provided in a structured environment within the MHC setting; (3-19-07)~~

~~ii. Be identified as a service need through the participant's comprehensive diagnostic assessment and be indicated on the individualized treatment plan with documented, concrete, and~~

~~measurable objectives and outcomes; and (3-29-12)~~

~~iii. Provide interventions for relieving symptoms, stabilizing behavior, and acquiring specific skills. These interventions must include the specific medical services, therapies, and activities that are used to meet the treatment objectives. (5-8-09)~~

~~b. Staff Qualifications for Partial Care Services. Licensed, qualified professionals providing partial care services must have, at a minimum, one (1) or more of the qualifications listed in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 715.01. (3-19-07)~~

~~e. Excluded Services. Services that focus on vocation, recreation, or education are not reimbursable under Medicaid Partial Care. Services that are provided outside the clinic facility are not reimbursable. Participants who receive skill training in Partial Care cannot receive skill training in psychosocial rehabilitation services. (4-4-13)~~

~~**119. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES: PROVIDER REIMBURSEMENT.**~~

~~**01. Medical Assistance Upper Limit.** The Department's medical assistance upper limit for reimbursement is the lower of: (3-21-12)~~

~~a. The mental health clinic's actual charge; or (3-21-12)~~

~~b. The allowable charge as established by the Department's medical assistance fee schedule. Mental health clinic reimbursement is subject to the provisions of 42 CFR 447.321. (3-21-12)~~

~~**02. Reimbursement.** For physician services where mid-levels are authorized to administer mental health services, the Department reimburses based on the Department's medical assistance fee schedule. (3-21-12)~~

~~**120. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR).**~~

~~Under 42 CFR 440.130(d) and in accordance with Section 39-3124, Idaho Code, the Department in each region will cover psychosocial rehabilitative services (PSR) for maximum reduction of mental disability. For PSR provided by a school district under an individualized education plan (IEP), refer to IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 850. (3-19-07)~~

~~**121.—122. (RESERVED)**~~

~~**123. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): DESCRIPTIONS.**~~

~~All services provided must be clinically appropriate in content, service location and duration and based on measurable and behaviorally specific and achievable objectives in accordance with the treatment plan. In addition to the services described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 709, the PSR program consists of the following services described in Subsections 123.01 through 123.04 of this rule. (5-8-09)~~

~~**01. Skill Training.** The service of skill training must be provided in accordance with the objectives specified in the individualized treatment plan. Skill training is reimbursable if~~

~~provided by an agency with a current provider agreement and the agency staff delivering the service meet the qualifications, in accordance with Section 131 of these rules. Skill training includes one (1) or more of the following:~~ (5-8-09)

~~a. Assistance in gaining and utilizing skills necessary to function adaptively in home and community settings and attain or retain capability for independence. This includes helping the participant learn personal hygiene and grooming, selecting and acquiring appropriate clothing, and other self-care skills needed for community integration. This service cannot be duplicative of other services the participant may be receiving from other programs.~~ (5-8-09)

~~b. Assistance in gaining and utilizing skills necessary for managing personal finances, living arrangements, and daily home care duties.~~ (5-8-09)

~~c. Individual interventions in social skill training directly related to the participant's mental illness to improve community functioning and to facilitate appropriate interpersonal behavior.~~ (5-8-09)

~~d. Assistance in gaining and utilizing cognitive skills for problem-solving everyday dilemmas, listening, symptom management, and self-regulation.~~ (5-8-09)

~~e. Assistance for gaining and utilizing communications skills for the participant to be able to express himself coherently to others including other service providers.~~ (5-8-09)

~~i. For participants receiving skill training for communication issues who cannot express necessary information to his healthcare providers or understand instructions given to him by healthcare providers, the PSR agency staff person may accompany the participant to medical appointments as a part of the communication skill training service.~~ (5-8-09)

~~ii. For reimbursement purposes, the PSR agency staff person must deliver a skill training service that is identified on the treatment plan during the appointment. Travel time and time waiting to meet with the Medicaid provider are not reimbursable.~~ (5-8-09)

~~iii. The individualized treatment plan must identify how the issue is to be resolved and include objectives toward independence in this area. For children, this service is not intended to replace the parent's responsibility in advocating for or attending appointments for their child.~~ (5-8-09)

~~f. Medication education may be provided by a licensed physician, licensed nurse, or a licensed practitioner of the healing arts within the scope of his practice under state law. This service focuses on educating the participant about the role and effects of medications in treating symptoms of mental illness, symptom management, and adherence to the treatment regimen.~~ (5-8-09)

~~g. Assistance for gaining and utilizing skills needed by the participant to arrange for his transportation, or to access and utilize the public transportation system.~~ (5-8-09)

~~02. **Community Reintegration.** The service of community reintegration must be provided in accordance with the objectives specified in the individualized treatment plan. The~~

~~service may include:~~ (5-8-09)

~~a. Assisting the participant with self-administration of medications by verbal prompts according to the direction of the prescribing physician. Verbal prompts must be delivered face-to-face and an assessment of the participant's functioning must be completed and documented. In cases where verbal prompts by phone are justified, they must be specifically prior authorized.~~ (5-8-09)

~~b. Assisting the participant with maintaining or obtaining services that the participant usually takes care of for himself but is temporarily unable to do so because of an exacerbation of his symptoms. The targeted skills must be necessary to maintain his status in the home or community.~~ (5-8-09)

~~c. Working with the participant's legal guardian immediately following the delivery of a mental health service in order to provide follow-up and support actions that facilitate the participant's positive response to the services.~~ (5-8-09)

~~03. **Group Skill Training.** Group skill training must be provided in accordance with the objectives specified in the individualized treatment plan. Group skill training is a service provided to two (2) or more individuals concurrently. Group skill training is reimbursable if provided by an agency with a current provider agreement and the agency staff person delivering the service meets the qualifications in accordance with Section 131 of these rules. This service includes one (1) or more of the following:~~ (5-8-09)

~~a. Medication education groups provided by a licensed physician, licensed nurse, or a licensed practitioner of the healing arts within the scope of his practice under state law. This service focuses on educating participants about the role and effects of medications in treating symptoms of mental illness, symptom management, and skills for adhering to their medical regimen. These groups must not be used solely for the purpose of group prescription writing.~~ (5-8-09)

~~b. Community Living skills groups that focus on occupation-related symptom management, symptom reduction, and skills related to appropriate job or school-related behaviors;~~ (5-8-09)

~~c. Communication and interpersonal skills groups, the goals of which are to improve communication skills and facilitate appropriate interpersonal behavior;~~ (3-19-07)

~~d. Symptom management groups to identify mental illness symptoms which are barriers to successful community integration, crisis prevention, problem identification and resolution, coping skills, developing support systems and planning interventions with teachers, employers, family members and other support persons; and~~ (3-19-07)

~~e. Activities of daily living groups which help participants learn skills related to personal hygiene, grooming, household tasks, use of transportation, socialization, and money management.~~ (3-19-07)

~~04. **Crisis Intervention Service.** Crisis support includes intervention for a participant~~

~~in crisis situations to ensure his health and safety or to prevent his hospitalization or incarceration. Crisis intervention service is reimbursable if provided by an agency with a current provider agreement and the agency staff delivering the service meet the qualifications under Section 131 of these rules. A crisis may be precipitated by loss of housing, employment or reduction of income, risk of incarceration, risk of physical harm, family altercation or other emergencies. PSR agency staff may deliver direct services within the scope of these rules or refer the participant to community resources to resolve the crisis or both. Crisis support may be provided prior to or after the completion of the assessment and service plan. Service is reimbursable if there is documentation that supports the need for the service and the individualized treatment is either authorized the next business day following the beginning of the crisis or prior authorized in anticipation of the need for crisis support. Crisis hours are authorized on a per incident basis.~~ (5-8-09)

~~**a.** Crisis Support in a Community. Limitations to reimbursement in this place of service are described in Subsection 124 of these rules.~~ (3-19-07)

~~**b.** Crisis Support in an Emergency Department.~~ (3-19-07)

~~**i.** A service provided in a hospital emergency department as an adjunct to the medical evaluation completed by the emergency department physician. This evaluation may include a psychiatric assessment.~~ (3-19-07)

~~**ii.** The goal of this service is to assist in the identification of the least restrictive setting appropriate to the needs of the participant.~~ (3-19-07)

~~**e.** Crisis Support Limitations. Crisis support services are available up to a total of ten (10) hours per week. This limitation is in addition to any other PSR service hours within that same time frame. Crisis support hours must be authorized by the Department.~~ (5-8-09)

~~124. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): COVERAGE AND LIMITATIONS.~~

~~The following service limitations apply to PSR agency services, unless otherwise authorized by the Department.~~ (5-8-09)

~~**01. Assessment.** Assessment services must not exceed four (4) hours per participant annually. The following assessments are included in this limitation:~~ (3-29-12)

~~**a.** Comprehensive Diagnostic Assessment. This assessment, or an addendum to the existing assessment must be completed for each participant at least once annually;~~ (3-29-12)

~~**b.** Occupational Therapy Assessment. The duration of this type of assessment is determined by the participant's benefits and the presenting reason for such an assessment.~~ (5-8-09)

~~**02. Psychological and Neuropsychological Testing.** Testing services are limited to two (2) computer administered testing sessions and four (4) assessment hours per year. Additional testing must be prior authorized by the Department. Testing services are not included in the annual assessment limitation described at Subsection 124.01. The duration of~~

~~psychological and neuropsychological testing is determined by the participant's benefits and the presenting reason for such an assessment. (3-29-12)~~

~~**03. Individualized Treatment Plan.** Two (2) hours are available for the development of the participant's initial treatment plan. Following the development of the initial treatment plan, all subsequent treatment must be based on timely updates to the initial plan. Treatment plan updates are considered part of the content of care and should occur as an integral part of the participant's treatment experience. (3-29-12)~~

~~**04. Psychotherapy.** Individual, family and group psychotherapy services are limited to a maximum of twenty four (24) hours annually. Services beyond six (6) hours weekly must be prior authorized. (5-8-09)~~

~~**05. Crisis Intervention Service.** A maximum of ten (10) hours of crisis support in a community may be authorized per crisis per seven (7) day period. Authorization must follow procedure described above at Subsection 123.04 of these rules. This limitation is in addition to any other PSR service hours within that same time frame. (5-8-09)~~

~~**06. Skill Training and Community Reintegration.** Services are limited to five (5) hours weekly in any combination of individual or group skill training and community reintegration for eligible participants up to twenty one (21) years of age. For participants aged twenty one (21) years of age or older, services are limited to four (4) hours weekly in any combination of individual or group skill training and community reintegration. Participants who receive skill training in psychosocial rehabilitation cannot receive skill training in partial care. Participants with both a developmental disability diagnosis and a qualifying mental health diagnosis, who want to receive skill training services from a PSR agency provider in addition to a developmental disability service provider, must obtain authorization from the Department prior to service implementation. (4-4-13)~~

~~**07. Pharmacological Management.** Pharmacological management services beyond twenty four (24) encounters per calendar year must be prior authorized by the Department. (5-8-09)~~

~~**08. Occupational Therapy.** Occupational therapy services must be prior authorized by the Department, based on the results of an occupational therapy evaluation completed by an Occupational Therapist licensed in accordance with IDAPA 22.01.09, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants." (5-8-09)~~

~~**09. Place of Service.** PSR agency services are to be home and community based. (5-8-09)~~

~~**a.** PSR agency services must be provided to the participant in his home and community whenever possible. Any other location, including a provider's office or clinic, may be used if the specific place of service is stated in the individualized treatment plan and is necessary to maximize the impact of the service. (5-8-09)~~

~~**b.** PSR agency services may be provided to a participant living in a residential or assisted living facility if the PSR services are determined by the Department to be appropriate,~~

~~desired by the resident, and are not the responsibility of the facility or another agency under the Negotiated Service Agreement for residential or assisted living facilities. (5-8-09)~~

~~**125. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): EXCLUDED SERVICES NOT REIMBURSABLE UNDER MEDICAID.**~~

~~Excluded services are those services that are not reimbursable under Medicaid PSR. The following is a list of those services: (3-19-07)~~

~~**01. Inpatient.** Treatment services rendered to participants residing in inpatient medical facilities including nursing homes, or hospitals, except those identified in Subsection 140.07 of these rules. (3-29-12)~~

~~**02. Recreational and Social Activities.** Activities which are primarily social or recreational in purpose. (3-19-07)~~

~~**03. Employment.** Job specific interventions, job training and job placement services which includes helping the participant develop a resume, applying for a job, and job training or coaching. (3-19-07)~~

~~**04. Household Tasks.** Staff performance of household tasks and chores. (3-19-07)~~

~~**05. Treatment of Other Individuals.** Treatment services for persons other than the identified participant. (3-19-07)~~

~~**06. Services Primarily Available Through Service Coordination Agencies.** Any service that is typically addressed by Service Coordination as described in Section 727 of these rules, is not included in the program of psychosocial rehabilitation services. The PSR agency staff should refer participants to service coordination agencies for these services. (5-8-09)~~

~~**07. Medication Drops.** Delivery of medication only; (3-19-07)~~

~~**08. Services Delivered on an Expired Individualized Treatment Plan.** Services provided between the expiration date of one (1) plan and the start date of the subsequent treatment plan. (3-19-07)~~

~~**09. Transportation.** The provision of transportation services and staff time to transport. (3-19-07)~~

~~**10. Inmate of a Public Institution.** Treatment services rendered to participants who are residing in a public institution as defined in 42 CFR 435.1009. (3-19-07)~~

~~**11. Services Not Listed.** Any other services not listed in Section 123 of these rules. (3-19-07)~~

~~**126.—127. (RESERVED)**~~

~~**128. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): RESPONSIBILITIES OF THE DEPARTMENT.**~~

~~The Department will administer the provider agreement for the provision of PSR agency services and is responsible for the following tasks: (5-8-09)~~

~~**01. Credentialing.** The Department is responsible for ensuring Medicaid PSR agencies meet credentialing requirements described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 712. (3-19-07)~~

~~**02. Prior Authorization Process.** Reimbursement for specific services that require prior authorization will be authorized from the date the required documentation is received by the Department. The Department will complete the prior authorization process within ten (10) working days from the date all the required information is received from the provider. The specific documentation that is required for prior authorization is dependent on the request for additional services. The Department must authorize the number of hours and type of services, as specifically required in these rules, which could be reasonably expected to address the participant's needs in relation to those services. (3-29-12)~~

~~**03. Notice of Decision.** At the point the Department makes a decision that a participant is ineligible for specific services, a notice of decision citing the reason(s) the participant is ineligible for those services must be issued by the Department. The notice of decision must be sent to the adult participant and a copy to his legal guardian, if any. When the participant is a minor child, the notice of decision must be sent to the minor child's parent or legal guardian. (3-29-12)~~

~~**04. Responding to Requests for Services.** When the Department is notified, in writing, by the provider of services that require prior authorization, the Department must review the request and either approve or deny the request within ten (10) working days of receipt. (3-29-12)~~

~~**05. Service System.** The Department is responsible for the development, maintenance and coordination of regional, comprehensive and integrated service systems. (3-19-07)~~

~~**129. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): PROVIDER RESPONSIBILITIES.**~~

~~**01. Provider Agreement.** Each provider must enter into a provider agreement with the Division of Medicaid for the provision of PSR agency services and also is responsible for the following tasks: (5-8-09)~~

~~**02. Service Availability.** Each provider must assure provision of PSR agency services to participants on a twenty-four (24) hour basis. (5-8-09)~~

~~**03. Comprehensive Diagnostic Assessment and Individualized Treatment Plan Development.** The provider agency is responsible to conduct a comprehensive diagnostic assessment and develop an individualized treatment plan for each new participant with input from the interdisciplinary team if these services have not already been completed by another provider. In the event the agency makes a determination that it cannot serve the participant, the agency must make appropriate referrals to other agencies to meet the participant's identified needs. (3-29-12)~~

~~04. **Individualized Treatment Plan.** The provider must develop an individualized treatment plan when one (1) has not already been developed in accordance with Section 116 of these rules. Providers must update the participant's treatment plan at least every one hundred twenty (120) days, or more frequently as necessary, until the participant is discharged from services. The signature of a licensed physician, or other licensed practitioner of the healing arts within the scope of his practice under state law is required on the individualized treatment plan indicating the services are medically necessary at least annually. The date of the initial plan is the date it is signed by the physician.~~ (3-29-12)

~~05. **Changes to Individualized Treatment Plan Objectives.** When a provider believes that an individualized treatment plan needs to be revised, the provider should make those revisions in collaboration with the participant's interdisciplinary team and obtain required signatures. Amendments and modifications to the treatment plan objectives must be justified and documented in the medical record.~~ (5-8-09)

~~06. **Effectiveness of Services.** Effectiveness of services, as measured by a participant's achievement of his plan objectives, must be monitored by the provider and changes to the individualized treatment plan must be initiated when service needs change or interventions are shown to be ineffective. These measures must be included on the participant's next treatment plan review.~~ (5-8-09)

~~07. **Healthy Connections Referral.** Providers must obtain a Healthy Connections referral if the participant is enrolled in the Healthy Connections program.~~ (3-19-07)

~~**130. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): PROVIDER AGENCY REQUIREMENTS.**~~

~~Each agency that enters into a provider agreement with the Department for the provision of PSR services must meet the following requirements:~~ (3-19-07)

~~01. **Agency.** A PSR agency must be a proprietorship, partnership, corporation, or other entity, employing at least two (2) staff qualified to deliver PSR services under Section 131 of these rules, and offering both direct and administrative services. Administrative services may include such activities as billing, hiring staff, assuring staff qualifications are met and maintained, setting policy and procedure, payroll.~~ (5-8-09)

~~02. **Criminal History Checks.**~~ (3-19-07)

~~a. The agency must verify that all employees, subcontractors, or agents of the agency providing direct care or PSR services have complied with IDAPA 16.05.06, "Criminal History and Background Checks."~~ (3-19-07)

~~b. Once an employee, subcontractor, or agent of the agency has completed a self-declaration form and has been fingerprinted, he may begin working for the agency on a provisional basis while awaiting the results of the criminal history check.~~ (3-19-07)

~~c. Once an employee, subcontractor, agent of the agency has received a criminal history clearance, any additional criminal convictions must be reported to the Department when the agency learns of the conviction.~~ (3-19-07)

~~03. **PSR Agency Staff Qualifications.** The agency must assure that each agency staff person delivering PSR services meets at least one (1) of the qualifications in Section 131 of these rules and maintains ongoing compliance with the education requirements defined in Subsection 130.09 or Subsection 131.03.c.iii. of this rule. (3-29-12)~~

~~04. **Additional Terms.** The agency must have signed additional terms to the general provider agreement with the Department. The additional terms must specify what direct services must be provided by the agency. The agency's additional terms may be revised or cancelled at any time. (5-8-09)~~

~~05. **Agency Employees and Subcontractors.** Employees and subcontractors of the agency are subject to the same conditions, restrictions, qualifications and rules as the agency. (3-19-07)~~

~~06. **Supervision.** The agency must provide staff with adequate case-specific supervision to insure that the tasks on a participant's individualized treatment plan can be implemented effectively in order for the individualized treatment plan objectives to be achieved. An agency staff person without a Master's degree must be supervised by a licensed master's level professional, as defined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 715.03. PSR agency staff must be supervised in accordance with their applicable status as follows: (3-29-12)~~

~~a. Certified Psychiatric Rehabilitation Practitioners (CPRP) may provide case-specific supervision to other CPRP applicants when the supervising CPRP is directly supervised by a Master's level professional defined in Subsection 715.03. (3-29-12)~~

~~b. PSR Specialist applicants who are working toward, or have achieved, the USPPRA Certificate in Children's Psychiatric Rehabilitation must be supervised by a licensed master's level professional, as defined in Subsection 715.03. (3-29-12)~~

~~c. The supervisors must ensure that the individual staff members demonstrate adequate competency to work with all populations assigned to them. (3-29-12)~~

~~d. Case-specific supervisory contact must be made weekly, at a minimum, with staff for whom supervision is a requirement. Documentation of supervision must be maintained by the agency and be available for review by the Department. (3-19-07)~~

~~e. An agency must assure that clinical supervision, as required in the rules of the Idaho Bureau of Occupational Licenses and the Idaho State Board of Medicine, is available to all staff who provide psychotherapy. The amount of supervision should be adequate to ensure that the individualized treatment plan objectives are achieved. Documentation of supervision must be maintained by the agency and be available for review by the Department. (5-8-09)~~

~~f. The licensed physician or other licensed practitioner of the healing arts must review and sign the individualized treatment plan as an indicator that the services are medically necessary and prescribed. (5-8-09)~~

~~07. **Staff-to-Participant Ratio.** The following treatment staff-to-participant ratios for group treatment services must be observed: (5-8-09)~~

~~a. For children under four (4) years of age, the ratio must be 1:1. No group work is allowed. (5-8-09)~~

~~b. For children four (4) to twelve (12) years of age, the ratio must be 1:6 for groups. Group size must not exceed twelve (12) participants. (5-8-09)~~

~~c. For children over twelve (12) years of age, the ratio must be 1:10 for groups. Group size must not exceed twelve (12) participants. (5-8-09)~~

~~08. **Family Participation Requirement.** The following standards must be observed for services provided to children: (5-8-09)~~

~~a. For a child under four (4) years of age, the child's parent or legal guardian should be actively involved by being present on the premises and available for consultation with the staff during the delivery of mental health services. The child's parent or legal guardian does not have to participate in the treatment session or be present in the room in which the service is being conducted; (5-8-09)~~

~~b. For a child four (4) to twelve (12) years of age, the child's parent or legal guardian should be actively involved. The child's parent or legal guardian does not have to participate in the treatment session, but must be available for consultation with the staff providing the service; (5-8-09)~~

~~c. For a child over twelve (12) years of age, the child's parent or legal guardian should be involved, as appropriate. If the interdisciplinary team recommends that the child's parent or legal guardian not be involved in any aspect of the treatment, then the reasons for excluding the child's parent or legal guardian must be documented in the medical record. (5-8-09)~~

~~d. For a child whose parent or legal guardian does not participate in the services, the provider must document efforts made to involve the parent or legal guardian and must make appropriate adjustments to the treatment plan to address the parent or legal guardian's lack of involvement. (5-8-09)~~

~~e. Nothing in these rules may interfere with compliance to provisions of Section 16-2428, Idaho Code, regarding confidentiality and disclosure of children's mental health information. (5-8-09)~~

~~09. **Continuing Education.** The agency must assure that all staff complete twenty (20) hours of continuing education annually from the date of hire. Four (4) hours every four (4) years must be in ethics training. Staff who are not licensed must select the discipline closest to their own and use the continuing education standards attached to that professional license. Nothing in these rules will affect professional licensing continuing education standards and requirements set by the Bureau of Occupational Licenses. (3-19-07)~~

~~10. Crisis Service Availability. PSR agencies must provide twenty-four (24) hour crisis response services for their participants or make contractual arrangement for the provision of those services. (5-8-09)~~

~~11. Restraints and Seclusion. (5-8-09)~~

~~a. Restraints and seclusion must not be employed under any circumstances except when an agency staff person employs physical holds as an emergency response to assault or aggression or other immediate safety risks in accordance with the following requirements in Subsections 130.11.a.i. through 130.11.a.iii.: (5-8-09)~~

~~i. The agency must have an accompanying policy and procedure that addresses the use of the such holds. (5-8-09)~~

~~ii. The physical holds employed must be a part of a nationally recognized non-violent crisis intervention model. (5-8-09)~~

~~iii. The staff person who employs the hold technique(s) must have evidence in his personnel record of current certification in the method. (5-8-09)~~

~~b. Provider agencies must develop policies that address the agency's response by staff to emergencies involving assault or aggression or other immediate safety risks. All policies and procedures must be consistent with licensure requirements, federal, state, and local laws, and be in accordance with accepted standards of healthcare practice. (5-8-09)~~

~~12. Building Standards, Credentialing and Ethics. All PSR agencies must comply with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 712 and Subsection 714.14. PSR agencies whose participants are in the agency building for treatment purposes must follow the rules in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 714.15. (5-8-09)~~

~~131. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): AGENCY STAFF QUALIFICATIONS.~~

~~All agency staff delivering direct services must have at least one (1) of the following credentials: (5-8-09)~~

~~01. Any of the Professions Listed Under IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 715.01. (5-8-09)~~

~~02. Clinician. A clinician must hold a master's degree, be employed by a state agency and meet the minimum standards established by the Idaho Division of Human Resources and the Idaho Department of Health and Welfare Division of Human Resources. (5-8-09)~~

~~03. Psychosocial Rehabilitation (PSR) Specialist. (5-8-09)~~

~~a. Individuals hired as of June 30, 2009, who are working as PSR Specialists to deliver Medicaid reimbursable mental health services may continue to do so until January 1, 2012. In order to continue working as a PSR specialist beyond this date, the worker must have completed a certificate program or earned a certification in psychiatric rehabilitation based upon~~

~~the primary population with whom he works in accordance with the requirements set by the USPRA. (3-29-12)~~

~~**b.** Individuals hired between July 1, 2009, and October 31, 2010, who are working as PSR Specialists to deliver Medicaid-reimbursable mental health services may continue to do so for a period not to exceed thirty (30) months from their initial date of hire. In order to continue as a PSR Specialist beyond a total period of thirty (30) months, the worker must have completed a certificate program or earned a certification in psychiatric rehabilitation based upon the primary population with whom he works in accordance with the requirements set by the USPRA. (3-29-12)~~

~~**e.** Individuals hired as of November 1, 2010, who are working as PSR Specialists to deliver Medicaid-reimbursable mental health services may continue to do so for a period not to exceed thirty (30) months from the initial date of hire. In order to continue as a PSR Specialist beyond a total period of thirty (30) months, the worker must have completed a certificate program or earned a certification in psychiatric rehabilitation based upon the primary population with whom he works in accordance with the requirements set by the USPRA. Such workers must have a bachelor's degree or higher in any field. (3-29-12)~~

~~**i.** Credential Required for PSR Specialists Working Primarily with Adults. (3-29-12)~~

~~(1) Applicants who intend to work primarily with adults, age eighteen (18) or older, must become a Certified Psychiatric Rehabilitation Practitioner in accordance with the USPRA requirements. (3-29-12)~~

~~(2) Applicants who work primarily with adults, but also intend to work with participants under the age of eighteen (18), must have training addressing children's developmental milestones, or have evidence of classroom hours in equivalent courses. The worker's supervisor must determine the scope and amount of training the worker needs in order to work competently with children assigned to the worker's caseload. (3-29-12)~~

~~**ii.** Credential Required for PSR Specialists Working Primarily with Children. (3-29-12)~~

~~(1) Applicants who intend to work primarily with children under the age of eighteen (18) must obtain a certificate in children's psychiatric rehabilitation in accordance with the USPRA requirements. (3-29-12)~~

~~(2) Applicants who primarily work with children, but who also intend to work with participants eighteen (18) years of age or older, must have training or have evidence of classroom hours addressing adult issues in psychiatric rehabilitation. The worker's supervisor must determine the scope and amount of training the worker needs in order to competently work with adults assigned to the worker's caseload. (3-29-12)~~

~~**iii.** Classroom Hours. Classroom hours completed for a USPRA credential may be used toward a PSR specialist applicant's continuing education requirements as described in Subsection 130.09 of these rules. The completion of required classroom hours must be documented in the agency's personnel records. (3-29-12)~~

~~d. An individual who is qualified to apply for licensure to the Idaho Bureau of Occupational Licenses, in the professions identified under Subsections 131.01 through 131.03 of this rule, who has failed his licensing exam or has been otherwise denied licensure is not eligible to provide services under the designation of PSR Specialist unless this individual has obtained one (1) of the USPPA credentials. (3-29-12)~~

~~132.—135. (RESERVED)~~

~~136. PSYCHOSOCIAL—REHABILITATIVE—SERVICES (PSR): RECORD REQUIREMENTS FOR PROVIDERS.~~

~~In addition to the development and maintenance of the individualized treatment plan, the following documentation must be maintained by the provider of PSR services: (3-19-07)~~

~~01. **Name.** Name of participant. (3-19-07)~~

~~02. **Provider.** Name of the provider agency and the agency staff person delivering the service. (3-19-07)~~

~~03. **Date, Time, Duration of Service, and Justification.** Documentation of the date, time, and duration of service, and the justification for the length of time which is billed must be included in the record. (3-19-07)~~

~~04. **Documentation of Progress.** The written description of the service provided, the place of service, and the response of the participant must be included in the progress note. A separate progress note is required for each contact with a participant. (3-19-07)~~

~~05. **Treatment Plan Review.** A documented outcome-specific review of progress toward each individualized treatment plan goal and objective must be kept in the participant's file. These reviews should occur intermittently, but not more than one hundred twenty (120) days apart on a continual basis until the participant is discharged. (3-29-12)~~

~~a. A copy of the review must be sent to the Department upon request. Failure to do so may result in a recoupment of reimbursement provided for services delivered after the intermittent staffing review date. (3-29-12)~~

~~b. The review must also include a reassessment of the participant's continued need for services. The review must occur at least every one hundred twenty (120) days and be conducted in visual contact with the participant. For children, the review must include a new CAFAS/PECFAS for the purpose of measuring changes in the participant's functional impairment. (5-8-09)~~

~~c. After eligibility has been determined, subsequent CAFAS/PECFAS scores are used to measure progress and functional impairment and should not be used to terminate services. (3-19-07)~~

~~06. **Signature of Staff Delivering Service.** The legible, dated signature, with degree credentials listed, of the staff person delivering the service. (3-19-07)~~

~~07. **Choice of Provider.** Documentation of the participant's choice of provider must be maintained in the participant's file prior to the implementation of the individualized treatment plan. (3-19-07)~~

~~08. **Closure of Services.** A discharge summary must be included in the participant's record and submitted to the Department identifying the date of closure, reason for ending services, progress on objectives, and referrals to supports and other services. (3-19-07)~~

~~09. **Payment Limitations.** Reimbursement is not allowed for missed appointments, attempted contacts, travel to provide the service, leaving messages, scheduling appointments for any purpose, transporting participants, or documenting services. For services paid at the fifteen (15) minute incremental rate, providers must comply with Medicaid billing requirements. (5-8-09)~~

~~10. **Informed Consent.** The agency must ensure that participants who receive services through the agency have obtained informed consent from the participant or his legal guardian indicating agreement with all of the elements on the individualized treatment plan including choice of the provider agency, designated services, times, dates, frequencies, objectives, goals, and exit criteria. For a minor child, informed consent must be obtained from the minor's parent or legal guardian. (5-8-09)~~

~~137.—139. (RESERVED)~~

~~140. **PSYCHOSOCIAL—REHABILITATIVE—SERVICES (PSR): PROVIDER REIMBURSEMENT.**~~

~~Payment for PSR agency services must be in accordance with rates established by the Department. The rate paid for services includes documentation. (5-8-09)~~

~~01. **Duplication.** Payment for services must not duplicate payment made to public or private entities under other program authorities for the same purpose. (3-19-07)~~

~~02. **Number of Staff Able to Bill.** Only one (1) staff member may bill for an assessment, individualized treatment plan, or case review when multiple agency staff are present. (5-8-09)~~

~~03. **Medication Prescription and Administration.** Medication prescription and administration may be billed only by physicians and other medical staff qualified under Title 54, Chapter 18, Idaho Code. (3-19-07)~~

~~04. **Recoupment.** Billing for services and receiving reimbursement for services that were not rendered or failure to comply with these rules must be cause for recoupment of payments for services, sanctions, or both. (3-19-07)~~

~~05. **Access to Information.** Upon request, the provider must provide the Department with access to all information required to review compliance with these rules. Failure by the provider to comply with such a request must result in termination of the Medicaid PSR Provider Agreement. (3-19-07)~~

~~06. **Evaluations and Tests.** Evaluations and tests are a reimbursable service if provided in accordance with the requirements in IDAPA 16.03.09, "Medicaid Basic Plan Benefits."~~ (5-8-09)

~~07. **Psychiatric or Medical Inpatient Stays.** Community reintegration services may be provided during the last thirty (30) days of inpatient stay or if the inpatient stay is not expected to last longer than thirty (30) days, when not duplicating those services included in the responsibilities of the inpatient facility. Treatment services are the responsibility of the facility.~~ (5-8-09)

~~08. **Reimbursement.**~~ (3-21-12)

~~a. For physician services where mid-levels are authorized to administer mental health services, the Department reimburses based on the Department's medical assistance fee schedule.~~ (3-21-12)

~~b. Crisis assistance for adults with serious and persistent mental illness (SPMI) will be paid based on the same reimbursement methodology as service coordination crisis intervention services defined in Subsection 736.09 of these rules.~~ (3-21-12)

~~141.—145. (RESERVED)~~

~~146. **PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): QUALITY OF SERVICES.** The Department must monitor the quality and outcomes of PSR agency services provided to participants, in coordination with the Divisions of Medicaid, Management Services, and Behavioral Health.~~ (5-8-09)

~~147.—199. (RESERVED)~~

(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)

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. ~~(4-4-13)~~

~~a.~~ 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 *Psychosocial Rehabilitation (PSR) 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. ~~(4-4-13)()~~

~~b.~~ *A participant who is seeking skill training from a PSR agency provider as well as a Developmental Disabilities service provider may receive services from both if the service objectives are not duplicative, and the comprehensive diagnostic assessment described in Section H4 of these rules clearly identifies the participant's need for skill training services that target skill deficits caused by the mental health condition.* ~~(4-4-13)~~

(BREAK IN CONTINUITY OF SECTIONS)

685. CHILDREN'S WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Family Training. Providers of family training must meet the requirements for habilitative intervention providers defined in Subsections 685.03 and 685.04 of this rule. (7-1-11)

02. Interdisciplinary Training. Providers of interdisciplinary training must meet the following requirements: (7-1-11)

- a.** Occupational Therapist, as defined in Section 734 under IDAPA 16.03.09, “Medicaid Basic Plan Benefits”; (7-1-11)
- b.** Physical Therapist, as defined in Section 734 under IDAPA 16.03.09, “Medicaid Basic Plan Benefits”; (7-1-11)
- c.** Speech-Language Pathologist, as defined in Section 734 under IDAPA 16.03.09, “Medicaid Basic Plan Benefits”; (7-1-11)
- d.** Practitioner of the healing arts; (7-1-11)
- e.** Habilitative intervention provider as defined in Subsections 685.03 and 685.04 of this rule; or (7-1-11)
- f.** Therapeutic consultation provider as defined in Subsection 685.05 of this rule. (7-1-11)

03. Habilitative Intervention. Habilitative intervention must be provided by a DDA certified to provide both support and intervention services under IDAPA 16.03.21, “Developmental Disabilities Agencies (DDA),” and is capable of supervising the direct services provided, or by the Infant Toddler Program. Providers of habilitative intervention must meet the following minimum qualifications: (7-1-13)

- a.** Must hold at least a bachelor’s degree in a human services field from a nationally-accredited university or college; (7-1-11)
- b.** Must be able to provide documentation of one (1) year’s supervised experience working with children with developmental disabilities. Experience must be gained through paid employment or university practicum experience or internship; (7-1-11)
- c.** Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide habilitative intervention; or (7-1-11)
- d.** Individuals working as Developmental Specialists for children age birth through three (3) or three (3) through 17, and individuals certified as Intensive Behavioral Intervention professionals prior to July 1, 2011, are qualified to provide habilitative intervention until June 30, 2013. The individual must meet the requirements of the Department-approved competency coursework by June 30, 2013 to maintain his certification. (7-1-11)

04. Habilitative Intervention for Children Birth to Three. In addition to the habilitative intervention qualifications listed in Subsections 685.04.a. through d. of this rule, habilitative intervention staff serving infants and toddlers from birth to three (3) years of age must have a minimum of two hundred forty (240) hours of professionally-supervised experience with young children who have developmental disabilities and one (1) of the following: (7-1-11)

- a.** An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education; or (7-1-11)
- b.** A Blended Early Childhood/Early Childhood Special Education (EC/ECSE) Certificate; or (7-1-11)
- c.** A bachelor's or master's degree in special education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, or nursing plus a minimum of twenty-four (24) semester credits in Early Childhood/Early Childhood Special Education (EC/ ECSE) from an accredited college or university. Courses taken must appear on college or university transcripts and must cover the following standards in their content: (7-1-11)
- i.** Promotion of development and learning for children from birth to three (3) years; (7-1-11)
 - ii.** Assessment and observation methods for developmentally appropriate assessment of young children; (7-1-11)
 - iii.** Building family and community relationships to support early interventions; (7-1-11)
 - iv.** Development of appropriate curriculum for young children, including IFSP and IEP development; (7-1-11)
 - v.** Implementation of instructional and developmentally effective approaches for early learning, including strategies for children who are medically fragile and their families; and (7-1-11)
 - vi.** Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development. (7-1-11)
- d.** Electives closely related to the content under Subsection 685.04.c.iii. of this rule may be approved by the Department with a recommendation from an institution of higher education. (7-1-11)
- e.** Developmental specialists who possess a bachelor's or master's degree listed above under Subsection 685.04.c.ii. of this rule, have completed a minimum of twenty (20) semester credits in EC/ECSE, and with Department approval are serving children under three (3) years of age as of July 1, 2005, will be allowed to continue providing services in accordance with their approved, conditional hiring agreement. (7-1-11)
- f.** When the Department in its role as lead agency for implementation of Part C of the Individuals with Disabilities Education Act (IDEA) has determined that there is a shortage of such qualified personnel to meet service needs in a specific geographic area: (7-1-11)
- i.** The Department may approve the most qualified individuals who are

demonstrating satisfactory progress toward completion of applicable course work in accordance with the individual's approved plan to meet the required standard within three (3) years of being hired. (7-1-11)

ii. Satisfactory progress will be determined on an annual review by the Department. (7-1-11)

iii. Individuals who have an approved plan for completion of twenty (20) semester credits in EC/ECSE prior to July 1, 2005, will be allowed to continue providing services so long as they demonstrate satisfactory progress on the plan and complete the requirements on the plan within three (3) years of their date of hire. (7-1-11)

05. Therapeutic Consultation. Therapeutic consultation may be provided by a DDA certified to provide both supports and intervention services under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," by an independent Medicaid provider under agreement with the Department, or by the Infant Toddler Program. Providers of therapeutic consultation must meet the following minimum qualifications: (7-1-13)

a. Doctoral or Master's degree in psychology, education, applied behavioral analysis, or have a related discipline with one thousand five hundred (1500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, or behavior analysis (may be included as part of degree program); and (7-1-11)

b. Two (2) years relevant experience in designing and implementing comprehensive behavioral therapies for children with DD and challenging behavior. (7-1-11)

c. Therapeutic consultation 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." (7-1-11)

d. Therapeutic consultation providers employed by a DDA or the Infant Toddler Program must be certified in CPR and first aid in accordance with the general training requirements under IDAPA 16.03.21 "Developmental Disabilities Services (DDA)." Independent therapeutic consultation providers must be certified in CPR and first aid prior to delivering services, and must maintain current certification thereafter. (7-1-13)

06. Crisis Intervention. Crisis intervention may be provided by a DDA certified to provide support and intervention services under IDAPA 16.03.21, "Developmental Disabilities Services (DDA)," by an independent Medicaid provider under agreement with the Department, or by the Infant Toddler Program. Providers of crisis intervention must meet the following minimum qualifications: (7-1-13)

a. Crisis Intervention professionals must meet the minimum therapeutic consultation provider qualifications described in Subsection 685.05 of this rule. (7-1-11)

b. Emergency intervention technician providers must meet the minimum habilitative support provider qualifications described under Subsection 665.02 of these rules. (7-1-11)

c. Crisis intervention 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." (7-1-11)

07. Continuing Training Requirements for Professionals. Each professional providing waiver services must complete at least twelve (12) hours of yearly training, six (6) hours of which must cover behavior methodology or interventions shown to be effective. If the individual has not completed the required training during any yearly training period, he may not provide waiver services beginning with the anniversary date of the following period, and thereafter, until the required number of training hours have accumulated. As training hours accumulate, they will be accounted first to any training-deficient prior yearly period before being applied to the current annual training period. Training hours may not be earned in a current annual training period to be applied to a future training period. (7-1-11)

08. Requirements for Clinical Supervision. All DD services must be provided under the supervision of a clinical supervisor. The clinical supervisor must meet the qualifications to provide habilitative intervention as defined in this rule. Clinical supervisor(s) are professionals employed by a DDA or the Infant Toddler Program on a continuous and regularly scheduled basis. (7-1-13)

a. The clinical supervisor is responsible for the oversight and supervision of service and support elements of the agency, including face-to-face supervision of agency staff providing direct services. (7-1-11)

b. The clinical supervisor must observe and review the direct services performed by all paraprofessional and professional staff on a monthly basis, or more often as necessary, to ensure staff demonstrate the necessary skills to correctly provide the services and support. (7-1-11)

c. Each DDA and the Infant Toddler Program must employ an adequate number of clinical supervisors to ensure quality service delivery and participant satisfaction. (7-1-13)

09. Requirements for Collaboration with Other Providers. (~~4-4-13~~)

~~a.~~ Providers of waiver services must coordinate with the family-centered planning team as specified on the plan of service. When a participant has had a psychological or psychiatric assessment, the results of the psychological or psychiatric assessment must be used when developing objectives to ensure therapies provided accommodate the participant's mental health needs and to ensure that none of the therapeutic methods are contra-indicated or delivered in a manner that presents a risk to the participant's mental health status. (~~7-1-13~~)()

~~b.~~ *A participant who is seeking skill training from a PSR agency provider as well as a Developmental Disabilities service provider may receive services from both if the service objectives are not duplicative, and the comprehensive diagnostic assessment described in Section 114 of these rules clearly identifies the participant's need for skill training services that target skill deficits caused by the mental health condition.* (~~4-4-13~~)

10. Requirements for Quality Assurance. Providers of children’s waiver services must demonstrate high quality of services, including treatment fidelity, through an internal quality assurance review process. (7-1-11)

11. DDA Services. In order for a DDA to provide waiver services, the DDA must be certified to provide both support and intervention services. Each DDA is required to provide habilitative supports. When a DDA opts to provide habilitative intervention services, the DDA must also provide habilitative supports and family training. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

720. SERVICE COORDINATION.

The Department will purchase service coordination for persons eligible for Enhanced Benefits who are unable, or have limited ability to gain access, coordinate or maintain services on their own or through other means. These rules are not applicable to behavioral health service coordination, also known as case management services, provided under the Idaho Behavioral Health Plan (IBHP) included in IDAPA 16.03.09, “Medicaid Basic Plan Benefits.”

~~(3-19-07)~~(____)

721. SERVICE COORDINATION: DEFINITIONS.

The following definitions apply for Sections 721 through 736 of these rules. (5-8-09)

01. Agency. An agency is a business entity that provides management, supervision, and quality assurance for service coordination and includes at least two (2) individuals, one (1) supervisor and a minimum of one (1) service coordinator. (5-8-09)

02. Brokerage Model. Referral or arrangement for services identified in an assessment. This model does not include the provision of direct services. (3-19-07)

03. Conflict of Interest. A situation in which an agency or person directly or indirectly influences, or appears to influence the direction of a participant to other services for financial gain. (5-8-09)

04. Crisis. An unanticipated event, circumstance or life situation that places a participant at risk of at least one (1) of the following: (3-19-07)

- a. Hospitalization; (3-19-07)
- b. Loss of housing; (3-19-07)
- c. Loss of employment or major source of income; (3-19-07)
- d. Incarceration; or (3-19-07)
- e. Physical harm to self or others, including family altercation or psychiatric relapse.

(3-19-07)

~~05. **High-Cost Services.** As used in Subsection 725.01 of these rules, high-cost services are medical services that result in expensive claims payment or significant state general fund expenditure that may include:~~ (3-19-07)

~~a. *Emergency room visits or procedures;* (3-19-07)~~

~~b. *Inpatient medical and psychiatric services;* (3-19-07)~~

~~c. *Nursing home admission and treatment;* (3-19-07)~~

~~d. *Institutional care in jail or prison;* (3-19-07)~~

~~e. *State, local, or county hospital treatment for acute or chronic illness; and* (3-19-07)~~

~~f. *Outpatient hospital services.* (3-19-07)~~

065. Human Services Field. A particular area of academic study in health care, social services, education, behavioral science or counseling. (5-8-09)

076. Paraprofessional. An adult with a high school diploma or equivalency who has at least twelve (12) months supervised work experience with the population to whom they will be providing services. (5-8-09)

087. Person-Centered Planning. A planning process facilitated by the service coordinator that includes the participant and individuals significant to the participant, to collaborate and develop a plan based on the expressed needs and desires of the participant. For children, this planning process must involve the child's family. (5-8-09)

098. Practitioner of the Healing Arts. For purposes of this rule, a nurse practitioner, physician assistant or clinical nurse specialist. (3-19-07)

109. Service Coordination. Service coordination is a case management activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of the individual. Service coordination is a brokerage model of case management. (5-8-09)

110. Service Coordination Plan. The service coordination plan, also known in these rules as the "plan," includes two components: (5-8-09)

a. An assessment that identifies the participant's need for service coordination as described in Section 730 of these rules; and (5-8-09)

b. A plan that documents the supports and services required to meet the service coordination needs of the participant as described in Section 731 of these rules. (5-8-09)

121. Service Coordination Plan Development. An assessment and planning process performed by a service coordinator using person-centered planning principles that results in a written service coordination plan. The plan must accurately reflect the participant's need for assistance in accessing and coordinating supports and services. (5-8-09)

132. Service Coordinator. An individual, excluding a paraprofessional, who provides service coordination to a Medicaid eligible participant, is employed by or contracts with a service coordination agency, and meets the training, experience, and other requirements in Section 729 of these rules. (5-8-09)

143. Supports. Formal and informal services and activities that are not paid for by the Department and that enable an individual to reside safely in the setting of his choice. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

724. ~~725.~~ (RESERVED)

~~725. SERVICE COORDINATION-ELIGIBILITY-INDIVIDUALS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS.~~

~~An adult is eligible for service coordination if he meets the following requirements in Subsections 725.01 through 725.03 of this rule. (5-8-09)~~

~~**01. Uses High Cost Services.** Is eighteen (18) years of age or older and uses, or has a history of using, high cost medical services associated with periods of increased severity of mental illness. (5-8-09)~~

~~**02. Diagnosis of Mental Illness.** (3-19-07)~~

~~**a.** The participant must have undergone a comprehensive diagnostic assessment that meets the definition in Section III of these rules. This assessment must be completed by one (1) of the licensed professionals listed under IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 715.02, and the participant must meet the criteria for: (5-8-09)~~

~~i. Serious and Persistent Mental Illness (SPMI) that meets the definition in Section III of these rules; (5-8-09)~~

~~ii. Delirium dementia, and amnesic disorders; other cognitive disorders; and mental disorders due to a general medical condition; or (5-8-09)~~

~~iii. Schizoid, schizotypal, paranoid personality disorders. (5-8-09)~~

~~**b.** If the only diagnosis is an intellectual disability or is a substance use related disorder, then the person is not included in the target population for mental health service coordination. (5-8-09)~~

~~**03. Need Assistance.** Have mental illness of sufficient severity to cause a disturbance~~

~~in their performance or coping skills in at least two (2) of the following areas, on either a continuous (more than one (1) year) or an intermittent (at least once per year) basis: (5-8-09)~~

~~**a.** Vocational or academic: Is unemployed, unable to work or attend school, is employed in a sheltered setting or supportive work situation, or has markedly limited skills and a poor work history. (3-19-07)~~

~~**b.** Financial: Requires public financial assistance for out-of-hospital maintenance and may be unable to procure such assistance without help, or the person is unable to support himself or manage his finances without assistance. (3-19-07)~~

~~**c.** Social and interpersonal: Has difficulty in establishing or maintaining a personal social support system, has become isolated, has no friends or peer group and may have lost or failed to acquire the capacity to pursue recreational or social interests. (3-19-07)~~

~~**d.** Family: Is unable to carry out usual roles and functions in a family, such as spouse, parent, or child, or faces gross familial disruption or imminent exclusion from the family. (3-19-07)~~

~~**e.** Basic living skills: Requires help in basic living skills, such as hygiene, food preparation, or other activities of daily living, or is gravely disabled and unable to meet daily living requirements. (3-19-07)~~

~~**f.** Housing: Has lost or is at risk of losing his current residence. (3-19-07)~~

~~**g.** Community: Exhibits inappropriate social behavior or otherwise causes a public disturbance due to poor judgment, bizarre, or intrusive behavior, which may result in intervention by law enforcement, the judicial system, or both. (3-19-07)~~

~~**h.** Health: Requires substantial assistance in maintaining physical health or in adhering to medically rigid prescribed treatment regimens. (3-19-07)~~

726. SERVICE COORDINATION: ELIGIBILITY: INDIVIDUALS UP TO THE AGE OF TWENTY-ONE.

To be eligible for children's service coordination, a participant must meet the following requirements in Subsections 726.01 through 726.05~~3~~. Eligibility is determined initially and annually by the Department based on information provided by the service coordination agency or the family. All information necessary to make the eligibility determination must be received by the Department twenty (20) business days prior to the anticipated start date of any service coordination services. The eligibility determination must be made by the Department prior to the initiation of initial and ongoing plan development and services. ~~(7-1-13)()~~

01. Age. From the age of thirty-seven (37) months through the month in which their twenty-first birthday occurs. (5-8-09)

02. Diagnosis. Must ~~be~~ have special health care needs requiring medical and multidisciplinary rehabilitation services identified by a physician or other practitioner of the healing arts ~~as having one (1) of the diagnoses found in Subsections 726.03 through 726.04 of this~~

~~rule to prevent or minimize a disability. (7-1-13)()~~

~~**03. Special Health Care Needs.** Have special health care needs requiring medical and multidisciplinary habilitation or rehabilitation services to prevent or minimize a disability. (3-19-07)~~

~~**04. Serious Emotional Disturbance (SED).** Have a serious emotional disturbance (SED) with an expected duration of at least one (1) year. The following definition of the SED target populations is based on the definition of SED found in the Children's Mental Health Services Act, Section 16-2403, Idaho Code. (3-19-07)~~

~~**a.** Presence of an emotional or behavioral disorder, according to the DSM-IV-TR or subsequent revisions to the DSM, which results in a serious disability; and (3-19-07)~~

~~**b.** Requires sustained treatment interventions; and (3-19-07)~~

~~**c.** Causes the child's functioning to be impaired in thought, perception, affect, or behavior. (3-19-07)~~

~~**d.** The disorder is considered to be a serious disability if it causes substantial impairment in functioning. Functional impairment must be assessed using the Child and Adolescent Functional Assessment Scale/Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS). Substantial impairment requires that the child scores in the "moderate" impairment range in at least two (2) of the subscales. One (1) of the two (2) must be from the following: (5-8-09)~~

~~**i.** Self-Harmful Behavior; (3-19-07)~~

~~**ii.** Moods/Emotions; or (3-19-07)~~

~~**iii.** Thinking. (3-19-07)~~

~~**e.** A substance abuse disorder, or conduct disorder, or developmental disorder, alone, does not constitute a serious emotional disturbance, although one (1) or more of these conditions may co-exist with serious emotional disturbance. (3-19-07)~~

~~**053. Need Assistance.** Have one (1) or more of the following problems in Subsection 726.05.a. through 726.06.e. of this rule associated with their diagnosis. **Medicaid-reimbursed service coordination services are not available for participants whose needs can be met by other service coordination or case management resources, including paid and non-paid sources. The participant must have needs for service coordination for one (1) or more of the following problems:** (7-1-13)()~~

~~**a.** The condition has resulted in a level of functioning below normal age level in one (1) or more life areas such as school, child care setting, family, or community; (5-8-09)~~

~~**b.** The child is at risk of placement in a more restrictive environment or the child is returning from an out of home placement as a result of the condition; (5-8-09)~~

c. There is danger to the health or safety of the child or the parent is unable to meet the needs of the child; (5-8-09)

d. Further complications may occur as a result of the condition without provision of service coordination services; or (3-19-07)

e. The child requires multiple service providers and treatments. (3-19-07)

727. SERVICE COORDINATION: COVERAGE AND LIMITATIONS.

Service coordination consists of services provided to assist individuals in gaining access to needed ~~medical, psychiatric, social, early intervention, educational, and other~~ services. Service coordination includes the following activities described in Subsections 727.01 through 727.10 of this rule. (5-8-09)()

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 ~~to address medical, psychiatric, social, early intervention, educational, and other services~~ needed by the participant. The plan must be updated at least annually and as needed to meet the needs of the participant. (5-8-09)()

03. Referral and Related Activities. Activities that help link the participant with ~~medical, psychiatric, social, early intervention, educational providers or other programs and services~~ **providers** that are capable of providing needed services to address identified needs and achieve goals specified in the service coordination plan. (5-8-09)()

04. Monitoring and Follow-Up Activities. Monitoring and follow-up contacts that are necessary to ensure the plan is implemented and adequately addresses the participant's needs. These activities may be with the participant, family members, providers, or other entities or individuals and conducted as frequently as necessary. These activities must include at least one face-to-face contact with the participant at least every ninety (90) days, to determine whether the following conditions are met: (5-8-09)

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

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

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

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

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

b. Crisis Assistance for Adults With a Developmental Disability. Crisis hours are not available until four and a half (4.5) hours of service coordination have already been provided in the month. Crisis assistance for adults with a developmental disability must be authorized by the Department and is based on community crisis supports as found in Section 507 through 515 of these rules. (5-8-09)

~~e. Crisis Assistance for Adults with Serious and Persistent Mental Illness. Initial crisis assistance is limited to a total of three (3) hours per calendar month. Additional crisis service coordination services must be authorized by the Department and may be requested when the participant is at imminent risk of reinstitutionalization within fourteen (14) days following discharge from a hospital, institution, jail or nursing home, or meets the criteria listed in Subsection 727.05.c.i. through 727.05.c.iii. of this rule; (5-8-09)~~

~~i. The participant is experiencing symptoms of psychiatric decompensation that interferes or prohibits the participant from gaining or coordinating necessary services; (5-8-09)~~

~~ii. The participant has already received the maximum number of monthly hours of ongoing service coordination and crisis service coordination hours; and (5-8-09)~~

~~iii. No other crisis assistance services are available to the participant under other Medicaid mental health option services, including Psychosocial Rehabilitation Services (PSR). (5-8-09)~~

dc. 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 *either* children's service coordination ~~or service coordination for adults with mental illness~~. The service coordination provider must document that the participant has made a free choice of service coordinators and direct service providers. (5-8-09)()

09. Limitations on Service Coordination. Service coordination is limited to ~~the following:~~ (5-8-09)

~~a. Service Coordination for Persons with Mental Illness. Up to five (5) hours per month of ongoing service coordination for participants with mental illness. (5-8-09)~~

~~b. Service Coordination for Children. Up to four and a half (4.5) hours per month for participants who meet the eligibility qualifications for Children's Service Coordination. (5-8-09)~~

~~c. Service Coordination for Adults with a Developmental Disability. Up to four and a half (4.5) hours per month for participants with developmental disabilities. (5-8-09)()~~

10. Limitations on Service Coordination Plan Assessment and Plan Development. Reimbursement for the annual assessment and plan development cannot exceed six (6) hours ~~annually for children, adult participants with mental illness, or adult participants diagnosed with developmental disabilities per year.~~ (3-29-12)()

728. SERVICE COORDINATION: PROCEDURAL REQUIREMENTS.

01. Prior Authorization for Service Coordination Services. ~~All service coordination s~~Services must be prior authorized by the Department, ~~except the following: according to the direction provided in the Medicaid Provider Handbook available at www.idmedicaid.com.~~ (5-8-09)()

~~a. Adult mental health service coordination services: service coordination plan development and five (5) hours of ongoing service coordination per month; and the first three (3) hours of crisis service coordination per month. For adults with mental illness, crisis service coordination over three (3) hours per month must be prior authorized. (5-8-09)~~

~~b. Children's service coordination services: four and a half (4.5) hours of ongoing service coordination per month. (5-8-09)~~

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 ~~except in the case of adults with serious and persistent mental illness; in which case the time limit is thirty (30) days.~~ (5-8-09)()

b. The plan must be updated at least annually and amended as necessary. (5-8-09)

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 which documents that the participant has been informed of the purposes of service coordination, his rights to refuse service coordination, and his right to choose his 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. ~~Mental health service coordination plans must also be signed by a physician or other practitioner of the healing arts.~~ 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 his 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.

(5-8-09)()

~~**04. Documentation of Crisis Assistance for Adults With Serious and Persistent Mental Illness.** Documentation to support authorization of crisis assistance beyond the monthly limitation must be submitted to the Department before such authorization may be granted. The crisis situation and the crisis service coordination services must be documented in the progress notes of the participant's medical record. Documentation to support delivery of crisis assistance must also be maintained in the participant's agency record and must include:~~

(5-8-09)

~~**a.** A description of the crisis, including identification of unanticipated events that precipitate the need for crisis service coordination services;~~

(5-8-09)

~~**b.** A brief review of service coordination and other services or supports available to, or already provided to, the participant to resolve the crisis;~~

(5-8-09)

~~**c.** A crisis resolution plan; and~~

(3-19-07)

~~**d.** Outcomes of crisis assistance service provision.~~

(3-19-07)

054. 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)

065. Participant Freedom of Choice. A participant must have freedom of choice when selecting from the service coordinators available to him. The service coordinator cannot restrict the participant's choice of other health care providers.

(5-8-09)

076. 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, ~~the service coordinators~~ must have ~~a~~ face-to-face contact with ~~the~~ **each** participant ~~except as described in Subsection 728.07.a. of this rule.~~ (5-8-09)()

~~a. Mental health service coordinators must have face-to-face contact every month with each participant.~~ (5-8-09)

ba. 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)

eb. 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)

087. 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)

098. 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 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 professional nurse (RN), and have twenty-four (24) months supervised work experience with the population being served. (5-8-09)

~~**d.** For mental health service coordination, the supervisor must have obtained the required supervised work experience in a mental health treatment setting with the serious and persistent mentally ill population. (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 professional 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. (~~5-8-09~~)

~~a.~~ Paraprofessionals must not conduct assessments, evaluations, person-centered planning meetings, ninety (90) day face-to-face contacts described in Section 728.076 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. (~~5-8-09~~)()

~~b.~~ *Mental Health Service Coordination does not allow for service provision by paraprofessionals.* (5-8-09)

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 IDAPA 16.05.06, "Criminal History and Background Checks." (5-8-09)

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)

730. SERVICE COORDINATION: PLAN DEVELOPMENT -- ASSESSMENT.

01. Assessment Process. The service coordination assessment must be completed by a service coordinator as part of the person-centered planning process. The focus of the assessment is to identify the participant's need for assistance in gaining and coordinating access to care and services. The participant must be included in the assessment process. The parent or legal guardian, when appropriate, and pertinent service providers as identified by the participant must also be included during the assessment process. The assessment component is used to determine the prioritized needs and services of the participant and must be documented in the plan. When the participant is a child, the assessment must include identification of the family's needs to

ensure the child's needs are met. (5-8-09)

02. Components of an Assessment. The components in the assessment of a participant's service coordination needs must document the following information; (5-8-09)

- a. Basic needs; (5-8-09)
- b. Medical needs; (5-8-09)
- c. Health and safety needs; (5-8-09)
- d. Therapy needs; (5-8-09)
- e. Educational needs; (5-8-09)
- f. Social and integration needs; (5-8-09)
- g. Personal needs; (5-8-09)
- h. Family needs and supports; (5-8-09)
- i. Long range planning; (5-8-09)
- j. Legal needs; and ~~(5-8-09)~~()
- k. Financial needs; ~~and~~ ~~(5-8-09)~~()

~~l. For adults with mental illness the comprehensive diagnostic assessment used to establish service coordination eligibility described in Section 725 of these rules (5-8-09)~~

~~03. Assessment for Mental Health Service Coordination. The assessment for mental health service coordination must not duplicate the comprehensive diagnostic assessment. (5-8-09)~~

(BREAK IN CONTINUITY OF SECTIONS)

736. SERVICE COORDINATION: PROVIDER REIMBURSEMENT.

01. Duplication. Participants are only eligible for one (1) type of service coordination. If they qualify for more than one (1) type, the participant must choose one (1). Service coordination payment must not duplicate payment made to public or private sector entities under other program authorities for this same purpose. (3-19-07)

02. Payment for Service Coordination. Subject to the service limitations in Subsection 736.06 of this rule, only the following services are reimbursable: (5-8-09)

- a.** Service coordination plan development defined in Section 721 of these rules. (5-8-09)
- b.** Face-to-face contact required in Subsection 728.076 of these rules. ~~(5-8-09)~~()
- c.** Two-way communication between the service coordinator and the participant, participant's service providers, family members, primary care givers, legal guardian, or other interested persons. (5-8-09)
- d.** Face-to-face contact between the service coordinator and the participant's family members, legal representative, primary caregivers, providers, or other interested persons. (3-19-07)
- e.** Referral and related activities associated with obtaining needed services as identified in the service coordination plan. (5-8-09)

03. Service Coordination During Institutionalization. Service coordination is reimbursable on the day a participant is admitted to a medical institution if the service is provided prior to admission. Service coordination is reimbursable on the day of discharge from a medical institution if the service is provided after discharge. (5-8-09)

- a.** Service coordination for reintegration into the community, can only be provided by and reimbursed to a service coordination agency when the following applies: (5-8-09)
 - i.** During the last fourteen (14) days of an inpatient stay which is less than one hundred eighty (180) days in duration; or (5-8-09)
 - ii.** During the last sixty (60) days of an inpatient stay of one hundred eighty (180) days or more. (5-8-09)
- b.** Service coordination providers may not file claims for reimbursement until the participant is discharged and using community services; (5-8-09)
- c.** Service coordination must not duplicate activities provided as part of admission or discharge planning activities of the medical institution. (5-8-09)

04. Incarceration. Service coordination is not reimbursable when the participant is incarcerated. (3-19-07)

05. Services Delivered Prior to Assessment. Payment for on-going service coordination will not be made prior to the completion of the service coordination plan. (5-8-09)

06. Payment Limitations. Reimbursement is not allowed for missed appointments, attempted contacts, travel to provide the service, leaving messages, scheduling appointments with the Medicaid service coordinator, transporting participants, or documenting services. (5-8-09)

- a.** Service coordination providers are paid in unit increments of fifteen (15) minutes each. A service coordinator can only be reimbursed for the amount of time worked and must not

bill for more than four (4) billing units per hour. The following table is an example of minutes to billing units. (5-8-09)

Services Provided Are More Than Minutes	Services Provided Are Less Than Minutes	Billing Units
8	23	1
22	38	2
37	53	3
52	68	4
67	83	5
82	98	6
97	113	7

(5-8-09)

b. Direct delivery of medical, educational, psychiatric, social, early intervention, or other service to which a participant has been referred is not reimbursable as service coordination. (5-8-09)

c. Activities that are an integral component of another covered Medicaid service are not reimbursable as service coordination. (5-8-09)

d. Activities that are integral to the administration of foster care programs are not reimbursable as service coordination. (5-8-09)

e. Activities that are integral to the administration of another non-medical program are not reimbursable as service coordination. 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)

07. Healthy Connections. A participant enrolled in Healthy Connection must receive a referral for assessment and provision of services from his Healthy Connections provider. To be reimbursed for service coordination, the Healthy Connections referral must cover the dates of service delivery. (3-21-12)

08. Group Service Coordination. Payment is not allowed for service coordination provided to a group of participants. (3-19-07)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.15 - RULES AND MINIMUM STANDARDS FOR SEMI-INDEPENDENT GROUP RESIDENTIAL FACILITIES FOR THE DEVELOPMENTALLY DISABLED OR MENTALLY ILL

DOCKET NO. 16-0315-1301 (CHAPTER REPEAL)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 39-4605, Idaho Code.

DESCRIPTIVE SUMMARY: There are no changes to the pending rule and it is being adopted as originally proposed. This chapter has been repealed in its entirety. The complete text of the proposed rule was published in the June 5, 2013, Idaho Administrative Bulletin, [Vol. 13-6, page 42](#).

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

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

There is no fiscal impact to any funds due to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Tamara Prisock at (208) 364-1971.

DATED this 21st day of November, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 39-4605, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than June 19, 2013.

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

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

The Department needs to repeal this chapter of rules because the chapter is obsolete. The Department stopped certifying Semi-Independent Group Residential Facilities for the Developmentally Disabled or Mentally Ill several years ago because these are private residential facilities and provide no Medicaid-reimbursed services, and the Department has limited resources in terms of survey staff.

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

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: There is no fiscal impact due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not feasible. The Department has notified the eight facilities impacted by this change of the fact that we will be repealing this rule chapter. The Department has not surveyed or certified these private facilities for several years due to limited resources in terms of survey staff. Negotiating with the providers or stakeholders would not change that outcome.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Tamara Prisock at (208) 364-1971.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before June 26, 2013.

DATED this 14th day of May, 2013.

LSO Rules Analysis Memo

IDAPA 16.03.15 IS BEING REPEALED IN ITS ENTIRETY

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.04.02 - IDAHO TELECOMMUNICATION SERVICE ASSISTANCE PROGRAM RULES

DOCKET NO. 16-0402-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-901 and 56-902, Idaho Code, as amended in Senate Bill 1013, and 47 CFR 54.405.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the July 3, 2013, Idaho Administrative Bulletin, [Vol. 13-7, pages 57 through 59](#). The changes made in this rulemaking aligned rules with statutory changes made by the 2013 Legislature.

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

There is no fiscal impact to state general funds for this rulemaking. Benefit funds are allocated through telephone companies and their customers.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the pending rule, contact Sara Herring at (208) 334-5752.

DATED this 3rd day of October, 2013.

Tamara Prisock
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**THE FOLLOWING NOTICE WAS PUBLISHED WITH
THE TEMPORARY AND PROPOSED RULE**

EFFECTIVE DATE: The effective date of the temporary rule is **July 1, 2013**.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-901 and 56-902, Idaho Code, as amended in Senate Bill 1013, and 47 CFR 54.405.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than July 17, 2013.

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

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

During the 2013 Legislative Session, statutory changes were made to Sections 56-901 and 56-902, Idaho Code, relating to telecommunication assistance under the "Idaho Telecommunication Service Assistance Program," or ITSAP. These rule changes are necessary to align with amendments to the law which are effective on July 1, 2013.

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

Senate Bill 1013, adopted by the 2013 Legislature, amended the ITSAP statutes which are effective on July 1, 2013.

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

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

There is no fiscal impact to state general funds for this rulemaking. Benefit funds are allocated through telephone companies and their customers.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rule is a temporary rule and was not feasible to negotiate because these rules need to align with Idaho Code on July 1, 2013.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Sara Herring at (208) 334-5752.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 24, 2013.

DATED this 5th day of June, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0402-1301

001. TITLE, SCOPE, AND PURPOSE.

01. Title. These rules are cited as IDAPA 16.04.02, “Idaho Telecommunication Service Assistance Program Rules.” (4-4-13)

02. Scope. These rules contain official requirements governing the program’s right to provide eligible recipients with a reduction of costs in telecommunication installation and service. (4-4-13)

03. Purpose. The purpose of these rules is to establish requirements of the Idaho Telecommunication Service Assistance Program (ITSAP) as authorized by Sections 62-610, 56-901, 56-902, 56-903, and 56-904, Idaho Code. ITSAP shall *maximize grant limited* federal “lifeline” contributions to Idaho’s low income customers. (~~4-4-13~~)()

(BREAK IN CONTINUITY OF SECTIONS)

010. DEFINITIONS.

- 01. Assistance Rate Discount.** A monthly discount to eligible “lifeline” subscribers for basic local service under the Idaho Telecommunication Service Assistance Program (ITSAP) authorized in Sections 56-901 through 56-904, and 62-610, Idaho Code. (4-4-13)
- 02. Community Action Agency.** A private, non-profit organization serving the low-income population in specified counties of the state which meet the requirements to be designated as a community action agency according to the Community Services Block Grant Act, and has entered into a contract with the Idaho Department of Health and Welfare for the provision of ITSAP services. (4-4-13)
- 03. Department.** The Idaho Department of Health and Welfare. (3-5-91)
- 04. Eligibility Application.** The current Participant Assessment Application form or the Application for Assistance (AFA) form. (7-1-99)
- 05. Eligible Basic Local Service.** A single *residence* telecommunication service at the *principal residence of the* eligible subscriber/*head of* household. (~~7-1-99~~)()
- 06. Federal Poverty Guidelines (FPG).** The poverty guidelines issued annually by the Department of Health and Human Services (HHS). The federal poverty guidelines are available on the U.S. Health and Human Services at <http://aspe.hhs.gov/poverty>. (4-4-13)
- 07. Head of Household.** The adult member of a household responsible for payment of at least fifty percent (50%) of the cost of the basic local service. (4-4-13)
- 08. Household.** A household is either an individual living alone or a group of individuals who are living together at the same address as one economic unit. A household may include related and unrelated persons. An “economic unit” consists of all adult individuals contributing to and sharing in the income and expenses of a household. An adult is any person eighteen (18) years or older. If an adult has no or minimal income, and lives with someone who provides financial support to him, both people shall be considered part of the same household. Children under the age of eighteen (18) living with their parents or guardians are considered to be part of the same household as their parents or guardians. (4-4-13)
- 09. Income.** Income is the gross amount of money actually received in the recipients household from all sources. (4-4-13)
- 10. ITSAP.** Idaho Telecommunication Service Assistance Program. (4-4-13)
- 11. Lifeline.** ITSAP component that provides a monthly discount rate to eligible subscribers on their basic local service costs. (4-4-13)
- 12. Provider.** The eligible telecommunication carrier providing basic local service to Idaho residents. (4-4-13)
- 13. Recipient.** A person who is determined eligible for ITSAP. (4-4-13)

14. Subscriber. A person applying for basic local service or, in whose name the basic local service is listed. The subscriber does not need to be the head of the household. (4-4-13)

(BREAK IN CONTINUITY OF SECTIONS)

110. ASSISTANCE DISCOUNT RATE.

An eligible “lifeline” recipient is given a monthly discount for basic local service in the amount of ~~three~~ two dollars and fifty cents (\$~~3~~2.50) ~~or an amount authorized by the Federal Communication Commission, whichever is greater.~~ The discount cannot exceed the rate charged for the grade of basic local service subscribed to by eligible recipient. ~~(4-4-13)~~()

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.05.01 - USE AND DISCLOSURE OF DEPARTMENT RECORDS

DOCKET NO. 16-0501-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice, the pending rule will become final and effective on July 1, 2014, after review by the legislature, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 39-242, 39-5403, 56-221, 56-222, 56-1003, and 56-1004, Idaho Code; also HIPAA: 45 CFR Subpart E, Section 164.510.

DESCRIPTIVE SUMMARY: There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 4, 2013, Idaho Administrative Bulletin, [Vol. 13-9, pages 118 and 119](#).

The U.S. Department of Health and Human Services (HHS) recently amended the HIPAA Privacy Rule. This rule change went into effect March 26, 2013. HHS amended the Privacy Rule to permit a covered entity (such as the Department) to disclose a decedent's health information to family members and others who were involved in the care or payment for care of the decedent prior to death. This rule change permits the Department to use or disclose health information, as allowed by the amended Privacy Rule.

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

There is no anticipated fiscal impact to any funds for this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Heidi Graham at (208) 334-5617.

DATED this 21st day of November, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720

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e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 39-242, 39-5403, 56-221, 56-222, 56-1003, and 56-1004, Idaho Code; also HIPAA: 45 CFR Subpart E, Section 164.510.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 18, 2013.

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

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

The U.S. Department of Health and Human Services (HHS) recently modified the HIPAA Privacy Rule. This rule change went into effect March 26, 2013. HHS modified the Privacy Rule to permit a covered entity (such as the Department) to disclose a decedent's health information to family members and others who were involved in the care or payment for care of the decedent prior to death. This rule change permits the Department to use or disclose health information, as allowed by the Privacy Rule.

This does not change the authority of a decedent's personal representative with regard to the decedent's health information. Thus, a personal representative would continue to have a right to access the decedent's health information relevant to such personal representation, and have authority to authorize uses and disclosures of the decedent's health information that are not otherwise permitted or required by HIPAA.

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

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

There is no anticipated fiscal impact to any funds for this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because there is really no negotiable content in this rulemaking. The rule change is being done to clarify the Department's Use and Disclosure rules and bring them into alignment with recent changes in HIPAA. While the rule change will give the Department a little more latitude regarding the release of decedent information, the effect will be minimal.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Heidi Graham at (208) 334-5617.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 25, 2013.

DATED this 2nd day of August, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0501-1301

190. RECORDS OF DECEDENTS.

Records of decedents are confidential for as long as the Department maintains the records, except as needed by: (4-2-08)

01. Law Enforcement. If there is suspicion that the death was the result of criminal conduct. (4-2-08)

02. Coroners and Medical Examiners. Information may be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. (4-2-08)

03. Funeral Directors. Confidential information may be given to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. If necessary to carry out their duties, confidential information may be disclosed to funeral directors prior to and in reasonable anticipation of the individual's death. (4-2-08)

04. Personal Representatives. While records are maintained, the same confidentiality requirements apply to the personal representative of the estate or other legal representative of the

deceased individual. Information may be disclosed to such representatives only to the extent necessary to perform their legal function, (4-2-08)

05. Family Members and Others. The Department may disclose health information to a family member, other relative, a close personal friend of the deceased individual, or any other person identified by the deceased individual. Information provided must be directly related to such person's involvement with the individual's care or payment for health care prior to the individual's death, unless doing so is inconsistent with any prior expressed preference of the individual that is known to the Department. ()

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.05.04 - RULES OF THE IDAHO COUNCIL ON DOMESTIC VIOLENCE
AND VICTIM ASSISTANCE GRANT FUNDING

DOCKET NO. 16-0504-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice, the pending rule becomes final and effective on July 1, 2014, after review by the legislature, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 39-5209, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The Idaho Council on Domestic Violence and Victim Assistance (ICDVVA) is revising the “Incorporation by Reference” section of these rules. Specifically, the documents entitled: “Domestic Violence Program and Personnel Standards” and the “Sexual Assault Program and Personnel Standards” are being combined into a single standards manual entitled: “Service Standards for ICDVVA-Funded Programs.” This revision is being done to reflect changes in federal regulations and program practices made since 1998, as well as incorporate program enhancements developed with providers to improve the quality of services to victims of crime in Idaho.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 2, 2013, Idaho Administrative Bulletin, [Vol. 13-10, pages 220 and 221](#).

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

There is no anticipated fiscal impact to any funds for this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Luann Dettman at (208) 332-1540.

DATED this 19th day of November, 2013.

Tamara Prisock
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e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE
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AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 39-5209, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 16, 2013.

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

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

The Idaho Council on Domestic Violence and Victim Assistance (ICDVVA) is revising the “Incorporation by Reference” section of these rules. Specifically, the documents entitled: “Domestic Violence Program and Personnel Standards” and the “Sexual Assault Program and Personnel Standards” are being combined into a single standards manual entitled: “Service Standards for ICDVVA-Funded Programs.” This revision is being done to reflect changes in federal regulations and program practices made since 1998, as well as incorporate program enhancements developed with providers to improve the quality of services to victims of crime in Idaho.

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

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

There is no anticipated fiscal impact to any funds for this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted and deemed not feasible because informal negotiated rulemaking has already been conducted. Changes to the standards manuals have been drafted in collaboration with the program's service providers.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the standards manual entitled: *Service Standards for ICDVVA-Funded Programs*, edition 2014-1, effective July 1, 2014, is being incorporated by reference into these rules to give it the force and effect of law. The document is not being published in this chapter of rules due to its length and format, but it is available upon request from the Idaho Council on Domestic Violence and Victim Assistance or at: <http://www.icdv.idaho.gov>.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Luann Dettman at (208) 332-1540.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 23, 2013.

DATED this 29th day of August, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0504-1301

004. INCORPORATION BY REFERENCE.

~~**01: General.** Unless provided otherwise, any reference in these rules to any document identified in Section 004 shall constitute the full incorporation into these rules of that document for the purposes of the reference, including any notes and appendices therein. The term "document" includes codes, standards, or rules which have been adopted by an agency of the state or of the United States or by any nationally recognized organization or association. (5-3-03)~~

~~**02: Availability of Reference Material.** Copies of the documents incorporated by reference into these rules are available: (5-3-03)~~

~~**a:** At the Idaho Council on Domestic Violence and Victim Assistance, 304 North 8th Street, Suite 140, P.O. Box 83720, Boise, Idaho 83720-0036. (3-30-11)~~

~~**b:** On the internet at: <http://www.icdv.idaho.gov>. (5-3-03)~~

031. Documents Incorporated by Reference. In accordance with Section 67-5229, Idaho Code, ~~the~~ the following documents are incorporated by reference into ~~these~~ this chapter of rules: ~~(5-3-03)~~()

a. ~~“Domestic Violence Program and Personnel Standards,”~~ “Service Standards for ICDVVA-Funded Programs,” Edition 2014-1, published by the Idaho Council on Domestic Violence and Victim Assistance, effective ~~November 20, 1998~~ July 1, 2014. ~~(5-3-03)~~()

b. “Minimum Standards for Domestic Violence Offender Intervention Programs,” published by the Idaho Council on Domestic Violence and Victim Assistance, edition 2011-1, effective July 1, 2011. (3-29-12)

~~**c.** “Sexual Assault Program and Personnel Standards,” published by the Idaho Council on Domestic Violence and Victim Assistance, effective April 27, 2001. (5-3-03)~~

02. Availability of Reference Material. Copies of the documents incorporated by reference into these rules are available: ()

a. At the Idaho Council on Domestic Violence and Victim Assistance, 304 North 8th Street, Suite 140, P.O. Box 83720, Boise, Idaho 83720-0036. ()

b. On the internet at: <http://www.icdv.idaho.gov>. ()

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.05.06 - CRIMINAL HISTORY AND BACKGROUND CHECKS

DOCKET NO. 16-0506-1302

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice, the pending rule becomes final and effective on July 1, 2014, after review by the legislature, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202(b), 56-203(2), 56-204A, 56-1004A, 56-1007, 39-1105, 39-1107, 39-1111, 39-1210(10), 39-1211(4), 39-3520 and 39-5604, Idaho Code.

DESCRIPTIVE SUMMARY: There are no changes to the pending rule and it is being adopted as originally proposed. These changes provide clarification for the criminal history and background check application, fingerprint, and submission process. The complete text of the proposed rule was published in the September 4, 2013, Idaho Administrative Bulletin, **Vol. 13-9, pages 120 through 127.**

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

There is no fiscal impact to any funds due to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Fernando Castro, at (208) 332-7999.

DATED this 21st day of November, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202(b), 56-203(2), 56-204A, 56-1004A, 56-1007, 39-1105, 39-1107, 39-1111, 39-1210(10), 39-1211(4), 39-3520 and 39-5604, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 18, 2013.

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

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

These rule changes provide clarification of the criminal history and background check application and fingerprint submission requirements and process. Other changes include:

1. Provide an appeal process for individuals whose records are disputed;
2. Update the crime list for disqualifying crimes, and conditional and unconditional denials;
3. Clarify when a clearance may be revoked and actions for noncompliance with rules; and
4. Clarify reporting changes to the Department for change in ownership, location, or name.

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

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

There is no anticipated fiscal impact to any funds due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted nor feasible because these rule changes are to clarify current policies and to provide a process to appeal findings. The Department did survey employers that use the Department's website for criminal history and background checks for their input.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact

Fernando Castro, at (208) 332-7999.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 25, 2013.

DATED this 1st day of August, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0506-1302

060. EMPLOYER REGISTRATION.

01. Initial Registration. Employers required to have Department criminal history and background checks on their employees, contractors, or staff must register with the Department and receive an employer identification number before criminal history and background check applications can be processed or accessed. ~~(7-1-12)~~()

02. Change in Name or Ownership. When an agency or facility: ()

a. Is acquired by another entity, the new ownership must register as a new employer and provide contact information to obtain a new employer identification number and website access within thirty (30) calendar days of acquisition. ()

b. Changes its name or location, the employer must provide the new name, location, and contact information to the Department within thirty (30) calendar days of the change. ()

(BREAK IN CONTINUITY OF SECTIONS)

130. SUBMISSION OF APPLICATION.

An application for a criminal history and background check must be initiated ~~on the Department's website, submitted,~~ and received ~~by on~~ the Department's website before a criminal history and background check can be processed. The application is pending until the Department issues a clearance or denial, or the individual withdraws the application. ~~The applicant has two options for processing the application:~~ ~~(7-1-12)~~()

~~01. On-Line Application Process. An individual may submit the application through the Criminal History Unit's website at <https://chu.dhw.idaho.gov>. Individuals who submit their application through the website may schedule a fingerprinting appointment at a Department~~

~~location. At the fingerprinting appointment, the Department will print the application and notarize the individual's signature.~~ (7-1-12)

~~02. Mail-in Application Process. An individual may complete the application provided on the Department's website, print the application, have it notarized, and mail it to the Criminal History Unit with the signed fingerprint card and applicable fee. The application must be mailed to: Criminal History Unit, P. O. Drawer B, Lewiston, ID 83501.~~ (7-1-12)

131. -- 139. (RESERVED)

140. SUBMISSION OF FINGERPRINTS.

The Department's criminal history and background check is a fingerprint-based check. Ten (10) rolled fingerprints must be collected from the individual and submitted to the Department within the time frame for submitting applications as provided in Section 150 of these rules in order for a criminal history and background check request to be processed. The Department must obtain fingerprints electronically at one each of its fingerprint locations, or the Department's fingerprint card must be used. A Department fingerprint card can be obtained by contacting the Criminal History Unit, described in Section 005 of these rules. (7-1-12)()

01. Department Fingerprinting Locations. A fingerprint appointment ~~may be~~ is scheduled at designated Department locations where the Department will collect the individual's fingerprints. A fee may be assessed when an individual misses the scheduled appointment as provided in Section 051 of these rules. The locations for the closest Department fingerprint collection office where an individual may submit fingerprints are listed on the Department's website, or you may contact the Criminal History Unit as described in Section 005 of these rules. (3-26-08)()

02. Submitting Fingerprints by Mail. When An individual may elects to have fingerprints collected by a local law enforcement agency or by the applicant's employer, the Department's fingerprint card must be used. The fingerprint card must be completed in accordance with the instructions provided, signed, and mailed along with the completed notarized application and applicable fee to: Criminal History Unit, P. O. Drawer B, Lewiston, ID 83501 the address indicated on the Department's website. The notarized application and fees must be received by the Department in the time frame required in Section 150 of these rules. (7-1-12)()

03. Submission of Reprints. In the event that an individual's submitted fingerprints are deemed unreadable by the Department, Idaho State Police, or the FBI, the applicant must comply with a request for reprints from the Department within fifteen (15) calendar days from the date of the notice. Failure to comply with the Department's reprint request will result in the applicant being unavailable to provide services. ()

141. -- 149. (RESERVED)

150. TIME FRAME FOR SUBMITTING APPLICATION AND FINGERPRINTS.

The completed notarized application and fingerprints must be received by the Department within twenty-one (21) days from the date of notarization whether submitted by mail or at a Department fingerprinting location. (7-1-12)()

01. Availability to Provide Services. The applicant: ()

a. Is available to provide services on the day the application is signed and notarized, as long as the applicant has not disclosed any disqualifying crimes or relevant records. The applicant must provide the Department a copy of the signed and notarized application to validate the date of applicant's availability to provide services. ()

b. ~~is not~~ Becomes unavailable to provide services or be licensed or certified when the notarized application is not received or the fingerprints have not been ~~rolled~~ collected within this time frame. (7-1-12)()

c. Who submits a complete application and fingerprints by mail, and the application is deemed inadequate or incomplete for processing by the Department, is unavailable to provide services until the application is received by the Department completed and corrected. ()

02. Incomplete Application. The criminal history and background check is incomplete and will not be processed by the Department if this time frame is not met. (7-1-12)

03. No Extension of Time Frame. The Department will not extend the twenty-one (21) day time frame, unless the applicant or employer provides just cause. An applicant for employment or employer can not submit a new application for the same purpose, or repeatedly resign and re-notarize the original application. (7-1-12)

(BREAK IN CONTINUITY OF SECTIONS)

170. AVAILABILITY TO PROVIDE SERVICES PENDING COMPLETION OF THE CRIMINAL HISTORY AND BACKGROUND CHECK.

An individual is available to provide services pending completion of the criminal history and background check as described in Subsections 170.01 and 170.02 of this rule. The individual must have submitted a signed notarized application and fingerprintings must be completed in the time frame ~~described~~ required in Section 150 of these rules, in order to provide services. (3-26-08)()

01. Employees of Providers, Contractors, Emergency Medical Services (EMS), or the Department. An individual is available to provide services on a provisional basis at the discretion of the employer or EMS Bureau as long as no disqualifying crimes or relevant records are disclosed on the application. The employer must review the application for any disqualifying crimes listed in Section 210 of these rules or other relevant records listed in Sections 230 and 240 of these rules. The employer ~~then~~ must ~~determines~~ whether the applicant poses a health or safety risk to vulnerable clients before allowing the individual to provide services until a clearance or denial is issued by the Department. (3-26-08)()

02. Individuals Licensed or Certified by the Department. Individuals applying for licensure or certification by the Department are not available to provide services or receive

licensure or certification until the criminal history and background check is complete and a clearance is issued by the Department. The following are individuals required to have a clearance prior to providing services: (3-26-08)

- a. Adoption or foster care applicants and adults in the home; (3-26-08)
- b. Certification or licensure applicants; (3-26-08)
 - i. Certified family homes; (3-26-08)
 - ii. Licensed child care providers; (3-26-08)

(BREAK IN CONTINUITY OF SECTIONS)

190. CRIMINAL HISTORY AND BACKGROUND CHECK CLEARANCE.

01. Department Clearance. A criminal history and background check clearance is issued by the Department once all relevant records and findings have been reviewed and the Department has cleared the applicant. The clearance will be published on the Department's website and the individual may print copies of the clearance. The employer must print out the clearance and maintain a copy readily available for inspection. (~~7-1-12~~)()

02. Revocation of Department Clearance. An individual's previously issued clearance may be revoked for the following: ()

a. The individual fails to comply with the Department's request to submit to a new criminal history and background check according to Subsection 300.04 of these rules. ()

b. The individual completes a new criminal history and background check and is found to have a criminal or relevant record that results in an inability to proceed action or in a denial as described in Sections 190 or 200 of these rules. ()

191. -- 199. (RESERVED)

200. UNCONDITIONAL DENIAL.

An individual who receives an unconditional denial is not available to provide services, have access, or to be licensed or certified by the Department. (3-26-08)

01. Reasons for an Unconditional Denial. Unconditional denials are issued for: (3-4-11)

- a. Disqualifying crimes described in Section 210 of these rules; (3-4-11)
- b. A relevant record on the Idaho Child Abuse Central Registry with a Level 1 or Level 2 finding; (7-1-12)

- c. A relevant record on the Nurse Aide Registry; ~~or~~ (7-1-12)()
- d. A relevant record on either the state or federal sex offender registries; or ()
- ~~d.e.~~ A relevant record on the state or federal Medicaid Exclusion List, described in Section 240 of these rules. (7-1-12)

02. Issuance of an Unconditional Denial. The Department will issue an unconditional denial within fourteen (14) days of completion of a criminal history and background check. (3-26-08)

03. Challenge of Department's Unconditional Denial. An individual has ~~thirty~~ twenty-eight (~~30~~28) days from the date the unconditional denial is issued to challenge the Department's unconditional denial. The individual must submit the challenge in writing and provide court records or other information which demonstrates the Department's unconditional denial is incorrect. These documents must be filed with the Criminal History Unit described in Section 005 of these rules. (~~3-4-11~~)()

a. If the individual challenges the Department's unconditional denial, the Department will review the court records, documents and other information filed by the individual. The Department will issue a decision within thirty (30) days of the receipt of the challenge. The Department's decision will be a final order under IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings," Section 152. (3-26-08)

b. If the individual does not challenge the Department's unconditional denial within thirty (30) days, it becomes a final order of the Department under IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings," Section 152. (3-26-08)

04. No Exemption Review. No exemption review, as described in Section 250 of these rules, is allowed for an unconditional denial. (3-26-08)

05. ~~Final Order~~ Appeal of an Unconditional Denial. Following a challenge of the Department's ~~final order~~ unconditional denial, an individual may appeal the Department's decision under the provisions in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings;" Section 152, may be appealed in District Court. The request to appeal an unconditional denial does not stay the action of the Department. (~~3-26-08~~)()

201. -- 209. (RESERVED)

210. DISQUALIFYING CRIMES RESULTING IN AN UNCONDITIONAL DENIAL. An individual is not available to provide direct care or services when the individual discloses or the criminal history and background check reveals a conviction for a disqualifying crime on his record as described in Subsections 210.01 and 210.02 of this rule. (3-26-08)

01. Disqualifying Crimes. The disqualifying crimes, described in Subsections 210.01.a. through 210.01.v. of this rule, or any substantially conforming foreign criminal violation, will result in an unconditional denial being issued. (7-1-12)

- a.** Abuse, neglect, or exploitation of a vulnerable adult, as defined in Section 18-1505, Idaho Code; (3-26-08)
- b.** Aggravated, first-degree and second-degree arson, as defined in Sections 18-801 through 18-803, and 18-805, Idaho Code; (3-26-08)
- c.** Crimes against nature, as defined in Section 18-6605, Idaho Code; (3-26-08)
- d.** Forcible sexual penetration by use of a foreign object, as defined in Section 18-6608, Idaho Code; (3-26-08)
- e.** Incest, as defined in Section 18-6602, Idaho Code; (3-26-08)
- f.** Injury to a child, felony or misdemeanor, as defined in Section 18-1501, Idaho Code; (3-26-08)
- g.** Kidnapping, as defined in Sections 18-4501 through 18-4503, Idaho Code; (3-26-08)
- h.** Lewd conduct with a minor, as defined in Section 18-1508, Idaho Code; (3-26-08)
- i.** Mayhem, as defined in Section 18-5001, Idaho Code; (3-26-08)
- j.** Manslaughter: (7-1-12)

 - i. Voluntary manslaughter, as defined in Section 18-4006(1) Idaho Code; (7-1-12)
 - ii. Involuntary manslaughter, as defined in Section 18-4006(2), Idaho Code; (7-1-12)
 - iii. Felony vehicular manslaughter, as defined in Section 18-4006(3)(a) and (b), Idaho Code; (7-1-12)
- k.** Murder in any degree or assault with intent to commit murder, as defined in Sections 18-4001, 18-4003, and 18-4015, Idaho Code; (7-1-12)
- l.** Poisoning, as defined in Sections 18-4014 and 18-5501, Idaho Code; (3-26-08)
- m.** Possession of sexually exploitative material, as defined in Section 18-1507A, Idaho Code; (3-26-08)
- n.** Rape, as defined in Section 18-6101, Idaho Code; (3-26-08)
- o.** Robbery, as defined in Section 18-6501, Idaho Code; (3-26-08)
- p.** Felony stalking, as defined in Section 18-7905, Idaho Code; (3-26-08)

- q.** Sale or barter of a child, as defined in Section 18-1511, Idaho Code; (3-26-08)
- r.** Sexual abuse or exploitation of a child, as defined in Sections 18-1506 and 18-1507, Idaho Code; (3-26-08)
- s.** Video voyeurism, as defined in Section 18-6609, Idaho Code; (3-26-08)
- t.** Enticing of children, as defined in Sections 18-1509 and 18-1509A, Idaho Code; (3-26-08)
- u.** Inducing individuals under eighteen (18) years of age into prostitution or patronizing a prostitute, as defined in Sections 18-5609 and 18-5611, Idaho Code; (3-26-08)
- v.** Any felony punishable by death or life imprisonment; or (3-26-08)
- w.** Attempt, conspiracy, accessory after the fact, or aiding and abetting, as defined in Sections 18-205, 18-306, 18-1701, and 19-1430, Idaho Code, to commit any of the disqualifying designated crimes. (3-29-10)

02. Disqualifying Five-Year Crimes. The Department will issue an unconditional denial for an individual who has been convicted of the following described crimes for five (5) years from the date of the conviction for the crimes listed in Subsections 210.02.a. through 210.02.~~j.~~ of this rule, or any substantially conforming foreign criminal violation: ~~(7-1-12)~~()

- a.** Any felony not described in Subsection 210.01, of this rule; (3-4-11)
- b.** Misdemeanor forgery of and fraudulent use of a financial transaction card, as defined in Sections 18-3123 through 18-3128, Idaho Code; (3-4-11)
- c.** Misdemeanor forgery and counterfeiting, as defined in Sections 18-3601 through 18-3620, Idaho Code; (3-4-11)
- d.** Misdemeanor identity theft, as defined in Section 18-3126, Idaho Code; (3-4-11)
- e.** Misdemeanor insurance fraud, as defined in Sections 41-293 and 41-294, Idaho Code; (3-4-11)
- f.** Misdemeanor public assistance fraud, as defined in Sections 56-227 and 56-227A, Idaho Code; (7-1-12)
- g.** Stalking in the second degree, as defined in Section 18-7906, Idaho Code;(7-1-12)
- h.** Misdemeanor vehicular manslaughter, as defined in Section 18-4006(3)(c), Idaho Code;~~or~~ ~~(7-1-12)~~()
- i.** Sexual exploitation by a medical care provider, as defined in Section 18-919, Idaho Code; or ()

i. Attempt, conspiracy, accessory after the fact, or aiding and abetting, as defined in Sections 18-205, 18-306, 18-1701, and 19-1430, Idaho Code, to commit any of the disqualifying five (5) year crimes. (3-29-10)

03. Underlying Facts and Circumstances. The Department may consider the underlying facts and circumstances of felony or misdemeanor conduct including a guilty plea or admission in determining whether or not to issue a clearance, regardless of whether or not the individual received one (1) of the following: (3-26-08)

- a.** A withheld judgment; (3-26-08)
 - b.** A dismissal, suspension, deferral, commutation, or a plea agreement where probation or restitution was or was not required; (3-26-08)
 - c.** An order according to Section 19-2604, Idaho Code, or other equivalent state law; (3-26-08)
- or
- d.** A sealed record. (3-26-08)

(BREAK IN CONTINUITY OF SECTIONS)

230. RELEVANT RECORDS RESULTING IN A CONDITIONAL DENIAL.

An individual is not available to provide direct care or services when the individual discloses or the criminal history and background check reveals a relevant record on his record as described Subsections 230.01 and 230.02 of this rule. (3-26-08)

01. Individuals Licensed or Certified by the Department or a Department Employee. A conditional denial may be issued when an individual who is licensed or certified by the Department, or who is a Department employee discloses, or the criminal history and background check reveals, a relevant record as defined in Subsections 230.01.a. through 230.01.f.d. of this rule: ~~(3-4-11)()~~

~~**a.** A plea, finding, or adjudication of guilt to any felony or misdemeanor, or any crime other than a traffic violation, that does not result in a suspension of the individual's driver's license; (3-26-08)~~

ba. A substantiated child protection complaint or a substantiated adult protection complaint; (3-26-08)

eb. The Department determines there is a potential health and safety risk to vulnerable adults or children; (3-26-08)

dc. The individual has falsified or omitted information on the application form; or ~~(3-26-08)()~~

~~e.~~ *The individual is on the Nurse Aide Registry with a negative finding; or* (3-4-11)

~~fd.~~ The Department determines additional information is required. (3-26-08)

02. Employees of Providers or Contractors. A conditional denial may be issued when an individual who is employed by a provider or contractor discloses, or the criminal history and background check reveals, a relevant record as defined in Subsections 230.02.a. through 230.02.eb. of this rule. (3-4-11)()

a. A substantiated child protection complaint or a substantiated adult protection complaint; or (3-26-08)()

~~b.~~ *The individual is on the Nurse Aide Registry with a negative finding; or* (3-4-11)

~~eb.~~ The Department determines additional information is required. (3-26-08)

03. Underlying Facts and Circumstances. The Department may consider the underlying facts and circumstances of felony or misdemeanor conduct including a guilty plea or admission in determining whether or not to issue a clearance, regardless of whether or not the individual received one (1) of the following: (3-26-08)

a. A withheld judgment; (3-26-08)

b. A dismissal, suspension, deferral, commutation, or a plea agreement where probation or restitution was or was not required; (3-26-08)

c. An order according to Section 19-2604, Idaho Code, or other equivalent state law; (3-26-08)
or

d. A sealed record. (3-26-08)

(BREAK IN CONTINUITY OF SECTIONS)

270. CRIMINAL OR RELEVANT RECORD - ACTION PENDING.

01. Notice of Inability to Proceed. When the applicant is identified as having a pending criminal action for a crime or relevant record that may disqualify him from receiving a clearance for the criminal history and background check, the Department may issue a notice of inability to proceed. (7-1-12)

02. Availability to Provide Services. The applicant is not available to provide service when a notice of inability to proceed or denial is issued by the Department. Any previous clearance issued by the Department will be revoked as described in Section 190 of these rules. (7-1-12)()

03. Reconsideration of Action Pending. In the case of an inability to proceed status, the applicant can submit documentation that the matter has been resolved to the Department for reconsideration within one hundred and twenty (120) calendar days from the date of notice. When the Department receives this documentation, the Department will notify the applicant of the reconsideration and issue a clearance or denial. When the Department's reconsideration results in a clearance after review, any previously revoked clearance will be restored as described in Section 190 of these rules. (~~7-1-12~~)()

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.05.07 - THE INVESTIGATION AND ENFORCEMENT OF FRAUD, ABUSE, AND MISCONDUCT

DOCKET NO. 16-0507-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202(b), 56-203(1) and (2), 56-209, 56-209h, 56-227, 56-227A through D, 56-1001, and 56-1003, Idaho Code.

DESCRIPTIVE SUMMARY: There are no changes to the pending rule and it is being adopted as originally proposed. These amendments align the rules with current statutes. The complete text of the proposed rule was published in the October 2, 2013, Idaho Administrative Bulletin, **Vol. 13-9, pages 222 through 226.**

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

There is no fiscal impact to any funds due to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Ben Johnson at (208) 334-6661.

DATED this 19th day of November, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
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P.O. Box 83720
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e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202(b), 56-203(1) and (2), 56-209, 56-209h, 56-227, 56-227A through D, 56-1001, and 56-1003, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 16, 2013.

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

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

Statutes governing this chapter of rules encompass all public assistance programs and providers, but the current rules limit the scope for investigations and enforcement actions to Medicaid providers and services. This rulemaking is being done to include all public assistance providers and programs in order to align these rules with statutes. By aligning the rules with statutes, the Department will increase accountability for all public assistance programs to help prevent fraud and abuse of public funds.

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

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

This rulemaking has no anticipated fiscal impact to state general funds or any other funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because it is not feasible to negotiate rules which are being changed to mirror statutes for public assistance programs.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Ben Johnson at (208) 334-6661.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 23, 2013.

DATED this 29th day of August, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0507-1301

010. DEFINITIONS AND ABBREVIATIONS.

For purposes of this chapter of rules, the following terms *will be used as defined below* apply. (3-30-07)()

01. Abuse or Abusive. Provider practices that are inconsistent with sound fiscal, business, child care, or medical practices, and result in an unnecessary cost to ~~the Medicaid a~~ public assistance program, in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, or in physical harm, pain or mental anguish to a medical assistance recipient. ~~It also includes recipient practices that result in unnecessary cost to the Medicaid program, or recipient utilization practices which may endanger their personal health or safety.~~ (3-30-07)()

02. Access to Documentation and Records. To review and copy records at the time a written request is made during normal business hours. Documentation includes all materials as described in Section 101 of these rules. (3-30-07)

03. Claim. Any request or demand for payment, or document submitted to initiate payment, of for items or services provided under ~~the state's medical a public~~ assistance program, whether under a contract or otherwise. (3-30-07)()

04. Conviction. An individual or entity is considered to have been convicted of a criminal offense: (3-30-07)

a. When a judgment of conviction has been entered against the individual or entity by a federal, state, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged; (3-30-07)

b. When there has been a finding of guilt against the individual or entity by a federal, state, or local court; (3-30-07)

c. When a plea of guilty or nolo contendere by the individual or entity has been accepted by a federal, state, or local court; or (3-30-07)

d. When the individual or entity has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld. (3-30-07)

05. Department. The Idaho Department of Health and Welfare, its authorized agent or designee. (3-30-07)

06. Exclusion. A specific person or provider will be precluded from directly or indirectly providing services and receiving reimbursement under Medicaid. (3-30-07)

07. Fraud or Fraudulent. An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. (3-30-07)

08. Knowingly, Known, or With Knowledge. A person, with respect to information or an action, who: ()

a. ~~#~~HHas actual knowledge of the information or an action; ()

b. ~~#~~Acts in deliberate ignorance of the truth or falsity of the information or the correctness or incorrectness of the action; or ()

c. ~~#~~Acts in reckless disregard of the truth or falsity of the information or the correctness or incorrectness of the action. (~~3-30-07~~)()

09. Managing Employee. A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency. (3-30-07)

10. Medicaid. Idaho's Medical Assistance Program. (3-30-07)

11. Medical Assistance. Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act, as amended. (3-30-07)

12. Ownership or Control Interest. A person or entity that: ()

a. ~~#~~HHas an ownership interest totaling twenty-five percent (25%) or more in an entity; ()

b. ~~#~~Is an officer or director of an entity that is organized as a corporation; ()

c. ~~#~~Is a partner in an entity that is organized as a partnership; or ()

d. ~~#~~Is a managing member in an entity that is organized as a limited liability company. (~~3-30-07~~)()

13. Participant. An individual or recipient who is eligible and enrolled in any public assistance program. ()

134. Person. An individual, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private. (3-30-07)

145. Program. ~~The~~ Any public assistance program, including the Medicaid P program and Idaho's State Plan, or any parts thereof, ~~including Idaho's State Plan.~~ (3-30-07)()

156. Provider. Any individual, organization, ~~agency,~~ or ~~business other~~ entity ~~furnishing medical goods providing items~~ or services ~~in compliance with Department rules who has a Medicaid provider number and has entered into a written provider agreement with the Department~~ under a public assistance program. (3-30-07)()

167. Provider Agreement. A written agreement between the Department and a provider or group of providers of supplies or services. This agreement contains any terms or conditions deemed appropriate by the Department. (3-30-07)

18. Public Assistance Program. Assistance for which provision is made in any federal or state law existing, or hereafter enacted, by the state of Idaho or the congress of the United States by which payments are made from the federal government to the state in aid, or in respect to payment by the state for welfare purposes to any category of needy person, and any other program of assistance for which provision for federal or state funds for aid may from time to time be made. ()

179. Recoup and Recoupment. The collection of funds for the purpose of recovering overpayments made to providers for items or services the Department has determined should not have been paid. The recoupment may occur through the collection of future claims paid or other means. (3-30-07)

1820. Sanction. Any abatement or corrective action taken by the Department which is appealable under Section 003 of these rules. (3-30-07)

1921. State Plan. The contract between the state and federal government under 42 U.S.C. section 1396a(a). (3-30-07)

202. Title XIX. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources. (3-30-07)

213. Title XXI. Title XXI of the Social Security Act, known as the ~~State~~ Children's Health Insurance Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children. (3-30-07)()

011. -- 019. (RESERVED)

020. DEPARTMENT ACTIONS.

When an instance of fraud, abuse, or other misconduct is identified, the Department will take action to correct the problem as provided in this section. Such corrective action may include, denial of payment, recoupment, payment suspension, provider agreement suspension, termination of provider agreement, imposition of civil monetary penalties, exclusion, recipient participant lock-in, referral for prosecution, or referral to state licensing boards. ~~(3-30-07)~~()

021. - 099. (RESERVED)

100. INVESTIGATION AND AUDITS.

Investigation and audits of provider fraud, abuse or misconduct conducted by the Department's Bureau of Audits and Investigations or its successor are governed under this chapter of rules. (3-30-07)

01. Investigation Methods. Under Section 56-227(e5), Idaho Code, the Department will investigate and identify potential instances of fraud, abuse, or other misconduct by any person related to or involvement in the public assistance programs administered by the Department. Methods may include: review of computerized reports, referrals to or from other agencies, health care providers or persons, or conducting audits and interviews, probability sampling and extrapolation, and issuing subpoenas to compel testimony or the production of records. Reviews may occur on either pre-payment or post-payment basis. ~~(3-30-07)~~()

02. Probability Sampling. Probability sampling shall be done in conformance with generally accepted statistical standards and procedures. "Probability sampling" means the standard statistical methodology in which a sample is selected based on the theory of probability, a mathematical theory used to study the occurrence of random events. (3-30-07)

03. Extrapolation. Whenever the results of a probability sample are used to extrapolate the amount to be recovered, the demand for recovery will be accompanied by a clear description of the universe from which the sample was drawn, the sample size and method used to select the sample, the formulas and calculation procedures used to determine the amount to be recovered, and the confidence level used to calculate the precision of the extrapolated overpayment. "Extrapolation" means the methodology whereby an unknown value can be estimated by projecting the results of a probability sample to the universe from which the sample was drawn with a calculated margin of error. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

210. SUSPENSION OF PAYMENTS PENDING INVESTIGATION.

The Department may suspend public-assistance payments in whole or part in a suspected case of fraud or abuse pending investigation and conclusion of legal proceedings related to the provider's alleged fraud or abuse. When payments have been suspended under this section of rule, the Department will provide for a hearing within thirty (30) days of receipt of any timely filed notice of appeal. ~~(3-30-07)~~()

01. Basis for Suspension of Payments. When the Department through reliable

evidence suspects fraud or abuse, or when a provider fails to provide immediate access to records, ~~Medicaid~~ **public-assistance** payments may be withheld or suspended. ~~(3-30-07)~~()

02. Notice of Suspension of Payments. The Department may **not** withhold **public-assistance** payments without first notifying the provider of its intention to do so. The Department will send written notice ~~according to 42 CFR 455-23(b)~~ within five (5) days of taking such action. ~~(3-30-07)~~()

03. Duration of Suspension of Payments. The withholding of payment actions under this section of rule will be temporary and will not continue after: (3-30-07)

a. The Department or the prosecuting authorities determine there is insufficient evidence of fraud or willful misrepresentation by the provider; or (3-30-07)

b. Legal proceedings related to the provider's alleged fraud or abuse are completed. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

230. TERMINATION OF PROVIDER STATUS.

Under Section 56-209h, Idaho Code, the Department may terminate the provider agreement of, or otherwise deny provider status for a period of five (5) years from the date the Department's action becomes final to, any individual or entity who: (3-30-07)

01. Submits an Incorrect Claim. Submits a claim with knowledge that the claim is incorrect, including reporting costs as allowable which were known to be disallowed in a previous audit, unless the provider clearly indicates that the item is being claimed to establish the basis for an appeal and each disputed item or amount is specifically identified. (3-30-07)

02. Fraudulent Claim. Submits a fraudulent claim. (3-30-07)

03. Knowingly Makes a False Statement. Knowingly makes a false statement or representation of material fact in any document required to be maintained or submitted to the Department. (3-30-07)

04. Medically Unnecessary. Submits a claim for an item or service known to be medically unnecessary. (3-30-07)

05. Immediate Access to Documentation. Fails to provide, upon written request by the Department, immediate access to documentation required to be maintained. (3-30-07)

06. Non-Compliance With Rules and Regulations. Fails repeatedly or substantially to comply with the rules and regulations governing medical assistance payments **or other public assistance program payments**. ~~(3-30-07)~~()

07. Violation of Material Term or Condition. Knowingly violates any material term or condition of its provider agreement. (3-30-07)

08. Failure to Repay. Has failed to repay, or was a managing employee or had an ownership or control interest in any entity that has failed to repay, any overpayments or claims previously found to have been obtained contrary to statute, rule, regulation, or provider agreement. (3-30-07)

09. Fraudulent or Abusive Conduct. Has been found, or was a managing employee in any entity which has been found, to have engaged in fraudulent conduct or abusive conduct in connection with the delivery of health care or public assistance items or services. (~~3-30-07~~)()

10. Failure to Meet Qualifications. Fails to meet the qualifications specifically required by rule or by any applicable licensing board. (3-30-07)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.06.01 - CHILD AND FAMILY SERVICES

DOCKET NO. 16-0601-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202(b) and 56-204A, Idaho Code, and Department appropriations for state fiscal year 2014.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the June 5, 2013, Idaho Administrative Bulletin, [Vol. 13-6, pages 43 and 44](#). The changes made to this rule increased the foster family stipend rates.

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

The 2013 Legislature added an ongoing increase of \$148,600 in state general funds to DHW appropriations for foster care reimbursements beginning in SFY 2014. There is no fiscal impact to any other funds due to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Erika Wainaina at (208) 334-6618.

DATED this 3rd day of October, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

**THE FOLLOWING NOTICE WAS PUBLISHED WITH
THE TEMPORARY AND PROPOSED RULE**

EFFECTIVE DATE: The effective date of the temporary rule is **July 1, 2013**.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b) and 56-204A, Idaho Code, and Department appropriations under House Bill 283 adopted by the 2013 Legislature.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than June 19, 2013.

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

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

The 2013 Legislature adopted the Department appropriations budget under House Bill 283. The legislative intent language specifically increased the foster family stipend rate in those appropriations. These rules are being amended to reflect this increase in the monthly reimbursement for a child in foster care based on the child's age.

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

This rule is being implemented as a temporary rule to reflect an increase in foster care rates for state fiscal year (SFY) 2014 that begins on July 1, 2013.

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

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

DHW appropriations in House Bill 283 added an ongoing increase of \$148,600 in state general funds for foster care reimbursements for SFY 2014. This funding increase is the only

fiscal impact to the state general fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rule is a temporary rule, and the determination was made that it was not feasible to negotiate this rulemaking.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Erika Wainaina at (208) 334-6618.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before June 26, 2013.

DATED this 14th day of May, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0601-1301

483. PAYMENT TO FAMILY ALTERNATE CARE PROVIDERS.

Monthly payments for care provided by family alternate care providers are:

Family Alternate Care Payments - Table 483			
Ages	0-5	6-12	13-18
Monthly Room and Board	\$ 304 ²⁹	\$ 339 ⁶⁶	\$ 453 ⁸⁷

(~~4-4-13~~)()

01. Gifts. An additional thirty dollars (\$30) for Christmas gifts and twenty dollars (\$20) for birthday gifts will be paid in the appropriate months. (5-8-09)

02. Clothing. Costs for clothing will be paid, based upon the Department's determination of each child's needs. All clothing purchased for a child in alternate care becomes the property of the child. (5-8-09)

03. School Fees. School fees due upon enrollment will be paid directly to the school or to the alternate care providers, based upon the Department's determination of the child's needs. (5-8-09)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.06.12 - RULES GOVERNING THE IDAHO CHILD CARE PROGRAM (ICCP)

DOCKET NO. 16-0612-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202, Idaho Code.

DESCRIPTIVE SUMMARY: There are no changes to the pending rule and it is being adopted as originally proposed. The amendments to these rules align with current practice for in-home child care. The complete text of the proposed rule was published in the October 2, 2013, Idaho Administrative Bulletin, [Vol. 13-9, pages 227 through 229](#).

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

This rulemaking has no anticipated fiscal impact to any funds, because the change is being made to reflect current practice.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Ericka Medalen at (208) 334-5641.

DATED this 21st day of November, 2013.

Tamara Prisock
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450 W. State Street - 10th Floor
P.O. Box 83720
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phone: (208) 334-5500
fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

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

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 16, 2013.

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

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

This rulemaking is to clarify and reflect current practices around in-home child care. ICCP respects the rights of these families and have not required health inspections in order for them to be eligible for a child-care subsidy. The current rules do not provide an exception for the health and safety inspections, which needs to be in rule. Federal law allows states to waive in-home child care health and safety inspection requirements but not training requirements.

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

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

This rulemaking has no anticipated fiscal impact to any funds, because the change is being made to reflect current practice.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not feasible because the change being made was putting into rule what is current practice for conducting business for in-home child care and would not impact those individuals affected by the change.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Ericka Medalen at (208) 334-5641.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 23, 2013.

DATED this 29th day of August, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0612-1301

401. IN-HOME CARE HEALTH AND SAFETY REQUIREMENTS.

Each in-home care provider is responsible to ensure that health and safety requirements are met for children being cared for in the children's own home. ()

01. Health and Safety Inspections. In-home health and safety inspections, described in Section 802 of these rules, are not required for in-home care providers caring for children in the children's own home. ()

02. Health and Safety Training. Because in-home care providers are exempt from health and safety inspections, each in-home care provider must complete health and safety training provided by the local Health District covering requirements listed in Section 802 of these rules. ()

~~402.~~ -- 499. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

802. HEALTH AND SAFETY REQUIREMENTS.

All providers must comply with the health and safety requirements listed in Subsections 802.01 through 802.10 of this rule. ~~The~~ All providers must agree to a health and safety inspection, with the exception of in-home child care described in Section 401 of these rules. Compliance with these standards does not exempt a provider from complying with stricter health and safety standards under state law, tribal law, local ordinance, or other applicable law. ~~(7-1-09)~~()

01. Age of Provider. All child care providers providing services must be eighteen (18) years old or older. Persons sixteen (16) or seventeen (17) years old may provide child care if they have direct, on-site supervision from a licensed child care provider who is at least eighteen (18) years old. (4-2-08)

02. Sanitary Food Preparation. Food for use in child care facilities must be prepared

and served in a sanitary manner. Utensils and food preparation surfaces must be cleaned and sanitized before using to prevent contamination. (4-2-08)

03. Food Storage. All food served in child care facilities must be stored to protect it from potential contamination. (4-2-08)

04. Hazardous Substances. Medicines, cleaning supplies, and other hazardous substances must be stored out of the reach of children. (4-2-08)

05. Emergency Communication. A telephone or some type of emergency communication system is required. (4-2-08)

06. Smoke Detectors, Fire Extinguishers, and Exits. A properly installed and operational smoke detector must be on the premises where child care occurs. Adequate fire extinguishers and fire exits must be available on the premises. (4-2-08)

07. Hand Washing. Each provider must wash his hands with soap and water at regular intervals, including before feeding, after diapering or assisting children with toileting, after nose wiping, and after administering first aid. (4-2-08)

08. CPR/First Aid. Providers must insure that at all times children are present at least one (1) adult on the premises has current certification in pediatric rescue breathing and first aid treatment from a certified instructor. (4-2-08)

09. Health of Provider. Each provider must certify that he does not have a communicable disease or any physical or psychological condition that might pose a threat to the safety of a child in his care. (4-2-08)

10. Child Abuse. Providers must report suspected child abuse to the appropriate authority. (4-2-08)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.06.12 - RULES GOVERNING THE IDAHO CHILD CARE PROGRAM (ICCP)

DOCKET NO. 16-0612-1302

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202, Idaho Code.

DESCRIPTIVE SUMMARY: There are no changes to the pending rule and it is being adopted as originally proposed. The amendments to these rules align with current practice and other Department rules for determining benefits for a child who lives in a joint custody situation. The complete text of the proposed rule was published in the November 6, 2013, Idaho Administrative Bulletin, [Vol. 13-11, pages 34 and 35](#).

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

There is no anticipated fiscal impact to the state general fund or any other funds due to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Ericka Medalen at (208) 334-5641.

DATED this 9th day of December, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
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e-mail: dhwrules@dhw.idaho.gov

**THE FOLLOWING NOTICE WAS PUBLISHED WITH
THE TEMPORARY AND PROPOSED RULE**

EFFECTIVE DATE: The effective date of the temporary rule is **October 1, 2013**.

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

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than November 20, 2013.

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

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

These rules are being aligned with other Department rules for determining benefits for a child who lives in a joint custody situation. Currently, the first parent to apply for ICCP benefits is the one who receives the benefits for the child. This rule change will provide a more equitable way in determining ICCP benefits when both parents apply for benefits for the same child, by giving the parent who has primary custody of the child the benefit.

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

This rule change confers a benefit to a parent who has primary custody of an eligible child in a joint custody situation when both parents apply for child care benefits for the same child.

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

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

There is no anticipated fiscal impact to the state general fund or any other funds due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rule is of a simple nature to align with other

Department rules for a child that is in a joint custody situation.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Genie Sue Weppner at (208) 364-5656.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before November 27, 2013.

DATED this 3rd day of October, 2013.

Tamara Prisock
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LSO Rules Analysis Memo

THE FOLLOWING IS THE TEMPORARY RULE OF DOCKET 16-0612-1302

105. ELIGIBLE CHILD.

A family can only receive child care benefits for eligible children. A child is eligible for child care benefits under the following conditions: (4-2-08)

01. Immunizations Requirements. A child must be immunized in accordance with IDAPA 16.02.11, "Immunization Requirements for Children Attending Licensed Daycare Facilities in Idaho." Child care benefits can continue during a reasonable period necessary for the child to be immunized. Parents must provide evidence that the child has been immunized unless the child is attending school. (4-2-08)

02. Citizenship or Alien Status Requirement. A child must be one (1) of the following: (4-2-08)

a. A citizen; (4-2-08)

b. Living lawfully in the United States. (4-2-08)

03. Child's Age Requirement. A child must be under thirteen (13) years of age, with the following exceptions: (4-2-08)

a. A child thirteen (13) years of age or older may be eligible for child care benefits if he meets one (1) or more of the following criteria: (4-2-08)

i. A child is eligible for child care benefits until the month of his eighteenth birthday if he is physically or mentally incapable of self-care, as verified by a licensed mental health professional or licensed practitioner of the healing arts. (4-2-08)

ii. A child may be eligible for child care benefits until the month of his eighteenth birthday if a court order, probation order, child protection, or mental health case plan requires constant supervision. (4-2-08)

b. A child who is eligible under Subsection 105.03.a. of this rule may receive child care benefits until the month of his nineteenth birthday if he is a full-time student and is expected to complete secondary school no later than the month of his nineteenth birthday. (5-1-11)

04. Joint Child Custody. A child may move from one (1) parent's home to the other parent's home on a regular basis. The child may be a member of either household, but not both households. If the parents cannot agree on the child's household for the child care ~~case benefit~~, the child is included in the household ~~of the first parent to apply who is both income and activity eligible~~ with primary custody. Primary custody is determined by where the child is expected to spend fifty-one percent (51%) or more of the nights during a benefit period. When only one (1) parent applies for ICCP benefits, the child may be included in that parent's household even though they do not have primary physical custody of the child. ~~(5-1-11)()~~

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.07.17 - ALCOHOL AND SUBSTANCE USE DISORDERS SERVICES

DOCKET NO. 16-0717-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice, the pending rule becomes final and effective on July 1, 2014, after review by the legislature, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 39-311, Idaho Code.

DESCRIPTIVE SUMMARY: There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 4, 2013, Idaho Administrative Bulletin, [Vol. 13-9, pages 132 through 139](#).

The Division of Behavioral Health (DBH) is working on building a peer recovery system and by removing the barrier around criminal history and background checks will provide more individuals to be in the peer recovery system. Definitions in this chapter were also updated.

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

There is no anticipated fiscal impact to the state general fund or any other funds due to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Treena Clark at (208) 364-6611.

DATED this 21st day of November, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 39-4605, Idaho Code.

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

ORIGINATING LOCATION -- LIVE MEETING
Tuesday, September 10, 2013
12:30 - 2:30 pm (PDT) -- 1:30 - 3:30 pm (MDT)

Idaho Department of Health and Welfare, Central Office
Conference Room 3A (3rd floor)
450 West State Street
Boise, ID 83702

VIDEOCONFERENCE LOCATIONS

Region I Office – Coeur d’Alene Main Conference Room 2195 Ironwood Court Coeur d’Alene, ID 83814	Region II Office – Lewiston 1st Floor Conference Rm. 1118 “F” Street Lewiston, ID 83501
Region III Office – Caldwell Owyhee Conference Room (Rm. 226) 3402 Franklin Road Caldwell, ID 83605	Region IV Office – Boise Room 142 1720 Westgate Drive, Suite A Boise, ID 83704
Region V Office – Twin Falls Room 116 823 Harrison Twin Falls, ID 83301	Region VI Office – Pocatello Room 225 421 Memorial Drive Pocatello, ID 83201

Region VII Office – Idaho Falls
Conference Room 240
150 Shoup Ave.
Idaho Falls, ID 83402

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

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

The Division of Behavioral Health (DBH) is currently working on building a peer recovery system and one issue that has come up as a barrier in Idaho is the requirement around criminal history and background checks. The current requirement does not work for the services that are being provided nor does it fit the model of recovery services that is being promoted. DBH has received complaints from SUD service providers regarding the current rule as it negatively impacts their workforce and ability to provide treatment services.

DBH has negotiated with providers and other interested parties to develop a criminal history and background check rule that both protects the client and acknowledges those who have been successful in their recovery by allowing them to work in the treatment field. The text of these proposed rule changes provides an administrative review on a case-by-case basis for individuals who do not receive a criminal history clearance to request a waiver. These rules provide for this waiver to help establish a peer recovery system for providers of alcohol and substance use disorders services.

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

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

There is no anticipated fiscal impact to the state general fund due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 3, 2013, Idaho Administrative Bulletin, [Vol. 13-4, pages 15 and 16](#), under Docket No. 16-0720-1301.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Treena Clark at (208) 364-6611.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 25, 2013.

DATED this 1st day of August, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0717-1301

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Criminal History and Background Check. All ~~current Department~~ owners, operators, employees, ~~applicants,~~ transfers, reinstated former employees, student interns, contractors, and employees, volunteers, ~~and others assigned to programs that involve~~ who provide direct ~~contact with children or vulnerable adults as described in Section 39-5302, Idaho Code,~~ care or services, or whose position requires regular contact with clients, must comply with the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." (5-8-09)(____)

02. Availability to Work or Provide Service. ~~Certain individuals are allowed to provide services after the self-declaration is completed as provided in Section 56-1004A, Idaho Code, except when they have disclosed a designated crime listed in IDAPA 16.05.06, "Criminal History and Background Checks." The criminal history check requirements applicable to each provider type are found in the rules that state the qualifications or certification of those providers. An individual listed in Subsection 009.01 of these rules is available to work on a provisional basis at the discretion of the employer or agency once the individual has submitted his criminal history and background check application, it has been signed and notarized, reviewed by the employer or agency, and no disqualifying crimes or relevant records are disclosed on the application. An individual must be fingerprinted within twenty-one (21) days of submitting his criminal history and background check application.~~ (5-8-09)(____)

a. An individual is allowed to work or have access to clients only under supervision until the criminal history and background check is completed. (____)

b. An individual, who does not receive a criminal history and background check clearance or a waiver granted under the provisions in this chapter, may not provide direct care or services, or serve in a position that requires regular contact with clients in an alcohol and substance use disorders treatment and recovery support services program. (____)

03. Waiver of Criminal History and Background Check Denial. An individual who

receives a conditional or unconditional denial for a criminal history and background check, may apply for a waiver to provide direct care or services, or serve in a position that requires regular contact with clients in an alcohol and substance use disorders treatment and recovery support services program. A waiver may be granted on a case-by-case basis upon administrative review by the Department of any underlying facts and circumstances in each individual case. A waiver will not be granted for crimes listed in Subsection 009.04 of this rule. ()

04. No Waiver for Certain Designated Crimes. No waiver will be granted by the Department for any of the following designated crimes or substantially conforming foreign criminal violations: ()

a. Forcible sexual penetration by use of a foreign object, as defined in Section 18-6608, Idaho Code; ()

b. Incest, as defined in Section 18-6602, Idaho Code; ()

c. Lewd conduct with a minor, as defined in Section 18-1508, Idaho Code; ()

d. Murder in any degree or assault with intent to commit murder, as defined in Sections 18-4001, 18-4003, and 18-4015, Idaho Code; ()

e. Possession of sexually exploitative material, as defined in Section 18-1507A, Idaho Code; ()

f. Rape, as defined in Section 18-6101, Idaho Code; ()

g. Sale or barter of a child, as defined in Section 18-1511, Idaho Code; ()

h. Sexual abuse or exploitation of a child, as defined in Sections 18-1506 and 18-1507, Idaho Code; ()

i. Enticing of children, as defined in Sections 18-1509 and 18-1509A, Idaho Code; ()

j. Inducing individuals under eighteen (18) years of age into prostitution or patronizing a prostitute, as defined in Sections 18-5609 and 18-5611, Idaho Code; ()

k. Any felony punishable by death or life imprisonment; or ()

l. Attempt, conspiracy, accessory after the fact, or aiding and abetting, as defined in Sections 18-205, 18-306, 18-1701, and 19-1430, Idaho Code, to commit any of the disqualifying designated crimes. ()

05. Administrative Review. An administrative review for a waiver may consist of a review of documents and supplemental information provided by the individual, a telephone interview, an in-person interview, or any other review deemed necessary by the Department. The Department may appoint a subcommittee to conduct administrative reviews provided for under Subsections 009.03 through 009.12 of this rule. ()

06. Written Request for Administrative Review and Waiver. A written request for a waiver must be sent to the Administrative Procedures Section, 450 W. State Street, P.O. Box 83720, Boise, Idaho 83720-0026 within fourteen (14) calendar days from the date of the issuance of a denial from the Department's Criminal History Unit. The fourteen (14) day period for submitting a request for a waiver may be extended by the Department for good cause. ()

07. Scheduling of Administrative Review. Upon receipt of a written request for a waiver, the Department will determine the type of administrative review to be held, and conduct the review within thirty (30) business days from the date of receipt. When an in-person review is appropriate, the Department will provide the individual at least seven (7) days notice of the review date. ()

08. Factors Considered During Administrative Review. During the administrative review, the following factors may be considered: ()

- a.** The severity or nature of the crimes or other findings; ()
- b.** The period of time since the incidents occurred; ()
- c.** The number and pattern of incidents being reviewed; ()
- d.** Circumstances surrounding the incidents that would help determine the risk of repetition; ()
- e.** The relationship between the incidents and the position sought; ()
- f.** Activities since the incidents, such as continuous employment, education, participation in treatment, completion of a problem-solving court or other formal offender rehabilitation, payment of restitution, or any other factors that may be evidence of rehabilitation. ()
- g.** A pardon that was granted by the Governor or the President; ()
- h.** The falsification or omission of information on the self-declaration form and other supplemental forms submitted; and ()
- i.** Any other factor deemed relevant to the review. ()

09. Administrative Review Decision. A notice of decision will be issued by the Department within fifteen (15) business days of completion of the administrative review. ()

10. Decision to Grant Waiver. The Department's decision to grant a waiver does not set a precedent for subsequent requests by an individual for a waiver. A waiver granted under this chapter is not a criminal history and background check clearance, and is only applicable to services and programs governed under this chapter. It does not apply to other Department programs requiring clearance of a criminal history and background check. ()

11. Revocation of Waiver. The Department may chose to revoke a waiver at its discretion for circumstances that it identifies as a risk to client health and safety, at any time. ()

12. Waiver Decisions Are Not Subject to Review or Appeal. The decision or actions of the Department concerning a waiver is not subject to review or appeal, administratively or otherwise. ()

13. Employer Responsibilities. A waiver granted by the Department is not a determination of suitability for employment. The employer is responsible for reviewing the results of a criminal history and background check even when a clearance is issued or a waiver is granted. Making a determination as to the ability or risk of the individual to provide direct care services or to serve in a position that requires regular contact with children and vulnerable adults is the responsibility of the employer. ()

010. DEFINITIONS - A THROUGH F.

For the purposes of these rules, the following terms are used as defined below: (5-8-09)

01. Adolescent. An individual between the ages of fourteen (14) and eighteen (18). (5-8-09)

02. Adult. An individual eighteen (18) years or older. (5-8-09)

03. Applicant. An adult or adolescent individual who is seeking alcohol or substance use disorders services through the Department who has completed or had completed on his behalf an application for alcohol or substance use disorder services. (5-8-09)

04. ASAM PPC-2R. Refers to the second edition, revised, manual of the patient placement criteria for the treatment of substance-related disorders, published by the American Society of Addiction Medicine. (5-8-09)

05. Assessment and Referral Services. A substance use disorders program provides these services in order to treat, provide services, or refer individuals. An assessment is designed to gather and analyze information regarding a client's current substance use disorder behavioral, social, medical, and treatment history. The purpose of the assessment is to provide sufficient information for problem identification and, if appropriate, substance use disorder related treatment or referral. (7-1-13)

06. Child. An individual under the age of fourteen (14) years. (7-1-13)

07. Client. A person receiving treatment for an alcohol or substance use disorder. The term "client" is synonymous with the terms: patient, resident, consumer, or recipient of treatment. (5-8-09)

08. Clinical Judgment. Refers to observations and perceptions based upon education, experience, and clinical assessment. This may include psychometric, behavioral, and clinical interview assessments that are structured, integrated, and then used to reach decisions, individually or collectively, about an individual's functional, mental, and behavioral attributes and

alcohol and substance use disorders service needs. (5-8-09)

09. Clinical Necessity. Alcohol or substance use disorder services are deemed clinically necessary when the Department, in the exercise of clinical judgment, would recommend services to an applicant for the purpose of evaluating, diagnosing, or treating alcohol or substance use disorders that are: (5-8-09)

a. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for treating the applicant's alcohol or substance use disorder; and (5-8-09)

b. Not primarily for the convenience of the applicant or service provider and not more costly than an alternative service or sequence of services and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the applicant's alcohol or substance use disorder. (5-8-09)

10. Clinical Team. A proposed client's clinical team may include: qualified clinicians, behavioral health professionals, professionals other than behavioral health professionals, behavioral health technicians and any other individual deemed appropriate and necessary to ensure that the assessment and subsequent treatment is comprehensive and meets the needs of the proposed client. (5-8-09)

11. Clinically Managed Low-Intensity Residential Treatment. Is a program that offers at least five (5) hours per week of outpatient or intensive outpatient treatment services along with a structured recovery environment, staffed twenty-four (24) hours per day, which provides sufficient stability to prevent or minimize relapse or continued use. This level of care is also known as a Halfway House. (5-8-09)

12. Clinically Managed Medium-Intensity Residential Treatment. Frequently referred to as residential care, programs provide a structured, twenty-four (24) hour intensive residential program for clients who require treatment services in a highly structured setting. This type of program is appropriate for clients who need concentrated, therapeutic services prior to community residence. Community reintegration of residents in this level of care requires case management activities directed toward networking clients into community-based recovery support services such as housing, vocational services or transportation assistance so that the client is able to attend mutual/self-help meetings or vocational activities after discharge. (5-8-09)

13. Comprehensive Assessment. Those procedures by which a substance use disorder clinician evaluates an individual's strengths, weaknesses, problems, needs, and determines priorities so that a service plan can be developed. (7-1-13)

14. Contracted Intermediary. A third party contractor of the Department who handles direct contracting with network providers for treatment services to include network management, claims payment, data gathering per Federal and State requirements and census management. (5-8-09)

15. Department. The Department of Health and Welfare or a person authorized to act on behalf of the Department. (5-8-09)

16. Early Intervention Services. Services that are designed to explore and address problems or risk factors that appear to be related to substance use. (7-1-13)

17. Emergency. An emergency exists if an adult or adolescent individual is gravely disabled due to mental illness or substance abuse or dependence or there is a substantial risk that physical harm will be inflicted by the proposed client: (5-8-09)

a. Upon his own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on himself; or (5-8-09)

b. Upon another person as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm. (5-8-09)

18. Federal Poverty Guidelines. Guidelines issued annually by the Federal Department of Health and Human Services establishing the poverty income limits. The federal poverty guidelines for the current year may be found at: <http://aspe.hhs.gov/poverty/>. (5-8-09)

011. DEFINITIONS - G THROUGH Z.

For the purposes of these rules, the following terms are used as defined below: ()

01. Good Cause. A valid and sufficient reason for not complying with the time frame set for submitting a written request for a waiver by an individual who does not receive a criminal history and background check clearance. ()

1902. Gravely Disabled. An adult or adolescent who, as a result of mental illness or substance abuse or dependence, is in danger of serious physical harm due to the person's inability to provide for any of his basic needs for nourishment, or essential medical care, or shelter or safety. (5-8-09)

203. Individualized Service Plan. A written action plan based on an intake eligibility screening and full clinical assessment, that identifies the applicant's clinical needs, the strategy for providing services to meet those needs, treatment goals and objectives and the criteria for terminating the specified interventions. (7-1-13)

2104. Intake Eligibility Screening. The collection of data, analysis, and review, which the Department, or its designee, uses to screen and determine whether an applicant is eligible for adult or adolescent alcohol or substance use disorder services available through the Department. (5-8-09)

2205. Intensive Outpatient Services. An organized service delivered by addiction professionals or addiction-credentialed clinicians, which provides a planned regimen of treatment consisting of regularly scheduled sessions within a structured program, for a minimum of nine (9) hours of treatment per week for adults and six (6) hours of treatment per week for adolescents. (5-8-09)

2306. Medically Monitored Detoxification. Means medically supervised twenty-four (24) hour care for patients who require hospitalization for treatment of acute alcohol intoxication or withdrawal, from one (1) or more other substances of abuse, and other medical conditions

which together warrant treatment in this type of setting. Length of stay varies depending on the severity of the disease and withdrawal symptoms. (7-1-13)

2407. Medically Monitored Inpatient Treatment. Medically supervised twenty-four (24) hour care for patients requiring hospitalization and treatment services. Medically monitored inpatient treatment provides treatment services and access to full range of services offered by the hospital. (7-1-13)

2508. Network Treatment Provider. A treatment provider who has facility approval through the Department and is contracted with the Department's Management Service Contractor. A list of network providers can be found at the Department's website given in Section 005 of these rules. The list is also available by calling these telephone numbers: 1 (800) 922-3406; or dialing 211. (5-8-09)

2609. Opioid Replacement Outpatient Services. This service is specifically offered to a client who has opioids as his substance use disorder. Services are offered under the guidelines of a federally accredited program. (7-1-13)

2710. Outpatient Services. An organized non-residential service, delivered in a variety of settings, in which addiction treatment personnel provide professionally directed evaluation and treatment for alcohol and substance use disorders. (5-8-09)

2811. Priority Population. Priority populations are populations who receive services ahead of other persons and are determined yearly by the Department based on federal regulations. A current list of the priority population is available from the Department. (7-1-13)

2912. Recovery Support Services. These services include: safe and sober housing that is staffed; transportation; child care; family education; life skills education; marriage education; drug testing; peer to peer mentoring; and case management. (5-8-09)

3013. Residential Social Detoxification. Means a medically supported twenty-four (24) hour, social rehabilitation residential program which provides physical care, education, and counseling as appropriate for the client's health and safety during his process of physical withdrawal from acute alcohol intoxication or withdrawal, or from one or more other substances of abuse. Social detoxification provides access into care and treatment of alcohol or substance use disorders through monitored withdrawal, evaluation of present or potential alcohol or substance dependency and other physical ailments, and intervention into the progression of the disease through timely utilization of resources. Length of stay in a social detoxification program varies from three (3) to seven (7) days depending on the severity of the disease and withdrawal symptoms. (5-8-09)

314. Sliding Fee Scale. A scale used to determine an individual's cost for services based on Federal Poverty Guidelines and found in IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules." (5-8-09)

3215. Substance Dependence. Substance dependence is marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use

alcohol or other drugs despite significant related problems. The cluster of symptoms can include: tolerance; withdrawal or use of a substance in larger amounts or over a longer period of time than intended; persistent desire or unsuccessful efforts to cut down or control substance use; a great deal of time spent in activities related to obtaining or using substances or to recover from their effects; relinquishing important social, occupational or recreational activities because of substance use; and continuing alcohol or drug use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been cause or exacerbated by such use as defined in the DSM-IV-TR. (5-8-09)

3316. Substance-Related Disorders. Substance-related disorders include disorders related to the taking of alcohol or another drug of abuse, to the side effects of a medication and to toxin exposures. They are divided into two (2) groups: the Substance Use Disorders and the Substance-Induced Disorders as defined in the DSM-IV-TR. (5-8-09)

3417. Substance Use Disorder. Includes Substance Dependence and Substance Abuse, according to the DSM-IV-TR. Substance Use Disorders are one (1) of two (2) subgroups of the broader diagnostic category of Substance-Related Disorders. (5-8-09)

3518. Substantial Material Change in Circumstances. A substantial and material change in circumstances which renders the Department's decision denying alcohol and substance use disorders services arbitrary and capricious. (5-8-09)

01+2. -- 099. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.07.20 - ALCOHOL AND SUBSTANCE USE DISORDERS TREATMENT
AND RECOVERY SUPPORT SERVICES FACILITIES AND PROGRAMS

DOCKET NO. 16-0720-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice, the pending rule becomes final and effective on July 1, 2014, after review by the legislature, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 39-311, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

These rules are being amended in the pending docket to remove the hired or contracted with after May 1, 2010, since it is no longer needed. The Division of Behavioral Health (DBH) is working on building a peer recovery system and by removing the barrier around criminal history and background checks will provide more individuals to be in the peer recovery system.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the September 4, 2013, Idaho Administrative Bulletin, [Vol. 13-9, pages 140 through 149](#).

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

There is no anticipated fiscal impact to the state general fund or any other funds due to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Treena Clark at (208) 364-6611.

DATED this 21st day of November, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 39-4605, Idaho Code.

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

ORIGINATING LOCATION -- LIVE MEETING
Tuesday, September 10, 2013
12:30 - 2:30 pm (PDT) -- 1:30 - 3:30 pm (MDT)

Idaho Department of Health and Welfare, Central Office
Conference Room 3A (3rd floor)
450 West State Street
Boise, ID 83702

VIDEOCONFERENCE LOCATIONS

Region I Office – Coeur d’Alene Main Conference Room 2195 Ironwood Court Coeur d’Alene, ID 83814	Region II Office – Lewiston 1st Floor Conference Rm. 1118 “F” Street Lewiston, ID 83501
Region III Office – Caldwell Owyhee Conference Room (Rm. 226) 3402 Franklin Road Caldwell, ID 83605	Region IV Office – Boise Room 142 1720 Westgate Drive, Suite A Boise, ID 83704

Region V Office – Twin Falls Room 116 823 Harrison Twin Falls, ID 83301	Region VI Office – Pocatello Room 225 421 Memorial Drive Pocatello, ID 83201
Region VII Office – Idaho Falls Conference Room 240 150 Shoup Ave. Idaho Falls, ID 83402	

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

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

The Division of Behavioral Health (DBH) is currently working on building a peer recovery system and one issue that has come up as a barrier in Idaho is the requirement around criminal history and background checks. The current requirement does not work for the services that are being provided nor does it fit the model of recovery services that is being promoted. DBH has received complaints from SUD treatment providers regarding the current rule as it negatively impacts their workforce and ability to provide treatment services.

DBH has negotiated with providers and other interested parties to develop a criminal history and background check rule that both protects the client and acknowledges those who have been successful in their recovery by allowing them to work in the treatment field. The text of these proposed rule changes provides an administrative review on a case-by-case basis for individuals who do not receive a criminal history clearance to request a waiver. These rules provide for this waiver to help establish a peer recovery system for providers of alcohol and substance use disorders treatment and recovery programs.

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

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

There is no anticipated fiscal impact to the state general fund due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 3, 2013, Idaho Administrative Bulletin, [Vol. 13-4, pages 15 and 16](#).

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Treena Clark at (208) 364-6611.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 25, 2013.

DATED this 1st day of August, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0720-1301

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Criminal History and Background Check. All owners, operators, employees, transfers, reinstated former employees, student interns, contractors and volunteers ~~hired or contracted with after May 1, 2010,~~ who provide direct care or services, or ~~have direct~~ whose position requires regular contact with clients ~~access,~~ must comply with the provisions of IDAPA 16.05.06, “Criminal History and Background Checks.” (5-1-10)()

02. Availability to Work. An individual listed in Subsection 009.01 of these rules is available to work on a provisional basis at the discretion of the employer or agency once the individual has submitted his criminal history and background check application, it has been signed and notarized, reviewed by the employer or agency, and no disqualifying crimes or relevant records are disclosed on the application. An individual must be fingerprinted within twenty-one (21) days of submitting his criminal history and background check application. ()

a. An individual is allowed to work or have access to clients only under supervision until the criminal history and background check is completed. (5-1-10)()

b. An individual, who does not receive a criminal history and background check clearance or a waiver granted under the provisions in this chapter, may not provide direct care or services, or serve in a position that requires regular contact with clients in an alcohol and substance use disorders treatment and recovery support services program. ()

03. Waiver of Criminal History and Background Check Denial. An individual who receives a conditional or unconditional denial for a criminal history and background check, may apply for a waiver to provide direct care or services, or serve in a position that requires regular

contact with clients in an alcohol and substance use disorders treatment and recovery support services program. A waiver may be granted on a case-by-case basis upon administrative review by the Department of any underlying facts and circumstances in each individual case. A waiver will not be granted for crimes listed in Subsection 009.04 of this rule. ()

04. No Waiver for Certain Designated Crimes. No waiver will be granted by the Department for any of the following designated crimes or substantially conforming foreign criminal violations: ()

a. Forcible sexual penetration by use of a foreign object, as defined in Section 18-6608, Idaho Code; ()

b. Incest, as defined in Section 18-6602, Idaho Code; ()

c. Lewd conduct with a minor, as defined in Section 18-1508, Idaho Code; ()

d. Murder in any degree or assault with intent to commit murder, as defined in Sections 18-4001, 18- 4003, and 18-4015, Idaho Code; ()

e. Possession of sexually exploitative material, as defined in Section 18-1507A, Idaho Code; ()

f. Rape, as defined in Section 18-6101, Idaho Code; ()

g. Sale or barter of a child, as defined in Section 18-1511, Idaho Code; ()

h. Sexual abuse or exploitation of a child, as defined in Sections 18-1506 and 18-1507, Idaho Code; ()

i. Enticing of children, as defined in Sections 18-1509 and 18-1509A, Idaho Code; ()

j. Inducing individuals under eighteen (18) years of age into prostitution or patronizing a prostitute, as defined in Sections 18-5609 and 18-5611, Idaho Code; ()

k. Any felony punishable by death or life imprisonment; or ()

l. Attempt, conspiracy, accessory after the fact, or aiding and abetting, as defined in Sections 18-205, 18-306, 18-1701, and 19-1430, Idaho Code, to commit any of the disqualifying designated crimes. ()

05. Administrative Review. An administrative review for a waiver may consist of a review of documents and supplemental information provided by the individual, a telephone interview, an in-person interview, or any other review deemed necessary by the Department. The Department may appoint a subcommittee to conduct administrative reviews provided for under Subsections 009.03 through 009.12 of this rule. ()

06. Written Request for Administrative Review and Waiver. A written request for

a waiver must be sent to the Administrative Procedures Section, 450 W. State Street, P.O. Box 83720, Boise, Idaho 83720-0026 within fourteen (14) calendar days from the date of the issuance of a denial from the Department's Criminal History Unit. The fourteen (14) day period for submitting a request for a waiver may be extended by the Department for good cause. ()

07. Scheduling of Administrative Review. Upon receipt of a written request for a waiver, the Department will determine the type of administrative review to be held, and conduct the review within thirty (30) business days from the date of receipt. When an in-person review is appropriate, the Department will provide the individual at least seven (7) days notice of the review date. ()

08. Factors Considered During Administrative Review. During the administrative review, the following factors may be considered: ()

- a.** The severity or nature of the crimes or other findings; ()
- b.** The period of time since the incidents occurred; ()
- c.** The number and pattern of incidents being reviewed; ()
- d.** Circumstances surrounding the incidents that would help determine the risk of repetition; ()
- e.** The relationship between the incidents and the position sought; ()
- f.** Activities since the incidents, such as continuous employment, education, participation in treatment, completion of a problem-solving court or other formal offender rehabilitation, payment of restitution, or any other factors that may be evidence of rehabilitation. ()
- g.** A pardon that was granted by the Governor or the President; ()
- h.** The falsification or omission of information on the self-declaration form and other supplemental forms submitted; and ()
- i.** Any other factor deemed relevant to the review. ()

09. Administrative Review Decision. A notice of decision will be issued by the Department within fifteen (15) business days of completion of the administrative review. ()

10. Decision to Grant Waiver. The Department's decision to grant a waiver does not set a precedent for subsequent requests by an individual for a waiver. A waiver granted under this chapter is not a criminal history and background check clearance, and is only applicable to services and programs governed under this chapter. It does not apply to other Department programs requiring clearance of a criminal history and background check. ()

11. Revocation of Waiver. The Department may chose to revoke a waiver at its discretion for circumstances that it identifies as a risk to client health and safety, at any time.

()

12. Waiver Decisions Are Not Subject to Review or Appeal. The decision or actions of the Department concerning a waiver is not subject to review or appeal, administratively or otherwise. ()

13. Employer Responsibilities. A waiver granted by the Department is not a determination of suitability for employment. The employer is responsible for reviewing the results of a criminal history and background check even when a clearance is issued or a waiver is granted. Making a determination as to the ability or risk of the individual to provide direct care services or to serve in a position that requires regular contact with children and vulnerable adults is the responsibility of the employer. ()

(BREAK IN CONTINUITY OF SECTIONS)

011. DEFINITIONS - D THROUGH H.

For the purposes of these rules, the following terms are used. (5-1-10)

01. Department. The Idaho Department of Health and Welfare. (5-1-10)

02. Detoxification Services. Services necessary to monitor individuals who are undergoing the systematic reduction of a toxic agent from the body during withdrawal. (5-1-10)

~~**03. Direct Client Access.** Direct client access means an employee, contractor, or volunteer who has accessibility to a client. (5-1-10)~~

043. Director. The Director of the Department of Health and Welfare or his designee. (5-1-10)

054. Discharge. The point at which the client's active involvement in treatment or recovery support services is terminated and the program no longer maintains active responsibility for the care of the client. (5-1-10)

065. Discharge Summary. A document written by the client's provider upon discharge from treatment and contains a summary of the following: (5-1-10)

a. Client status at discharge; (5-1-10)

b. Treatment progress; (5-1-10)

c. Summaries of services to be provided after discharge; and (7-1-13)

d. Referrals for further treatment. (5-1-10)

076. Early Intervention Services. Services that are designed to explore and address

problems or risk factors that appear to be related to substance use. (7-1-13)

087. Education. Strategies that teach people critical information about alcohol and other drugs and the physical, emotional, and social consequences of their use. (5-1-10)

098. Executive Director. The individual who is responsible for the overall management of the program or facility. The executive director is appointed by the governing body to act on its behalf. The term “executive director” is synonymous with the terms “administrator,” “director,” “superintendent,” “president,” “vice-president,” and “executive vice-president.” (5-1-10)

109. Facility/location. The individual building or buildings, including furnishings and fixtures, or locations where persons with alcohol or substance use disorders receive services. The term “facility” is synonymous with office, clinic, or physical plant. (5-1-10)

10. Good Cause. A valid and sufficient reason for not complying with the time frame set for submitting a written request for a waiver by an individual who does not receive a criminal history and background check clearance. ()

11. Governing Body. The individual or individuals, board of directors, group, or agency that has ultimate authority and responsibility for the overall operation of an alcohol and substance use disorders treatment or recovery support services facility or program and for full compliance with these rules and minimum standards. (5-1-10)

12. Group Counseling. The application of formal counseling techniques involving interaction among members of a group of clients. (5-1-10)

13. Guardian. (5-1-10)

a. Under Title 15, Chapter 5, Part 2, Idaho Code, an individual who has been appointed by a court of law to have and exercise the powers and responsibilities of a parent who has not been deprived of custody of his minor and unemancipated child; (5-1-10)

b. Under Title 66, Chapter 3 and 4, Idaho Code, an individual who has been appointed by a court of law to have and exercise the powers and responsibilities of a guardian for a person who is mentally ill or with a developmental disability; or (5-1-10)

c. Under Title 15, Chapter 5, Part 3, Idaho Code, an individual who has been appointed by a court of law to assist any incapacitated person to the extent that he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person. (5-1-10)

(BREAK IN CONTINUITY OF SECTIONS)

138. JOINT COMMISSION OR CARF ACCREDITATION.

The Department may approve programs or renew a program's certificate of approval based upon Joint Commission or CARF accreditation under the following conditions: ~~(5-1-10)~~()

01. Organization Chart Verifying Staffing Credentials. Organization chart with verification that staff meet minimum credential or certification standards: ~~(5-1-10)~~()

02. Criminal History and Background Checks. Satisfactory evidence that the owner, applicant, person proposed as executive director, ~~and all~~ employees, transfers, reinstated former employees, student interns, contractors, ~~and~~ volunteers, ~~and any other persons hired or contracted with after May 1, 2010,~~ who provide ~~direct~~ care or services, or ~~have access to~~ whose ~~position requires regular contact with~~ clients, have ~~successfully passed~~ ~~received~~ a criminal history and background check ~~clearance, or have a waiver~~ as described in Section 009 of these rules: ~~(5-1-10)~~()

03. Tuberculosis Testing. The personnel policies and procedures must establish tuberculosis testing requirements. All staff members, volunteers, and trainees, must have upon employment, or engagement, and every three (3) years thereafter, a tuberculin skin test by the Mantoux method, or a blood test for tuberculosis infection. Staff members, volunteers, and trainees who are known to be a positive reactor may have a tuberculosis blood test or chest x-ray examination in lieu of a required tuberculin skin test. Personnel who have active tuberculosis must be restricted from employment and attendance at the facility until it is determined by a treating physician that the tuberculosis is non-infectious. Results of the testing must be documented in personnel record: ~~and~~ ~~(7-1-13)~~()

04. Application Fee. Payment of non-refundable application or renewal fee as described in Sections 130 and 135 of these rules. (5-1-10)

(BREAK IN CONTINUITY OF SECTIONS)

210. PERSONNEL POLICIES AND PROCEDURES.

All alcohol and substance use disorders treatment or recovery support services programs must have and adhere to personnel policies and procedures that meet the following standards: (5-1-10)

01. Required Personnel Policies and Procedures. Personnel policies and procedures must be developed, adopted and maintained to promote the objectives of the program and provide for a sufficient number of qualified substance use disorders professionals, treatment and support staff to render the services of the program and provide quality care during all hours of operation. (5-1-10)

a. All personnel policies must be written, reviewed on an annual basis by the executive director and governing body, and signed and dated when reviewed or revised. (5-1-10)

b. The personnel policies must include procedures for recruiting, selecting, promoting and terminating staff. (5-1-10)

c. The personnel policies and procedures must apply to all employees, but may differ with respect to job classifications. (5-1-10)

d. The personnel policies and procedures must include information on the following: (5-1-10)

i. Employee benefits; (5-1-10)

ii. Recruitment and promotion; (5-1-10)

iii. Orientation; (5-1-10)

iv. Training and staff development; (5-1-10)

v. Employee grievances; (5-1-10)

vi. Safety and employee injuries; (5-1-10)

vii. Relationships with employee organizations; (5-1-10)

viii. Disciplinary systems; (5-1-10)

ix. Suspension and termination mechanisms; (5-1-10)

x. Wages, hours and salary administration; (5-1-10)

xi. Rules of conduct; (5-1-10)

xii. Lines of authority; and (5-1-10)

xiii. Performance appraisals and evaluation schedule. (5-1-10)

e. The personnel policies and procedures must include a mechanism for determining that all personnel are capable of performing assigned tasks. (5-1-10)

f. The personnel policies and procedures must ensure that personnel who have a communicable disease, infectious wound or other transmittable condition and who provide care or services to clients or have access to clients are required to implement protective infection control techniques in accordance with these rules. If protective infection control techniques are not implemented, personnel who have a communicable disease, infectious wound or other transmittable condition must not work until the infectious state is corrected and non-infectious; or be reassigned to other areas where contact with others is not expected and the likelihood of transmission of infection is absent; or seek other remedies that will avoid spreading the infection. (5-1-10)

g. The personnel policies and procedures must describe methods and procedures for supervising all personnel, including volunteers and students. (5-1-10)

h. The personnel policies and procedures must assure confidentiality of personnel records and specify who has access to personnel information. (5-1-10)

i. There must be documentation to verify that the policies and procedures are made available to and discussed with each employee at the time of hire and are made available to others upon request. (5-1-10)

j. A mechanism must be established for notifying employees of changes in the policies and procedures. (5-1-10)

k. The personnel policies and procedures must establish tuberculosis testing requirements for all staff members. Each employee must have upon employment, and every three (3) years thereafter, a tuberculin skin test by the Mantoux method, or tuberculosis blood test. An employee who is known to be a positive reactor may have a tuberculosis blood test or chest x-ray examination in lieu of a required tuberculin skin test. Personnel who have active tuberculosis must be restricted from employment and attendance at the facility until it is determined by a treating physician that the tuberculosis is non-infectious. Results of the testing must be documented in personnel record. (7-1-13)

l. The personnel policies and procedures must establish the requirement for CPR training and basic first aid training. A minimum of one (1) CPR and First Aid trained staff must be onsite during business hours. Staff responsible for client care must complete this training within ninety (90) days of employment. Additionally, the policies and procedures must establish the methods for renewal of CPR and first aid certification so that they remain current at all times. (5-1-10)

m. The personnel policies and procedures must establish the provision for criminal history background checks for all employees as described in Section 009 of these rules. (5-1-10)

n. The personnel policies and procedures must establish the provision of clinical supervision. (5-1-10)

o. Policy and procedures must be written that establish a drug free workplace. (5-1-10)

02. Hiring Practices. Hiring practices must be specified in the written policies and procedures and must be consistent with the needs of the program and its services. (5-1-10)

a. The selection of personnel must be based on criteria that are demonstrably related to the job under consideration. (5-1-10)

b. Qualified substance use disorders professional staff must participate in determining what training, experience, and demonstrated competence will be required for assuming specific clinical service responsibility. (5-1-10)

c. There must be documentation to verify that qualified substance use disorders professionals meet all federal, state and local requirements for licensure, registration or certification. (5-1-10)

03. Equal Employment Opportunity. No alcohol and substance use disorders treatment or recovery support services program approved under these rules will discriminate on the basis of race, creed, color, religion, age, gender, national origin, veteran, or disability, except in those instances where bona fide occupational qualifications exist. (5-1-10)

04. Responsible Staff Member to Implement Personnel Policies and Procedures. The executive director must appoint a staff member to implement and coordinate personnel policies and procedures to accomplish the following tasks: (5-1-10)

- a.** Develop a written organizational plan for personnel services; (5-1-10)
- b.** Maintain personnel records; (5-1-10)
- c.** Disseminate employment information to staff; (5-1-10)
- d.** Develop staff orientation programs; (5-1-10)
- e.** Implement procedures designed to assure compliance with federal, state and local laws related to employment practices; and (5-1-10)
- f.** Supervise the processing of employment-related forms. (5-1-10)

05. Contents of Personnel Record for Each Staff Member. A personnel record must be kept on each staff member and must contain the following items: (5-1-10)

- a.** Application for employment including a record of the employee's education or training and work experience. This may be supplemented by a resume; (5-1-10)
- b.** A written record of all findings from verbal contacts with references, and letters of recommendation; (5-1-10)
- c.** Verification of licensure, certification, registration or renewals; (5-1-10)
- d.** A signed and dated commitment to a code of ethics appropriate for alcohol and substance use disorders treatment staff; (5-1-10)
- e.** Number of hours per pay period, wage and salary information, including all adjustments; (5-1-10)
- f.** Performance appraisals or contract compliance evaluation; (7-1-13)
- g.** Counseling actions; (5-1-10)
- h.** Disciplinary actions; (5-1-10)
- i.** Commendations; (5-1-10)

- j.** Employee incident reports; (5-1-10)
- k.** A Verification of a Department criminal history and background check clearance, or a waiver issued by the Department as described in Section 009 of these rules; ~~(5-1-10)~~()
- l.** Results of tuberculosis testing, treatment taken, including dates of treatment, for tuberculosis infection; (7-1-13)
- m.** Verification of employee and emergency orientation procedures; and (5-1-10)
- n.** Verification of current cardiopulmonary resuscitation (CPR) training and basic first aid training, in accordance with the requirements under Subsection 01.1. of this rule and under Subsections 392.03, 520.03.d., and 520.04. For employees in direct care at Residential Social Detoxification Settings, verification of additional training specific to detoxification prior to being charged with the responsibility of client care. (7-1-13)

06. Job Description for a Position in the Program. For each position in the program, there must be a written job description that specifies the duties and responsibilities of the position and the minimum level of education, training or related work experience required or needed to fulfill it. (5-1-10)

- a.** Each job description must specify the following: (5-1-10)
 - i.** The position title; (5-1-10)
 - ii.** The program, department, service, or unit; (5-1-10)
 - iii.** Direct supervisor's title; (5-1-10)
 - iv.** Positions supervised, if any; (5-1-10)
 - v.** Clear descriptions of job functions; and (5-1-10)
 - vi.** Clinical, administrative, and procedural responsibility and authority. (5-1-10)
- b.** Each job description must accurately reflect the job and must be revised whenever a change in qualifications, duties, supervision, or any other major job-related factor is made. (5-1-10)
- c.** Each job description must be comprehensive enough to enable a new employee to understand the position, job functions, responsibility, chain-of-command, and authority. (5-1-10)
- d.** Each job description must be sufficiently detailed to serve as a basis for performance appraisals. (5-1-10)

07. Performance Appraisals. Performance appraisals must be conducted and must be related to the job description and job performance. (5-1-10)

- a.** The criteria used to evaluate job performance must be measurable and relate to the skills, knowledge and attitudes that the job requires. (5-1-10)
- b.** Performance appraisals must be conducted, at a minimum, annually. (5-1-10)
- c.** Performance appraisals must be in writing. (5-1-10)
- d.** There must be documentation to verify that the employee has reviewed the evaluation and has had an opportunity to comment on it. The employee must sign the appraisal after review and comments are completed. (5-1-10)
- e.** The program must develop policies and procedures to follow when there is a serious discrepancy between the staff member's actual job performance and the criteria for an acceptable level of job performance. (5-1-10)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.07.30 - BEHAVIORAL HEALTH COMMUNITY CRISIS CENTERS
DOCKET NO. 16-0730-1301 (NEW CHAPTER)
NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice the pending rule becomes final and effective on July 1, 2014, after review by the legislature, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to the Regional Mental Health Services Act, Title 39, Chapter 31, Idaho Code; also Sections 56-1003, 56-1004, 56-1004A, 56-1007 and 56-1009, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The proposed chapter establishes the benefit and eligibility process for behavioral health community crisis centers in the state of Idaho. These programs will provide behavioral health crisis services to persons residing in Idaho. The amendments to the pending rule remove an incorporation by reference document, "Idaho Behavioral Health Standards, Idaho Department of Health and Welfare, 2013," as well as grammar and minor clarification changes.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The original text of the proposed rule was published in the October 2, 2013, Idaho Administrative Bulletin, [Vol. 13-10, pages 230 through 239](#).

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following item is being incorporated by reference into these rules to give them the force and effect of law. This document is not being reprinted in this chapter of rules due to its length and format and because of the cost for republication.

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), 2013.

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

These rules will provide an opportunity for the development of behavioral health community crisis centers and the Department of Health and Welfare may be making a budget request separate from these rules. However, there is no anticipated fiscal impact to the state general fund or any

other funds due to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Casey Moyer at (208) 334-4916.

DATED this 27th day of November, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720

Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to the Regional Mental Health Services Act, Title 39, Chapter 31, Idaho Code; also Sections 56-1003, 56-1004, 56-1004A, 56-1007 and 56-1009, Idaho Code.

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

ORIGINATING LOCATION -- LIVE MEETING
Friday, October 18, 2013
12:30 - 2:30 pm (PDT) -- 1:30 - 3:30 pm (MDT)

Idaho Department of Health and Welfare, Central Office
Conference Room 3A (3rd floor)
450 West State Street
Boise, ID 83702

VIDEOCONFERENCE LOCATIONS

Region I Office – Coeur d’Alene
Main Conference Room
2195 Ironwood Court
Coeur d’Alene, ID 83814

Region II Office – Lewiston
1st Floor Conference Rm.
1118 “F” Street
Lewiston, ID 83501

Region III Office – Caldwell Owyhee Conference Room (Rm. 226) 3402 Franklin Road Caldwell, ID 83605	Region IV Office – Boise Room 137 1720 Westgate Drive, Suite A Boise, ID 83704
Region V Office – Twin Falls Room 116 823 Harrison Twin Falls, ID 83301	Region VI Office – Pocatello Room 225 421 Memorial Drive Pocatello, ID 83201
Region VII Office – Idaho Falls Conference Room 240 150 Shoup Ave. Idaho Falls, ID 83402	

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

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

The proposed chapter establishes the benefit and eligibility process for behavioral health community crisis centers in the state of Idaho. These programs will provide behavioral health crisis services to persons residing in Idaho.

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

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

These rules will provide an opportunity for the development of behavioral health community crisis centers. The Department of Health and Welfare may be making a budget request separate from these rules. However, there is no anticipated fiscal impact to the state general fund or any other funds due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because it was not feasible due to the fact that there is currently a lack of identifiable representatives of affected interests. Behavioral health community crisis centers are a component of the Idaho Behavioral Health system of care transformation. In the transformed structure, the Department of Health and Welfare retains its role as the state mental health authority and has responsibility for oversight of the behavioral health system of care. The proposed chapter establishes behavioral health community crisis centers and does not impact existing processes for private providers. There are no stakeholders outside of the Department at

this time.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following two items are being incorporated by reference into these rules to give them the force and effect of law. These documents are not being reprinted in this chapter of rules due to their length and format and because of the cost for republication.

1. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-V), 2013.
2. *Idaho Behavioral Health Standards*, Idaho Department of Health and Welfare, 2013.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Casey Moyer at (208) 334-4916.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 23, 2013.

DATED this 29th day of August, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0730-1301

IDAPA 16
TITLE 07
CHAPTER 30

16.07.30 - BEHAVIORAL HEALTH COMMUNITY CRISIS CENTERS

000. LEGAL AUTHORITY.

The Idaho Legislature has delegated to the Department of Health and Welfare, as the state mental health authority, the responsibility to ensure that mental health services are available throughout the state of Idaho to individuals who need such care and who meet certain eligibility requirements under the Regional Mental Health Services Act. This chapter is authorized under the Regional Mental Health Services Act, Title 39, Chapter 31, Idaho Code, as well as Sections 56-1003, 56-1004, 56-1004A, 56-1007, and 56-1009, Idaho Code. ()

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.07.30, “Behavioral Health Community Crisis Centers.” ()

02. Scope. These rules establish the benefit and eligibility process for behavioral health community crisis centers in the state of Idaho. These programs provide behavioral health crisis services to persons residing in Idaho. ()

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements that pertain to the interpretation of the rules of this chapter, or to the documentation of compliance with the rules of this chapter. These materials are available for public inspection and copying at cost in the main office of the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702. ()

003. ADMINISTRATIVE APPEALS.

Administrative appeals and contested cases are governed by the provisions of IDAPA 16.05.03, “Rules Governing Contested Case Proceedings and Declaratory Rulings.” ()

004. INCORPORATION BY REFERENCE.

The following document *is* incorporated by reference in this chapter of rules: American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), Arlington, VA, American Psychiatric Association, 2013, copies of the manual are available from the American Psychiatric Association, 1000 Wilson Blvd., Arlington VA 22209-3901. A copy of the manual is also available for public review at the Department of Health And Welfare, 450 West State Street, Boise, Idaho, 83702. ()

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE NUMBER -- INTERNET WEBSITE.

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the state of Idaho. ()

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. ()

03. Street Address. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. ()

04. Telephone. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. ()

05. Internet Websites. The Department internet website is found at <http://www.healthandwelfare.idaho.gov>. ()

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS ACT COMPLIANCE AND REQUESTS.

01. Confidentiality of Records. Any disclosure of confidential information used or disclosed in the course of the Department's business is subject to the restrictions in state or federal law, federal regulation, and IDAPA 16.05.01, "Use and Disclosure of Department Records." ()

02. Public Records Act. The Department will comply with Sections 9-337 through 9-350, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempt, all public records in the custody of the Department are subject to disclosure. ()

007. -- 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Criminal History and Background Check. All owners, operators, employees, transfers, reinstated former employees, student interns, contractors, and volunteers who provide direct care or services, or whose position requires regular contact with clients, must comply with the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." ()

02. Availability to Work or Provide Service. An individual listed in Subsection 009.01 of these rules is available to work on a provisional basis at the discretion of the employer or agency once the individual has submitted his criminal history and background check application, it has been signed and notarized, reviewed by the employer or agency, and no disqualifying crimes or relevant records are disclosed on the application. An individual must be fingerprinted within twenty-one (21) days of submitting his criminal history and background check application. ()

a. An individual is allowed to work or have access to clients only under supervision until the criminal history and background check is completed. ()

b. An individual, who does not receive a criminal history and background check clearance, or a waiver granted under the provisions in this chapter, may not provide direct care or services, or serve in a position that requires regular contact with clients in a behavioral health community crisis center. ()

03. Waiver of Criminal History and Background Check Denial. An individual, who receives a conditional or unconditional denial for a criminal history and background check, may apply for a waiver to provide direct care or services, or serve in a position that requires regular contact with clients in a behavioral health community crisis center. A waiver may be granted on a case-by-case basis upon administrative review by the Department of any underlying facts and circumstances in each individual case. A waiver will not be granted for crimes listed in Subsection 009.04 of this rule. ()

04. No Waiver for Certain Designated Crimes. No waiver will be granted by the

Department for any of the following designated crimes or substantially conforming foreign criminal violations: ()

a. Forcible sexual penetration by use of a foreign object, as defined in Section 18-6608, Idaho Code; ()

b. Incest, as defined in Section 18-6602, Idaho Code; ()

c. Lewd conduct with a minor, as defined in Section 18-1508, Idaho Code; ()

d. Murder in any degree or assault with intent to commit murder, as defined in Sections 18-4001, 18-4003, and 18-4015, Idaho Code; ()

e. Possession of sexually exploitative material, as defined in Section 18-1507A, Idaho Code; ()

f. Rape, as defined in Section 18-6101, Idaho Code; ()

g. Sale or barter of a child, as defined in Section 18-1511, Idaho Code; ()

h. Sexual abuse or exploitation of a child, as defined in Sections 18-1506 and 18-1507, Idaho Code; ()

i. Enticing of children, as defined in Sections 18-1509 and 18-1509A, Idaho Code; ()

j. Inducing individuals under eighteen (18) years of age into prostitution or patronizing a prostitute, as defined in Sections 18-5609 and 18-5611, Idaho Code; ()

k. Any felony punishable by death or life imprisonment; or ()

l. Attempt, conspiracy, accessory after the fact, or aiding and abetting, as defined in Sections 18-205, 18-306, 18-1701, and 19-1430, Idaho Code, to commit any of the disqualifying designated crimes. ()

05. Administrative Review. An administrative review for a waiver may consist of a review of documents and supplemental information provided by the individual, a telephone interview, an in-person interview, or any other review deemed necessary by the Department. The Department may appoint a subcommittee to conduct administrative reviews provided for under Subsections 009.03 through 009.12 of this rule. ()

06. Written Request for Administrative Review and Waiver. A written request for a waiver must be sent to the Administrative Procedures Section, 450 W. State Street, P.O. Box 83720, Boise, Idaho 83720-0026 within fourteen (14) calendar days from the date of the issuance of a denial from the Department's Criminal History Unit. The fourteen (14) day period for submitting a request for a waiver may be extended by the Department for good cause. ()

07. Scheduling of Administrative Review. Upon receipt of a written request for a

waiver, the Department will determine the type of administrative review to be held, and conduct the review within thirty (30) business days from the date of receipt. When an in-person review is appropriate, the Department will provide the individual at least seven (7) days notice of the review date. ()

08. Factors Considered During Administrative Review. During the administrative review, the following factors may be considered: ()

- a.** The severity or nature of the crimes, or other findings; ()
- b.** The period of time since the incidents occurred; ()
- c.** The number and pattern of incidents being reviewed; ()
- d.** Circumstances surrounding the incidents that would help determine the risk of repetition; ()
- e.** The relationship between the incidents and the position sought; ()
- f.** Activities since the incidents, such as continuous employment, education, participation in treatment, completion of a problem-solving court or other formal offender rehabilitation, payment of restitution, or any other factors that may be evidence of rehabilitation. ()
- g.** A pardon that was granted by the Governor or the President; ()
- h.** The falsification or omission of information on the self-declaration form and other supplemental forms submitted; and ()
- i.** Any other factor deemed relevant to the review. ()

09. Administrative Review Decision. A notice of decision will be issued by the Department within fifteen (15) business days of completion of the administrative review. ()

10. Decision to Grant Waiver. The Department's decision to grant a waiver does not set a precedent for subsequent requests by an individual for a waiver. A waiver granted under this chapter is not a criminal history and background check clearance, and is only applicable to services and programs governed under this chapter. It does not apply to other Department programs requiring clearance of a criminal history and background check. ()

11. Revocation of Waiver. The Department may choose to revoke a waiver at its discretion for circumstances that it identifies as a risk to client health and safety, at any time. ()

12. Waiver Decisions are not Subject to Review or Appeal. The decision or actions of the Department concerning a waiver are not subject to review or appeal, administratively or otherwise. ()

13. Employer Responsibilities. A waiver granted by the Department is not a determination of suitability for employment. The employer is responsible for reviewing the results of a criminal history and background check even when a clearance is issued or a waiver is granted. Making a determination as to the ability or risk of the individual to provide direct care services or to serve in a position that requires regular contact with children and vulnerable adults is the responsibility of the employer. ()

010. DEFINITIONS AND ABBREVIATIONS.

For the purposes of these rules, the following terms are used as defined below: ()

01. Adolescent. An individual between the ages of fourteen (14) and eighteen (18). ()

02. Adult. An individual eighteen (18) years of age or older. ()

03. Applicant. An adult individual who is seeking crisis services through a behavioral health community crisis center who has completed, or has had completed on his behalf, an application for services. ()

04. Behavioral Health Community Crisis Center. An outpatient facility operated *24 hours a day, 7 days a week, 365 days a year* by a hospital or mental health center that provides evaluation, intervention, and referral for individuals experiencing a crisis due to serious mental illness or a serious mental illness with co-occurring substance use disorder. The facility may not provide services to a client for more than twenty-three (23) hours and fifty-nine (59) minutes from the time the client arrives at the facility. The facility must discharge or transfer the client to the appropriate level of care. ()

05. Child. An individual under the age of fourteen (14) years. ()

06. Client. A person receiving services through a behavioral health community crisis center. The term “client” is synonymous with the following terms: patient, participant, resident, consumer, or recipient of treatment or services. ()

07. Department. The Idaho Department of Health and Welfare or its designee. The Department is designated as the state mental health authority under Section 39-3124, Idaho Code. ()

08. Facility. A behavioral health community crisis center, or a person authorized to act on its behalf. ()

09. Good Cause. A valid and sufficient reason, *as determined by the Department*, for not complying with the time frame set for submitting a written request for a waiver by an individual who does not pass a criminal history and background check. ()

10. Individualized Service Plan. A written action plan based on an intake assessment that identifies the applicant’s needs, strategies for services to meet those needs, treatment goals, and objectives. ()

11. Intake Assessment. The collection of data, analysis, and review used to screen and determine whether an applicant is eligible for behavioral health community crisis services. ()

12. Outpatient Crisis Services. An organized non-residential service, delivered in a variety of settings, in which behavioral health treatment personnel provide professionally directed evaluation and treatment for individuals experiencing crisis situations. ()

011. -- 099. (RESERVED)

**General Provisions Of Behavioral Health Community Crisis Centers
(Sections 100 through 250)**

100. ACCESSING BEHAVIORAL HEALTH COMMUNITY CRISIS CENTER SERVICES.

Services may be accessed by eligible applicants through an application and request for an initial intake eligibility assessment. ()

01. Application for Services. An application for services is completed by the applicant upon entry into the facility. The voluntarily completed application serves as consent for further assessment of the applicant. ()

02. Intake Assessment. The facility will conduct a mental health screening using a Department approved instrument. The facility staff will gather information as needed, in order to complete the screening and intake process. ()

101. INTAKE ASSESSMENT.

The facility must establish admission criteria that assess the individual client's needs and the appropriateness of the services to meet those needs. ()

01. Eligibility. At a minimum, admission criteria must require that the client: ()

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

b. *Demonstrate impairment, or symptoms, or both, consistent with a DSM-V diagnosable behavioral health condition;* ()

c. *Be medically stable, as defined by the Medical Director, with the exception of the person's demonstrated impairment consistent with a DSM-V diagnosable behavioral health condition;* and ()

d. Be in need of frequent observation on an ongoing basis. ()

02. The Facility Determines Eligibility and Capacity for Community Crisis Services. The total number of adults who are eligible for behavioral health community crisis services through the facility will be established by the facility. The facility may, in its sole discretion, limit or prioritize behavioral health services, define eligibility criteria, or establish the

number of persons eligible based upon such factors as availability of funding, the degree of financial need, the degree of clinical need, or other factors. ()

03. Ineligibility Conditions. An adult who does not meet the requirements under Subsection 101.01 of this rule is not eligible for behavioral health community crisis services. An adult with a diagnosis of developmental disorder alone, may be eligible for Department services under IDAPA 16.04.11, “Developmental Disability Agencies,” for developmental disability services. ()

102. ELIGIBILITY DETERMINATION.

01. Notification of Eligibility Determination. The facility will determine the adult’s eligibility for behavioral health community crisis services in accordance with Section 101 of these rules within one (1) hour of completing an intake assessment. The written notice will include: ()

- a. Client name and identifying information; ()
- b. A statement of the decision; ()
- c. A concise statement of the reasons for the decision; and ()
- d. Referral to other appropriate community resources, when applicable. ()

02. Right to Accept or Reject Services. If the facility determines that an applicant is eligible for services through the facility, an individual has the right to accept or reject services offered by the facility. ()

03. Reapplication for Community Crisis Services. If the facility determines that an applicant is not eligible for services through the facility, the applicant may reapply after twenty-four (24) hours, or at any time upon a showing of a substantial, material change in circumstances. ()

04. Information that Must be Provided to the Participant. Upon admission, or as soon as possible if not clinically appropriate upon admission, the facility must provide each client with the following: ()

- a. A written statement of client rights which, at a minimum, includes the applicable patient rights; ()
- b. A copy of the crisis response facility grievance procedure; and ()
- c. The written rules of conduct, including the consequences for violating the rules. ()

103. EMERGENCY SERVICES.

01. Identification of Emergency Services Needed. If emergency services are

clinically necessary, as determined by facility staff, the facility will identify the emergency services that are consistent with the applicant's level of need and a preliminary finding from the intake assessment. ()

02. Immediate Intervention. The facility must ensure inpatient care is *accessible* through a transfer agreement for clients in need of a higher level of care. ()

03. Client Management. Use of de-escalation techniques including physical and nonphysical methods, by trained staff is permissible *in accordance with center policy*. ()

104. -- 199. (RESERVED)

200. INDIVIDUALIZED SERVICE PLAN.

01. Individualized Service Plan. A service plan will be developed by the facility in collaboration with the client, and may include service providers. This plan will be specific, measurable, and realistic in identification of the goal(s) for crisis stabilization, relevant areas of concern, and desired results as outlined in the Idaho Behavioral Health Standards. ()

02. Referrals. The facility must make referrals for services that would help prevent or diminish future crises at the time of the client's discharge. Referrals may include additional treatment, training, or community-based services, such as assistance securing housing. ()

201. -- 205. (RESERVED)

206. OUTCOMES FOR COMMUNITY CRISIS CENTERS.

Outcomes for behavioral health community crisis centers are measured through the administration of a satisfaction survey and a standardized assessment tool. ()

207. USE OF PUBLIC FUNDS AND BENEFITS.

Public funds and benefits will be used to provide services for eligible adults under Section 102 of these rules. Services are planned and implemented to maximize community integration and the individual's ability to provide adequate safety and well-being in his community. Services are individually planned to meet the unique needs of each participant. ()

208. -- 210. (RESERVED)

211. CLINICAL RECORDS.

Every behavioral health community crisis center must maintain, control, and supervise client records and is responsible for maintaining their quality in accordance with the requirements set forth in these rules. ()

01. Active Client Records Kept at the Facility Site. The active client's records must be kept at the facility site where the client is being treated. ()

02. Compilation, Storage, Dissemination, and Accessibility of Client Records. The facility must have written policies and procedures governing the *compilation*, storage, dissemination, and accessibility of client records. ()

03. Electronic Storage of Client Data. When a facility stores client data in electronic *or* other types of automated information systems, they must have security measures to prevent inadvertent or unauthorized access to such data. ()

04. Length of Maintenance of Client Records. Client records must be maintained for a minimum of five (5) years from the date they are officially closed. ()

212. CONTENTS OF CLIENT RECORDS.

01. Intake Assessment. As defined in Section 101 of these rules. ()

02. Eligibility Determination. As defined in Section 102 of these rules. ()

03. Service Plan. As defined in Section 200 of these rules. ()

04. Progress Notes. ()

a. The facility must maintain progress notes for each client. ()

b. The progress notes must be completed following the intake assessment and eligibility determination and updated by the end of each shift into the client's clinical record. ()

c. The progress notes must describe at minimum the following: ()

i. Client's physical condition; ()

ii. Mental status; ()

iii. Involvement in treatment services; and ()

iv. Contain a signature and date of staff member completing the note. ()

05. Discharge Summary. A discharge summary must be entered into the client record and will contain at minimum: ()

a. Client status at discharge; ()

b. Treatment progress; ()

c. Summary of services provided; and ()

d. Referral for further treatment. ()

213. -- 249. (RESERVED)

250. FINANCIAL RESPONSIBILITY FOR COMMUNITY CRISIS CENTER SERVICES.

Individuals receiving behavioral health community crisis services through the Department are responsible for paying for the services provided. Individuals must complete a “Fee Determination Form” prior to the delivery of behavioral health community crisis services. The financial responsibility for each service will be in accordance with the individual’s ability to pay as determined under Sections 300 and 400 of IDAPA 16.07.01, “Behavioral Health Sliding Fee Schedules.” ()

251. -- 999. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.07.33 - ADULT MENTAL HEALTH SERVICES

DOCKET NO. 16-0733-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice the pending rule becomes final and effective on July 1, 2014, after review by the legislature, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 39-3133, Idaho Code.

DESCRIPTIVE SUMMARY: There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 4, 2013, Idaho Administrative Bulletin, [Vol. 13-9, pages 150 through 156](#).

The Division of Behavioral Health (DBH) is working on building a peer recovery system and by removing the barrier around criminal history and background checks will provide more individuals to be in the peer recovery system. Definitions in this chapter were also updated.

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

There is no anticipated fiscal impact to the state general fund or any other funds due to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Treena Clark at (208) 364-6611.

DATED this 29th day of October, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500; fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 39-4605, Idaho Code.

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

ORIGINATING LOCATION -- LIVE MEETING
Tuesday, September 10, 2013
12:30 - 2:30 pm (PDT) -- 1:30 - 3:30 pm (MDT)

Idaho Department of Health and Welfare, Central Office
Conference Room 3A (3rd floor)
450 West State Street
Boise, ID 83702

VIDEOCONFERENCE LOCATIONS

Region I Office – Coeur d’Alene Main Conference Room 2195 Ironwood Court Coeur d’Alene, ID 83814	Region II Office – Lewiston 1st Floor Conference Rm. 1118 “F” Street Lewiston, ID 83501
Region III Office – Caldwell Owyhee Conference Room (Rm. 226) 3402 Franklin Road Caldwell, ID 83605	Region IV Office – Boise Room 142 1720 Westgate Drive, Suite A Boise, ID 83704
Region V Office – Twin Falls Room 116 823 Harrison Twin Falls, ID 83301	Region VI Office – Pocatello Room 225 421 Memorial Drive Pocatello, ID 83201
Region VII Office – Idaho Falls Conference Room 240 150 Shoup Ave. Idaho Falls, ID 83402	

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

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

The Division of Behavioral Health (DBH) is currently working on building a peer delivery system and one issue that has come up as a barrier in Idaho is the requirement around criminal history and background checks. The current requirement does not work for the services that are being provided nor does it fit the model of services that is being promoted. DBH has received complaints from mental health service providers regarding the current rule as it negatively impacts their workforce and ability to provide mental health services.

DBH has negotiated with providers and other interested parties to develop a criminal history and background check rule that both protects the client and acknowledges those who have been successful in their recovery by allowing them to work in the mental health field. The text of these proposed rule changes provides an administrative review on a case-by-case basis for individuals who do not receive a criminal history clearance to request a waiver. These rules provide for this waiver to help establish a peer delivery system for providers of adult mental health services.

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

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

There is no anticipated fiscal impact to the state general fund due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 3, 2013, Idaho Administrative Bulletin, [Vol. 13-4, pages 15 and 16](#), under Docket No. 16-0720-1301.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Treena Clark at (208) 364-6611.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 25, 2013.

DATED this 1st day of August, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0733-1301

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Criminal History and Background Check. All ~~current Department~~ owners, operators, employees, ~~applicants,~~ transfers, reinstated former employees, student interns, ~~contractors, and employees,~~ volunteers, ~~and others assigned to programs that involve~~ who provide direct ~~contact with children or vulnerable adults as described in Section 39-5302, Idaho Code,~~ care or services, or whose position requires regular contact with clients, must comply with the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." (5-8-09)(____)

02. Availability to Work or Provide Service. ~~Certain individuals are allowed to provide services after the self-declaration is completed as provided in Section 56-1004A, Idaho Code, except when they have disclosed a designated crime listed in IDAPA 16.05.06, "Criminal History and Background Checks." The criminal history check requirements applicable to each provider type are found in the rules that state the qualifications or certification of those providers. An individual listed in Subsection 009.01 of these rules is available to work on a provisional basis at the discretion of the employer or agency once the individual has submitted his criminal history and background check application, it has been signed and notarized, reviewed by the employer or agency, and no disqualifying crimes or relevant records are disclosed on the application. An individual must be fingerprinted within twenty-one (21) days of submitting his criminal history and background check application.~~ (5-8-09)(____)

a. An individual is allowed to work or have access to clients only under supervision until the criminal history and background check is completed. (____)

b. An individual, who does not receive a criminal history and background check clearance or a waiver granted under the provisions in this chapter, may not provide direct care or services, or serve in a position that requires regular contact with clients accessing adult mental health services through the Department. (____)

03. Waiver of Criminal History and Background Check Denial. An individual who receives a conditional or unconditional denial for a criminal history and background check, may apply for a waiver to provide direct care or services, or serve in a position that requires regular contact with clients accessing adult mental health services through the Department. A waiver may be granted on a case-by-case basis upon administrative review by the Department of any underlying facts and circumstances in each individual case. A waiver will not be granted for crimes listed in Subsection 009.04 of this rule. (____)

04. No Waiver for Certain Designated Crimes. No waiver will be granted by the

Department for any of the following designated crimes or substantially conforming foreign criminal violations: ()

a. Forcible sexual penetration by use of a foreign object, as defined in Section 18-6608, Idaho Code; ()

b. Incest, as defined in Section 18-6602, Idaho Code; ()

c. Lewd conduct with a minor, as defined in Section 18-1508, Idaho Code; ()

d. Murder in any degree or assault with intent to commit murder, as defined in Sections 18-4001, 18- 4003, and 18-4015, Idaho Code; ()

e. Possession of sexually exploitative material, as defined in Section 18-1507A, Idaho Code; ()

f. Rape, as defined in Section 18-6101, Idaho Code; ()

g. Sale or barter of a child, as defined in Section 18-1511, Idaho Code; ()

h. Sexual abuse or exploitation of a child, as defined in Sections 18-1506 and 18-1507, Idaho Code; ()

i. Enticing of children, as defined in Sections 18-1509 and 18-1509A, Idaho Code; ()

j. Inducing individuals under eighteen (18) years of age into prostitution or patronizing a prostitute, as defined in Sections 18-5609 and 18-5611, Idaho Code; ()

k. Any felony punishable by death or life imprisonment; or ()

l. Attempt, conspiracy, accessory after the fact, or aiding and abetting, as defined in Sections 18-205, 18-306, 18-1701, and 19-1430, Idaho Code, to commit any of the disqualifying designated crimes. ()

05. Administrative Review. An administrative review for a waiver may consist of a review of documents and supplemental information provided by the individual, a telephone interview, an in-person interview, or any other review deemed necessary by the Department. The Department may appoint a subcommittee to conduct administrative reviews provided for under Subsections 009.03 through 009.12 of this rule. ()

06. Written Request for Administrative Review and Waiver. A written request for a waiver must be sent to the Administrative Procedures Section, 450 W. State Street, P.O. Box 83720, Boise, Idaho 83720-0026 within fourteen (14) calendar days from the date of the issuance of a denial from the Department's Criminal History Unit. The fourteen (14) day period for submitting a request for a waiver may be extended by the Department for good cause. ()

07. Scheduling of Administrative Review. Upon receipt of a written request for a

waiver, the Department will determine the type of administrative review to be held, and conduct the review within thirty (30) business days from the date of receipt. When an in-person review is appropriate, the Department will provide the individual at least seven (7) days notice of the review date. ()

08. Factors Considered During Administrative Review. During the administrative review, the following factors may be considered: ()

- a.** The severity or nature of the crimes or other findings; ()
- b.** The period of time since the incidents occurred; ()
- c.** The number and pattern of incidents being reviewed; ()
- d.** Circumstances surrounding the incidents that would help determine the risk of repetition; ()
- e.** The relationship between the incidents and the position sought; ()
- f.** Activities since the incidents, such as continuous employment, education, participation in treatment, completion of a problem-solving court or other formal offender rehabilitation, payment of restitution, or any other factors that may be evidence of rehabilitation. ()
- g.** A pardon that was granted by the Governor or the President; ()
- h.** The falsification or omission of information on the self-declaration form and other supplemental forms submitted; and ()
- i.** Any other factor deemed relevant to the review. ()

09. Administrative Review Decision. A notice of decision will be issued by the Department within fifteen (15) business days of completion of the administrative review. ()

10. Decision to Grant Waiver. The Department's decision to grant a waiver does not set a precedent for subsequent requests by an individual for a waiver. A waiver granted under this chapter is not a criminal history and background check clearance, and is only applicable to services and programs governed under this chapter. It does not apply to other Department programs requiring clearance of a criminal history and background check. ()

11. Revocation of Waiver. The Department may chose to revoke a waiver at its discretion for circumstances that it identifies as a risk to client health and safety, at any time. ()

12. Waiver Decisions Are Not Subject to Review or Appeal. The decision or actions of the Department concerning a waiver is not subject to review or appeal, administratively or otherwise. ()

13. Employer Responsibilities. A waiver granted by the Department is not a determination of suitability for employment. The employer is responsible for reviewing the results of a criminal history and background check even when a clearance is issued or a waiver is granted. Making a determination as to the ability or risk of the individual to provide direct care services or to serve in a position that requires regular contact with children and vulnerable adults is the responsibility of the employer. ()

010. DEFINITIONS.

For the purposes of these rules, the following terms are used as defined below: (5-8-09)

01. Adult. An individual eighteen (18) years of age or older. (5-8-09)

02. Adult Mental Health Services. Adult mental health services include psychiatric clinical services, case management, individual therapy, group therapy, psychosocial rehabilitation (PSR), assertive community treatment (ACT), patient assistance program (PAP), benefit assistance, co-occurring disorders treatment, and pharmacological education. Mental health services do not include educational or vocational services related to traditional academic subjects or vocational training, experimental procedures, habilitation, or any other services which are primarily recreational or diversional in nature. (5-8-09)

03. Applicant. An adult individual who is seeking mental health services through the Department who has completed, or had completed on his behalf, an application for mental health services. (5-8-09)

04. Client. A person receiving mental health services through the Department. The term "client" is synonymous with the following terms: patient, participant, resident, consumer, or recipient of treatment or services. (5-8-09)

05. Clinical Judgment. Refers to observations and perceptions based upon education, experience, and clinical assessment. This may include psychometric, behavioral, and clinical interview assessments that are structured, integrated, and then used to reach decisions, individually or collectively, about an individual's functional, mental, and behavioral attributes and mental health service needs. (5-8-09)

06. Clinical Necessity. Adult mental health services are deemed clinically necessary when the Department, in the exercise of clinical judgment, recommends services to an applicant for the purpose of evaluating, diagnosing, or treating a mental illness and that are: (5-8-09)

a. Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for treating the applicant's mental illness; and (5-8-09)

b. Not primarily for the convenience of the applicant or service provider, not more costly than an alternative service or sequence of services, and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the applicant's mental illness. (5-8-09)

07. Clinical Team. A proposed client's clinical team may include: qualified clinicians, behavioral health professionals, professionals other than behavioral health professionals,

behavioral health technicians, and any other individual deemed appropriate and necessary to ensure that the treatment is comprehensive and meets the needs of the proposed client. (5-8-09)

08. Department. The Idaho Department of Health and Welfare or its designee. The Department is designated as the State Mental Health Authority under Section 39-3124, Idaho Code. (5-8-09)

09. Emergency. An emergency exists if an adult individual is gravely disabled due to mental illness or there is a substantial risk that physical harm will be inflicted by the proposed client: (5-8-09)

a. Upon his own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on himself; or (5-8-09)

b. Upon another person, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm. (5-8-09)

10. Federal Poverty Guidelines. Guidelines issued annually by the Federal Department of Health and Human Services establishing the poverty income limits. The federal poverty guidelines for the current year may be found at: <http://aspe.hhs.gov/poverty/>. (5-8-09)

11. Functional Impairment. Difficulties that substantially impair or limit role functioning with an individual's basic daily living skills, or functioning in social, family, vocational, or educational contexts including psychiatric, health, medical, financial, and community or legal area, or both. (5-8-09)

12. Good Cause. A valid and sufficient reason for not complying with the time frame set for submitting a written request for a waiver by an individual who does not receive a criminal history and background check clearance. ()

123. Gravely Disabled. An adult who, as a result of mental illness, is in danger of serious physical harm due to the person's inability to provide for any of his basic needs for nourishment, essential medical care, shelter, or safety. (5-8-09)

134. Individualized Treatment Plan. A written action plan based on an intake eligibility assessment, that identifies the applicant's clinical needs, the strategy for providing services to meet those needs, treatment goals and objectives, and the criteria for terminating the specified interventions. (5-8-09)

145. Intake Eligibility Assessment. The collection of data, analysis, and review that the Department uses to screen and determine whether an applicant is eligible for mental health services available through the Department. (5-8-09)

156. Serious Mental Illness (SMI). Means any of the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Text Revision (DSM-IV-TR): (5-8-09)

a. Schizophrenia; (5-8-09)

- b. Paranoia and other psychotic disorders; (5-8-09)
- c. Bipolar disorders (mixed, manic and depressive); (5-8-09)
- d. Major depressive disorders (single episode or recurrent); (5-8-09)
- e. Schizoaffective disorders; and (5-8-09)
- f. Obsessive-compulsive disorders. (5-8-09)

167. Serious and Persistent Mental Illness (SPMI). A primary diagnosis under DSM-IV-TR of Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified (NOS) for a maximum of one hundred twenty (120) days without a conclusive diagnosis. The psychiatric disorder must be of sufficient severity to cause a substantial disturbance in role performance or coping skills in at least two (2) of the following functional areas in the last six (6) months: (5-8-09)

- a. Vocational or educational, or both. (5-8-09)
- b. Financial. (5-8-09)
- c. Social relationships or support, or both. (5-8-09)
- d. Family. (5-8-09)
- e. Basic daily living skills. (5-8-09)
- f. Housing. (5-8-09)
- g. Community or legal, or both. (5-8-09)
- h. Health or medical, or both. (5-8-09)

178. Sliding Fee Scale. A scale used to determine an individual's financial obligation for services based on Federal Poverty Guidelines and found in IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules." (5-8-09)

189. Substantial Material Change in Circumstances. A substantial and material change in circumstances which renders the Department's decision denying mental health services arbitrary and capricious. (5-8-09)

IDAPA 22 - BOARD OF MEDICINE

22.01.03 - RULES FOR THE LICENSURE OF PHYSICIAN ASSISTANTS

DOCKET NO. 22-0103-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 54-1806 and 54-1807A, Idaho Code.

DESCRIPTIVE SUMMARY: There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 2, 2013 Idaho Administrative Bulletin, [Vol. 13-10, pages 313 through 315](#).

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: N/A. There will be no impact on the general fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Nancy M. Kerr, Executive Director, Phone: (208) 327-7000.

DATED this 23rd day of October, 2013.

Nancy M. Kerr, Executive Director
Idaho State Board of Medicine
1755 Westgate Drive, Ste. 140, Boise, ID
PO Box 83720
Boise, ID 83720-0058
Phone: (208) 327-7000
Fax: (208) 327-7005

**THE FOLLOWING NOTICE WAS PUBLISHED WITH
THE TEMPORARY AND PROPOSED RULE**

EFFECTIVE DATE: The effective date of the temporary rule is [August 28, 2013](#).

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Section(s) 54-1806 and 54-1807A, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 16, 2013.

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

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

To comply rule with Sections 54-1705 and 54-1719, Idaho Code, and the new rules for Prescriber Drug Outlets codified in IDAPA 27.01.01, “Rules of the Idaho Board of Pharmacy.”

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

Temporary rule adoption is appropriate to comply with Sections 54-1705 and 54-1719, Idaho Code, and IDAPA 27.01.01.

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

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: None. There will be no impact on the general fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because there are no issues arising from compliance to the changes of Sections 54-1705 and 54-1719, Idaho Code, and IDAPA 27.01.01.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule and how an electronic copy can be obtained or, if otherwise unavailable, where copyrighted or other proprietary materials may be obtained: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Nancy M. Kerr, Executive Director, Idaho State Board of Medicine, (208) 327-7000 or visit the Board’s website at: www.bom.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 23, 2013.

DATED this 28th day of August, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 22-0103-1301

042. PRESCRIPTION WRITING.

01. Approval and Authorization Required. A physician assistant may issue written or oral prescriptions for legend drugs and controlled drugs, Schedule II through V only in accordance with approval and authorization granted by the Board and in accordance with the current delegation of services agreement and shall be consistent with the regular prescriptive practice of the supervising or alternate supervising physician. (4-9-09)

02. Application. A physician assistant who wishes to apply for prescription writing authority shall submit to the Board an application for such purpose on forms supplied by the Board. In addition to the information contained in the general application for physician assistant approval, the application for prescription writing authority shall include the following information: (3-16-04)

a. Documentation of all pharmacology course content completed, the length and whether a passing grade was achieved (at least thirty (30) hours). (7-1-93)

b. A statement of the frequency with which the supervising physician will review prescriptions written or issued. (3-16-04)

c. A signed affidavit from the supervising physician certifying that, in the opinion of the supervising physician, the physician assistant is qualified to prescribe the drugs for which the physician assistant is seeking approval and authorization. (3-16-04)

d. The physician assistant to be authorized to prescribe Schedule II through V drugs shall be registered with the Federal Drug Enforcement Administration and the Idaho Board of Pharmacy. (3-15-02)

03. Prescription Forms. Prescription forms used by the physician assistant must be printed with the name, address, and telephone number of the physician assistant and of the supervising physician. A physician assistant shall not write prescriptions or complete or issue

prescription blanks previously signed by any physician. (3-16-04)

04. Record Keeping. The physician assistant shall maintain accurate records, accounting for all prescriptions issued and medication delivered. (3-16-04)

05. Pharmaceutical Samples. The physician assistant who has prescriptive authority may request, receive, sign for and distribute professional samples of drugs and devices in accordance with his current delegation of services agreement and consistent with the regular prescriptive practice of the supervising physician. (3-16-04)

06. Prescriber Drug Outlet. The physician assistant who has prescriptive authority may dispense prescriptive drugs or devices directly to patients under the direction of the supervising physician and in accordance with IDAPA 27.01.01, "Rules of the Idaho State Board of Pharmacy." ()

~~043. DELIVERY OF MEDICATION.~~

~~01. Pre-Dispensed Medication.~~ The physician assistant may legally provide a patient with more than one (1) dose of a pre-dispensed medication upon obtaining formal prior approval from the Board. The pre-dispensed medications shall be provided for a limited period to be determined on the basis of individual circumstances. (4-9-09)

~~02. Consultant Pharmacist.~~ The physician assistant shall have a consultant pharmacist responsible for providing the physician assistant with pre-dispensed medication in accordance with federal and state statutes for packaging, labeling, and storage. (3-19-99)

~~03. Limitation of Items.~~ The pre-dispensed medication shall be limited to only those categories of drug identified in the delegation of services agreement and consistent with the regular prescriptive practice of the supervising physician, except a physician assistant may provide other necessary emergency medication to the patient as directed by a physician. (4-9-09)

~~04. Exception From Limited Period.~~ Physician assistants in agencies, clinics or both, providing family planning, communicable disease and chronic disease services under government contract or grant may provide pre-dispensed medication for these specific services and shall be exempt from the limited period upon obtaining formal prior approval from the Board. (4-9-09)

~~0443.~~ -- 050. (RESERVED)

IDAPA 22 - BOARD OF MEDICINE

22.01.13 - RULES FOR THE LICENSURE OF DIETITIANS

DOCKET NO. 22-0113-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 54-3503 and 54-3505, Idaho Code.

DESCRIPTIVE SUMMARY: There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 2, 2013 Idaho Administrative Bulletin, [Vol. 13-10, pages 316 through 318](#).

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: There will be no impact on the general fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Nancy M. Kerr, Executive Director, Phone: (208) 327-7000.

DATED this 23rd day of October, 2013.

Nancy M. Kerr, Executive Director
Idaho State Board of Medicine
1755 Westgate Drive, Ste. 140, Boise, ID
PO Box 83720
Boise, ID 83720-0058
Phone: (208) 327-7000
Fax: (208) 327-7005

**THE FOLLOWING NOTICE WAS PUBLISHED WITH
THE TEMPORARY AND PROPOSED RULE**

EFFECTIVE DATE: The effective date of the temporary rule is [August 28, 2013](#).

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 54-3503 and 54-3505, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 16, 2013.

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

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

The supporting reasons and purposes for adopting this temporary rule are to identify the new name of the accrediting agency for dietetic educational programs and correct the erroneous citation of Section 54-3710, Idaho Code, to the correct citation of section 54-3505, Idaho Code.

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 following reasons:

The temporary adoption of the rule is appropriate to acknowledge the new name of the accrediting agency for dietetic education programs from American Dietetic Association to Academy of Nutrition and Dietetics and correct an erroneous citation. Protection of the public health, safety, or welfare.

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

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: N/A. There will be no impact on the general fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because there are no issues due to the facts that only the name of the accrediting agency for dietetic educational programs has been changed and an erroneous citation will be corrected.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule and how an electronic copy can be obtained or, if otherwise unavailable, where copyrighted or other proprietary materials may be obtained: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Nancy M. Kerr, Executive Director, Idaho State Board of Medicine, (208) 327-7000 or visit the Board's website at: www.bom.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 23, 2013.

DATED this 22nd day of August, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 22-0113-1301

021. APPLICATION FOR LICENSURE.

01. Application. Each applicant for licensure shall submit a completed written application to the board on forms prescribed by the board, together with the application fee. The application shall be verified and under oath and shall require the following information: (12-28-94)

a. A certificate of successful completion of a program approved by the ~~American Dietetic Association~~ Academy of Nutrition and Dietetics or its successor and a certificate of successful completion of a dietetic internship or preprofessional program approved or accredited by the ~~American Dietetic Association~~ Academy of Nutrition and Dietetics or its successor; (12-28-94)()

b. The disclosure of any criminal conviction or charges against the applicant other than minor traffic offenses; (12-28-94)

c. The disclosure of any disciplinary action against the applicant by any state professional regulatory agency or professional organization; (12-28-94)

d. The disclosure of the denial of registration or licensure by any state or district regulatory body; (12-28-94)

e. Not less than two (2) certificates of recommendation from persons having personal knowledge of the applicant's character; (12-28-94)

f. Two (2) unmounted photographs of the applicant, no larger than three inches by four inches (3" x 4") (head and shoulders), taken not more than one (1) year prior to the date of

the application; (12-28-94)

g. A copy of any registration by the Commission on Dietetic Registration, if applicable; (12-28-94)

h. A copy of examination results or the application to write the qualifying exam and the date the examination is scheduled; (4-2-03)

i. Such other information as deemed necessary for the Board to identify and evaluate the applicant's credentials; and (4-2-03)

j. A Provisional License Dietitian/Monitor Affidavit, if applicable. (4-2-03)

02. Personal Interview. The Board may, at its discretion, require the applicant to appear for a personal interview. (12-28-94)

(BREAK IN CONTINUITY OF SECTIONS)

032. DENIAL OR REFUSAL TO RENEW, SUSPENSION OR REVOCATION OF LICENSE.

01. Disciplinary Authority. A new or renewal application may be denied or a license may be suspended or revoked by the Board, and every person licensed pursuant to Title 54, Chapter 35, Idaho Code and these rules is subject to disciplinary actions or probationary conditions pursuant to the procedures and powers established by and set forth in Section 54-~~3710~~**3505**, Idaho Code, IDAPA 04.11.01, "Idaho Rules of Administrative Procedure of the Attorney General," and IDAPA 22.01.07, "Rules of Practice and Procedure of the Board of Medicine." (~~3-27-13~~)()

02. Grounds for Discipline. In addition to the grounds set forth in Section 54-3510, Idaho Code, applicants may be refused licensure and licensees are subject to discipline upon the following grounds, including but not limited to: (12-28-94)

a. Being guilty of unprofessional conduct, including the provision of care which fails to meet the standard of care provided by other qualified licensees within the state of Idaho. (12-28-94)

b. Violating any provisions of this act or any of the rules promulgated by the Board under the authority of the act. (12-28-94)

c. Being convicted of a crime which may or would have a direct and adverse bearing on the licensee's ability to practice dietetics; (3-27-13)

d. Demonstrating a manifest incapacity to carry out the functions of the licensee's ability to practice dietetics or deemed unfit by the Board to practice dietetics; (3-27-13)

- e.** Using any controlled substance or alcohol which may or would have a direct and adverse bearing on the licensee's ability to practice dietetics; (3-27-13)
- f.** Misrepresenting educational or experience attainments; (3-27-13)
- g.** Failing to maintain adequate dietetic records. Adequate dietetic records mean legible records that contain subjective information, an evaluation or report of objective findings, assessment or diagnosis, and the plan of care; (3-27-13)
- h.** Failure to monitor and be responsible for the activities of the provisionally licensed graduate dietitian; (3-27-13)
- i.** Employing, directing or supervising the unlicensed practice of dietetics; (3-27-13)
- j.** Practicing in an area of dietetics for which the licensee is not trained; (3-27-13)
- k.** Commission of any act of sexual contact, misconduct, exploitation or intercourse with a patient or former patient or related to the licensee's practice of dietetics; (3-27-13)
- l.** Failing to report to the Board any known act or omission of a licensee, applicant, or any other person, that violates any of the rules promulgated by the Board under the authority of the act; (3-27-13)
- m.** Interfering with an investigation or disciplinary proceeding by willful misrepresentation of facts or by use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding, investigation or other legal action; (3-27-13)
- n.** Failure to obey federal and local laws and rules governing the practice of dietetics; (3-27-13)

or
- o.** Failure to be lawfully present in the United States. (3-27-13)

IDAPA 23 - BOARD OF NURSING

23.01.01 - RULES OF THE IDAHO BOARD OF NURSING

DOCKET NO. 23-0101-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is acted on by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1404, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule published in the September 4, 2013 Idaho Administrative Bulletin, [Vol. 13-9, pages 171 through 175](#).

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Sandra Evans, M.A. Ed., R.N., Executive Director, (208) 334-3110 ext. 2476.

DATED this 2nd day of October, 2013.

Sandra Evans, M.A. Ed., R.N.
Executive Director
Board of Nursing
280 N. 8th St. (8th & Bannock)
Suite 210
P. O. Box 83720
Boise, ID 83720-0061
Phone: 334-3110 ext. 2476
Fax: (208) 334-3536

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-1404, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 18, 2013.

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

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

Delegation is the process of transferring to a competent individual the authority to perform a selected nursing task in a selected situation. The nurse's decision to delegate a specific task/function/activity should not be restricted by regulation but should, instead, be dependent on the needs of the client, stability of client condition, complexity of the task, predictability of outcome and available resources to meet these needs and the judgment of the nurse. This rule is necessary to allow licensed nurses to appropriately delegate without limiting their authority to determine which tasks can be safely delegated in any individual circumstance and/or setting and to engage in other relationships where the structure and/or setting is not conducive to the delegation process and where the patient/client will benefit from the identified role and responsibilities of the nurse. Thus rulemaking deletes the list of specific functions codified at IDAPA 23.01.01.490.06 that cannot be delegated to an unlicensed assistive person by a licensed nurse, thereby allowing nurses to determine appropriate tasks/functions/activities that can be safely delegated in a given situation based on the nurse's informed judgment that the safety and well-being of the client will not be compromised by delegation of the task; and adds to the partial listing of tasks that fall within a licensed nurse's functions to include engaging in interfaces other than delegation in certain settings codified at IDAPA 23.01.01.401.02 and 460.02.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the July 3, 2013 Idaho Administrative Bulletin, [Vol. 13-7, pages 69 and 70](#).

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Sandra Evans, M.A. Ed., R.N., Executive Director, (208) 334-3110 ext. 2476.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 25, 2013.

DATED this 31st day of July, 2013.

Legislative Services Rules Analyses

THE FOLLOWING IS THE TEXT OF DOCKET NO. 23-0101-1301

401. LICENSED REGISTERED NURSE (RN).

In addition to providing hands-on nursing care, licensed registered nurses work and serve in a broad range of capacities including, but not limited to, regulation, delegation, management, administration, teaching, and case management. Licensed registered nurses, also referred to as registered nurses or as “RNs,” are expected to exercise competency in judgment, decision making, implementation of nursing interventions, delegation of functions or responsibilities, and administration of medications and treatments prescribed by legally authorized persons. (5-3-03)

01. Standards of Practice. A licensed registered nurse adheres to the decision-making model set forth in Section 400 of these rules. (5-3-03)

02. Functions. A partial listing of tasks within the licensed registered nurse’s function follows. This listing is for illustrative purposes only, it is not exclusive. The licensed registered nurse: (5-3-03)

- a.** Assesses the health status of individuals and groups; (5-3-03)
- b.** Utilizes data obtained by assessment to identify and document nursing diagnoses which serve as a basis for the plan of nursing care; (5-3-03)
- c.** Collaborates with the patient, family, and health team members; (5-3-03)
- d.** Develops and documents a plan for nursing intervention based on assessment,

- analysis of data, identified nursing diagnoses and patient outcomes; (5-3-03)
- e. Is accountable and responsible for implementation of planned and prescribed nursing care; (5-3-03)
 - f. Maintains safe and effective nursing care by: (5-3-03)
 - i. Maintaining a safe environment; (5-3-03)
 - ii. Evaluating patient status and instituting appropriate therapy or procedures which might be required in emergency situations to stabilize the patient's condition or prevent serious complications in accordance with standard procedures established by the policy-making body in the health care setting, including but not limited to administration of intravenous drugs and starting intravenous therapy based on protocols if the patient has been assessed and determined to be in peril; (5-3-03)
 - iii. Acting as a patient's advocate; (5-3-03)
 - iv. Applying principles of asepsis and infection control and universal standards when providing nursing care; (5-3-03)
 - v. Implementing orders for medications and treatments issued by an authorized prescriber; and (5-3-03)
 - vi. Providing information and making recommendations to patients and others in accordance with employer policies; (5-3-03)
 - g. Utilizes identified goals and outcomes to evaluate responses to interventions; (5-3-03)
 - h. Collaborates with other health professionals by: (5-3-03)
 - i. Communicating significant changes in a patient's status or responses to appropriate health team professionals; (5-3-03)
 - ii. Coordinating the plan of care with other health team professionals; and (5-3-03)
 - iii. Consulting with nurses and other health team members as necessary; (5-3-03)
 - i. Teaches the theory and practice of nursing; and (5-3-03)
 - j. Facilitates, mentors and guides the practice of nursing formally and informally in practice settings. (5-3-03)
 - k. Engages in other interfaces with healthcare providers and other workers in settings where there is not a structured nursing organization and in settings where health care plays a secondary role, where the nurse needs to identify the nursing role and responsibility for the particular type of interface, for example, teaching, supervising, consulting, advising, etc. ()**

03. Chief Administrative Nurse. A licensed registered nurse functioning as chief administrative nurse is accountable and responsible for: (5-3-03)

a. Prescribing, directing and evaluating the quality of nursing services including but not limited to staff development and quality improvement; (7-1-96)

b. Assuring that organizational policies and procedures, job descriptions and standards of nursing practice conform to the Nursing Practice Act and nursing practice rules; (7-1-96)

c. Assuring that the knowledge, skills and abilities of nursing care staff are assessed and that nursing care activities do not exceed the legally defined boundaries of practice; and (7-1-96)

d. Assuring that documentation of all aspects of the nursing organization is maintained. (7-1-96)

04. Management Role. A licensed registered nurse functioning in a management role shall be accountable and responsible for: (5-3-03)

a. The quality and quantity of nursing care provided by nursing personnel under his supervision; (5-3-03)

b. Managing and coordinating nursing care in accordance with established guidelines for delegation; and (5-3-03)

c. Providing leadership in formulating, interpreting, implementing, and evaluating the objectives and policies of nursing practice. (7-1-96)

(BREAK IN CONTINUITY OF SECTIONS)

460. LICENSED PRACTICAL NURSE (LPN).

Licensed practical nurses function in dependent roles. Licensed practical nurses, also referred to as LPNs, provide nursing care at the delegation of a licensed registered nurse, licensed physician, or licensed dentist pursuant to rules established by the Board. The stability of the patient's environment, the patient's clinical state, and the predictability of the outcome determine the degree of direction and supervision that must be provided to the licensed practical nurse. (5-3-03)

01. Standards. The licensed practical nurse shall be personally accountable and responsible for all actions taken in carrying out nursing activities and adheres to the decision-making model set forth in Section 400 of these rules. (5-3-03)

02. Functions. A partial listing of some of the functions that are included within the legal definition of licensed practical nurse, Section 54-1402(3), Idaho Code, (Nursing Practice

Act) follows. This list is for example only, it is not complete. The licensed practical nurse: (5-3-03)

- a.** Contributes to the assessment of health status by collecting, reporting and recording objective and subjective data; (5-3-03)
- b.** Participates in the development and modification of the plan of care; (5-3-03)
- c.** Implements aspects of the plan of care; (5-3-03)
- d.** Maintains safe and effective nursing care; (5-3-03)
- e.** Participates in the evaluation of responses to interventions; (5-3-03)
- f.** Fulfills charge nurse responsibilities in health care facilities as allowed by state and federal law; (5-3-03)
- g.** Delegates to others as allowed by application of the decision-making model; and (5-3-03)
- h.** Accepts delegated assignments only as allowed by application of the decision-making model. (5-3-03)

i. Engages in other interfaces with healthcare providers and other workers in settings where there is not a structured nursing organization and in settings where health care plays a secondary role, where the nurse needs to identify the nursing role and responsibility for the particular type of interface, for example, teaching, supervising, consulting, advising, etc. ()

461. -- 489. (RESERVED)

490. UNLICENSED ASSISTIVE PERSONNEL (UAP).

The term unlicensed assistive personnel, also referred to as “UAP,” is used to designate unlicensed personnel employed to perform nursing care services under the direction and supervision of licensed nurses. The term unlicensed assistive personnel also includes licensed or credentialed health care workers whose job responsibilities extend to health care services beyond their usual and customary roles and which activities are provided under the direction and supervision of licensed nurses. (5-3-03)

01. Not a Substitute for the Licensed Nurse. Unlicensed assistive personnel may complement the licensed nurse in the performance of nursing functions, but may not substitute for the licensed nurse; unlicensed assistive personnel may not redelegate a delegated act. (5-3-03)

02. Delegation. The nursing care tasks that may be delegated to unlicensed assistive personnel shall be stated in writing in the practice setting. Decisions concerning delegation will be determined in accordance with the provisions of Section 400 of these rules. (5-3-03)

03. Training. The following training requirements apply to all unlicensed assistive personnel. The training program shall: (5-3-03)

a. Include written objectives which describe the expected outcomes for the learner and which can be evaluated by written or oral examination and by clinical demonstration of competency or application; (5-3-03)

b. Incorporate learning experiences appropriate to the stated objectives; (5-3-03)

c. Be conducted by licensed registered nurses and other licensed health professionals, including, but not limited to, physicians, pharmacists, psychologists, social workers, and dietitians; (5-3-03)

d. Include an evaluation mechanism to determine the effectiveness of the program; and (5-3-03)

e. Address the general unlicensed assistive personnel curriculum content areas set forth in Paragraph 681.04.g. of these rules. (5-3-03)

04. Nurse Aide Registry. In addition to the foregoing training requirements, UAP desiring placement on the Nurse Aide Registry must comply with the requirements set forth in Sections 600 through 681 of these rules. (5-3-03)

05. Assistance With Medications. Where permitted by law, after completion of a Board-approved training program, unlicensed assistive personnel in care settings may assist patients who cannot independently self-administer medications, provided that: (5-3-03)

a. A plan of care has been developed by a licensed registered nurse; (7-1-96)

b. The act has been delegated by a licensed nurse; (7-1-96)

c. Written and oral instructions have been given to the unlicensed assistive personnel by a licensed nurse concerning the reason(s) for the medication, the dosage, expected effects, adverse reactions or side effects, and action to take in an emergency; (7-1-96)

d. The medication is in the original pharmacy-dispensed container with proper label and directions or in an original over-the-counter container or the medication has been removed from the original container and placed in a unit container by a licensed nurse. Proper measuring devices must be available for liquid medication that is poured from a pharmacy-dispensed container. Inventories of narcotic medications must be maintained; (7-1-96)

e. Any medication dosages not taken and the reasons thereof are recorded and reported to appropriate supervisory persons; and (5-3-03)

f. Assistance with medication may include: breaking a scored tablet, crushing a tablet, instilling eye, ear or nose drops, giving medication through a pre-mixed nebulizer inhaler or gastric (non-nasogastric) tube, assisting with oral or topical medications and insertion of suppositories. (7-1-96)

06. Prohibitions and Limitations. Unlicensed assistive personnel are prohibited from

performing any licensed nurse functions that are specifically defined in Section 54-1402, Idaho Code. (3-30-07)

~~a.~~ Unlicensed assistive personnel may not be delegated procedures involving acts that require nursing assessment or diagnosis, establishment of a plan of care or teaching, the exercise of nursing judgment, or procedures requiring specialized nursing knowledge, skills or techniques. (5-3-03)()

~~b.~~ *Examples of procedures that should not be delegated to unlicensed assistive personnel include, but are not limited to:* (5-3-03)

- ~~i.~~ *Sterile procedures;* (5-3-03)
 - ~~ii.~~ *Preparation or administration of injections;* (5-3-03)
 - ~~iii.~~ *Start, stop or adjust any IV therapy;* (5-3-03)
 - ~~iv.~~ *Oxygen adjustment without clear direction from a licensed nurse;* (5-3-03)
 - ~~v.~~ *Nasogastric tube feedings or medication administration;* (5-3-03)
 - ~~vi.~~ *Mixing or compounding medications;* (5-3-03)
 - ~~vii.~~ *Prepare, apply or adjust intermittent positive pressure breathing machines;* (5-3-03)
 - ~~viii.~~ *Assisting with either preparation or administration of non-routine medications;* (5-3-03)
- and
- ~~ix.~~ *Any act not consistent with Subsection 490.02 of these rules.* (5-3-03)

IDAPA 23 - BOARD OF NURSING

23.01.01 - RULES OF THE IDAHO BOARD OF NURSING

DOCKET NO. 23-0101-1302

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is acted on by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1404, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule published in the October 2, 2013 Idaho Administrative Bulletin, [Vol. 13-10, pages 319 through 322](#).

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Sandra Evans, M.A. Ed., R.N., Executive Director, (208) 334-3110 ext. 2476.

DATED this 24th day of October, 2013.

Sandra Evans, M.A. Ed., R.N., Executive Director
Board of Nursing
280 N. 8th St. (8th & Bannock), Ste. 210
P. O. Box 83720
Boise, ID 83720-0061
Phone: 334-3110 ext. 2476
Fax: (208) 334-3536

**THE FOLLOWING NOTICE WAS PUBLISHED WITH
THE TEMPORARY AND PROPOSED RULE**

EFFECTIVE DATE: The effective date of the temporary rule is **July 1, 2013**.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Section 54-1404, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 16, 2013.

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

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

A change in Nurse Licensure Compact Model Rules necessitates a similar change in a Board rule. The amendment will increase from thirty (30) to ninety (90) days the period a nurse moving to Idaho may practice on the privilege granted by his/her existing license in another Compact state while his/her application for new residency is processed.

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

Idaho is a participating state in the Nurse Multistate Licensing Compact. The Compact administrators have agreed to increase a uniform time-period applicable to licensing decisions. This increase will benefit nurses moving to Idaho from another Compact state.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the wording of the rulemaking is mandatory in compliance with uniform licensing requirements of the Nurse Multistate Licensing Compact.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Sandra Evans, M.A. Ed., R.N., Executive Director, (208) 334-3110 ext. 2476.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 23, 2013.

DATED this 30th day of August, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 23-0101-1301

077. MULTISTATE LICENSURE.

- 01. Definitions.** In Section 077, the following terms have the meanings indicated. (3-15-02)
- a.** Board means the regulatory body responsible for issuing nurse licenses. (3-15-02)
 - b.** Compact means the Nurse Multistate Licensing Compact. (3-15-02)
 - c.** Coordinated Licensure Information System (CLIS) means an integrated process for collecting, storing, and sharing information on nurse licensing and enforcement activities related to nurse licensing laws, which is administered by a nonprofit organization composed of and controlled by state nurse licensing boards. (3-15-02)
 - d.** Home state means the party state that is the nurse's primary state of residence. (3-15-02)
 - e.** Party state means a state that is a signatory on the compact. (3-15-02)
 - f.** Primary state of residence means the state of a person's declared fixed permanent and principal home for legal purposes; domicile. (3-29-10)
 - g.** Public means an individual or entity other than designated staff or representatives

of party state boards or the National Council of State Boards of Nursing, Inc. (3-15-02)

02. Examination. No applicant may be issued a compact license granting a multistate privilege to practice unless the applicant first obtains a passing score on the applicable NCLEX (National Council Licensure Examination): (4-4-13)

a. NCLEX-RN for registered nursing; or (4-6-05)

b. NCLEX-PN for practical nursing. (4-6-05)

03. Issuance of License in Compact Party State. (3-15-02)

a. A nurse applying for a license in a home party state shall produce evidence of the nurse's primary state of residence. This evidence shall include a declaration signed by the licensee. Further evidence that may be requested includes, but is not limited to: (3-15-02)

i. Driver's license with a home address; (3-15-02)

ii. Voter registration card displaying a home address; (3-29-10)

iii. Federal income tax return declaring the primary state of residence; (3-29-10)

iv. Military Form No. 2058 - state of legal residence certificate; or (3-29-10)

v. W2 from U.S. Government or any bureau, division, or agency thereof, indicating the declared state of residence. (3-29-10)

b. A nurse on a visa from another country applying for licensure in a party state may declare either the country of origin or the party state as the primary state of residence. If the foreign country is declared the primary state of residence, a single state license will be issued by the party state. (3-29-10)

c. A license issued by a party state is valid for practice in all other party states unless clearly designated as valid only in the state which issued the license. (3-29-10)

d. When a party state issues a license authorizing practice only in that state and not authorizing practice in other party states (i.e., a single state license), the license shall be clearly marked with words indicating that it is valid only in the state of issuance. (3-29-10)

e. A nurse changing primary state of residence, from one (1) party state to another party state, may continue to practice under the former home state license and multistate licensure privilege during the processing of the nurse's licensure application in the new home state for a period not to exceed ~~thirty ninety~~ (390) days. (3-15-02)()

f. The licensure application in the new home state of a nurse under pending investigation by the former home state shall be held in abeyance, and the ~~thirty ninety~~ (390) day period in Paragraph 077.03.e. of these rules shall be stayed until resolution of the pending investigation. (4-4-13)()

g. The former home state license is not valid upon the issuance of a new home state license. (3-15-02)

h. If a decision is made by the new home state denying licensure, the new home state shall notify the former home state within ten (10) business days, and the former home state will take action in accordance with that state's laws and regulations. (3-15-02)

04. Multistate Licensure Privilege Limitations. (3-15-02)

a. Home state boards shall include, in all disciplinary orders or agreements that limit practice or require monitoring, the requirement that the licensee subject to the order or agreement shall limit the licensee's practice to the home state during pendency of the disciplinary order or agreement. (3-15-02)

b. The requirement referred to in Paragraph 077.04.a. of these rules may, in the alternative, allow the nurse to practice in other party states with prior written authorization from both the home state and other party state boards. (3-30-07)

c. An individual who had a license that was surrendered, revoked, suspended, or an application denied for cause in a prior state of primary residence, may be issued a single state license in a new primary state of residence until such time as the individual would be eligible for an unrestricted license by the prior state(s) of adverse action. Once eligible for licensure in the prior state(s), a multistate license may be issued. (3-29-10)

05. Information System. (3-15-02)

a. Levels of Access. (3-15-02)

i. Public access to nurse licensure information shall be limited to: (3-15-02)

(1) The licensee's name; (3-15-02)

(2) Jurisdictions of licensure; (3-15-02)

(3) Licensure expiration date; (3-15-02)

(4) Licensure classification and status; (3-15-02)

(5) Public emergency, summary, and final disciplinary actions, as defined by contributing state authority; and (3-15-02)

(6) The status of multistate licensure privileges. (3-15-02)

ii. Non-party state boards shall have access to all CLIS data except current significant investigative information and other information as limited by contributing party state authority. (3-15-02)

- iii. Party state boards shall have access to all CLIS data contributed by the party states and other information as allowed by contributing non-party state authority. (3-15-02)
- b. Right to Review.** (3-15-02)
- i. The licensee may request, in writing, to the home state board to review data relating to the licensee in the CLIS. (3-15-02)
- ii. If a licensee asserts that any data relating to the licensee is inaccurate, the burden of proof is on the licensee to provide evidence substantiating that claim. (3-15-02)
- iii. Within ten (10) business days, the Board shall correct information that it finds to be inaccurate in the CLIS. (3-15-02)
- c. Changes in Disciplinary Data.** (3-15-02)
- i. Within ten (10) business days, the Board shall report to CLIS: (3-15-02)
- (1) Disciplinary action, agreement or order requiring participation in alternative programs or which limit practice or require monitoring unless the agreement or order relating to participation in alternative programs is required to remain nonpublic by the contributing state authority; (3-15-02)
- (2) Dismissal of the complaint; and (3-15-02)
- (3) Changes in status of disciplinary action, or licensure encumbrance. (3-15-02)
- ii. The Board shall delete current significant investigative information from the CLIS within ten (10) business days after: (3-15-02)
- (1) A disciplinary action; (3-15-02)
- (2) An agreement or order requiring participation in alternative programs; (3-15-02)
- (3) An agreement or agreements, which limit practice or require monitoring; or (3-15-02)
- (4) Dismissal of a complaint. (3-15-02)
- iii. The CLIS administrator shall make changes to licensure information in the CLIS within ten (10) business days upon notification by a board. (3-15-02)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.06.01 - RULES FOR THE LICENSURE OF OCCUPATIONAL THERAPISTS AND OCCUPATIONAL THERAPY ASSISTANTS

DOCKET NO. 24-0601-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is acted on by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-3717, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 4, 2013 Idaho Administrative Bulletin, [Vol. 13-9, pages 176 through 178](#).

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cherie Simpson at 208-334-3233.

DATED this 28th day of October, 2013.

Tana Cory, Bureau Chief
Bureau of Occupational Licenses
700 W State St.
P O Box 83720
Boise, ID 83720-0063
Phone: 208-334-3233
Fax: 208-334-3945

**THE FOLLOWING NOTICE WAS PUBLISHED WITH
THE TEMPORARY AND PROPOSED RULE**

EFFECTIVE DATE: The effective date of the temporary rule is **July 1, 2013**.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Section 54-3717, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 18, 2013.

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

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

House Bill 33 which passed in the 2013 legislative session allows the Board to issue a limited permit for a period of six (6) months or as extended by the Board. The Occupational Therapy Licensure Board is updating the limited permit rules to comply with the statute.

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

House Bill 33 which passed in the 2013 legislative session allows the Board to issue a limited permit for a period of six (6) months or as extended by the Board. The Board is updating the limited permit rules to comply with the law change.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rules pertaining to limited permits require amendment to comply with the law change approved in 2013.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed

rule, contact Cherie Simpson at 208 334-3233.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 25, 2013.

DATED this 9th day of August, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-0601-1301

021. APPLICATION FOR LICENSURE.

01. Licensure by Examination. Each applicant for licensure by examination shall submit a completed written application to the Board, on forms prescribed by the Board, together with the application fee. The application shall be verified and under oath and shall require the following information: (7-1-99)

a. A certificate of graduation from an approved occupational therapy curriculum; or an approved occupational therapy assistant's curriculum accredited by the American Occupational Therapy Association's Accreditation Council for Occupational Therapy Education, or an accrediting agency recognized by the United States Secretary of Education, the Council for Higher Education Accreditation, or both; (4-2-03)

b. The disclosure of any criminal conviction or charges against the applicant other than minor traffic offenses; (1-5-88)

c. The disclosure of any disciplinary action against the applicant by any state professional regulatory agency or professional organization; (1-5-88)

d. The disclosure of the issuance or denial of registration or licensure by any state or district regulatory body; (4-2-03)

e. Not less than two (2) certificates of recommendation from persons having personal knowledge of the applicant's character; (1-5-88)

f. One (1), three by four inch (3" x 4") or smaller unmounted photograph of the applicant's head and shoulders, taken not more than one (1) year before the application date; (3-29-10)

g. Such other information as deemed necessary for the Board to identify and evaluate

the applicant's credentials; and (1-5-88)

h. A copy of the application to write the qualifying exam and the date the examination is scheduled. (1-5-88)

02. Licensure by Endorsement. An applicant may be eligible for licensure without examination if he or she meets all of the other qualifications prescribed in Section 54-3709, Idaho Code, and also holds a current valid license or registration from some other state, territory or district of the United States, or certified by the National Board for Certification in Occupational Therapy providing they meet Idaho standards and are equivalent to the requirements for licensure pursuant to these rules. (3-29-10)

a. Each applicant for licensure by endorsement shall submit a completed written application to the Board on forms prescribed by the Board, together with the application fee. The application shall be verified, under oath, and contain the specific information in Subsection 021.01.a. through 021.01.g. of these rules. (3-29-10)

b. Proof of such licensure or registration shall be verified in a manner acceptable to the Board. (1-5-88)

03. Limited Permit. The Board may issue a Limited Permit to a graduate occupational therapist or graduate occupational therapy assistant who meets the requirements set forth by Sections 54-3706(1) and 54-3706(2), Idaho Code, who has not yet passed the examination as required in Paragraph 020.04.a. of these rules. (3-29-10)

a. Each person applying for a limited permit must submit a completed written application to the Board on forms prescribed by the Board, together with the required fee. (3-29-10)

b. A Limited Permit shall only allow a person to practice occupational therapy in association with and under the supervision of a licensed occupational therapist. (1-5-88)

c. A Limited Permit shall be valid ~~only until the person is granted or denied a license under Section 54-3710, Idaho Code, or until the results of the examination are available to the Board, whichever occurs first; provided however, a Limited Permit shall not be effective for more than~~ six (6) months from the date of issue. ~~(3-29-10)()~~

d. A Limited Permit may ~~only be renewed once~~ extended by the Board for good cause. ~~(1-5-88)()~~

04. Temporary License. The Board may issue a temporary license to a person applying for licensure as an occupational therapist or an occupational therapy assistant if the person is currently licensed and in good standing to practice in another jurisdiction and meets that jurisdiction's requirements for licensure by endorsement. (3-29-10)

a. Each person applying for temporary licensure must submit a completed written application to the Board on forms prescribed by the Board, together with the required fee. (3-29-10)

b. A temporary license shall automatically expire once the Board has processed the person's application for licensure and issued or denied the applied-for license, or in six (6) months after the date on which the Board issued the temporary license, whichever is sooner. (3-29-10)

05. Personal Interview. The Board may, at its discretion, require the applicant to appear for a personal interview. (1-5-88)

06. Occupational Therapists Practicing in Idaho on Effective Date of These Rules. All persons practicing occupational therapy in Idaho and holding American Occupational Therapy Certification Board (AOTCB) registration on January 5, 1988, shall qualify for license by endorsement. (3-29-10)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.13.01 - RULES GOVERNING THE PHYSICAL THERAPY LICENSE BOARD

DOCKET NO. 24-1301-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is acted on by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-2206, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The Board of Physical Therapy is amending Rule 016.02.c. to retain a portion of the proposed rule that was stricken due to comments received on the proposed rule.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the August 7, 2013 Idaho Administrative Bulletin, [Vol. 13-8, pages 288 through 290](#).

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Cherie Simpson at 208 334-3233.

DATED this 5th day of November, 2013.

Tana Cory, Bureau Chief
Bureau of Occupational Licenses
700 W State St.
P O Box 83720
Boise, ID 83720-0063
Phone: 208-334-3233
Fax: 208-334-3945

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-2206, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 21, 2013.

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

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

The Physical Therapy Licensure Board is revising the supervision rule to increase the number of patient visits or the amount of time before the supervisor must re-evaluate the patient and the plan of care being provided by a Physical Therapy Assistant. This added flexibility in the supervision of assistants will especially benefit those patients and physical therapists practicing in rural areas.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the Board desires to revise its supervision rule to provide more flexibility when supervising assistants. The Board has worked with the state association on this rule.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at 208 334-3233.

Anyone may submit written comments regarding this proposed rulemaking. All written

comments must be directed to the undersigned and must be delivered on or before August 28, 2013.

DATED this 24th day of June, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-1301-1301

016. SUPERVISION (RULE 16).

A physical therapist shall supervise and be responsible for patient care given by physical therapist assistants, supportive personnel, physical therapy students, and physical therapist assistant students. (3-19-07)

01. Procedures and Interventions Performed Exclusively by Physical Therapist.

The following procedures and interventions shall be performed exclusively by a physical therapist: (3-19-07)

- a.** Interpretation of a referral for physical therapy if a referral has been received. (3-19-07)
- b.** Performance of the initial patient evaluation and problem identification including a diagnosis for physical therapy and a prognosis for physical therapy. (3-19-07)
- c.** Development or modification of a treatment plan of care which is based on the initial evaluation and which includes long-term and short-term physical therapy treatment goals. (3-19-07)
- d.** Assessment of the competence of physical therapist assistants, physical therapy students, physical therapist assistant students, and supportive personnel to perform assigned procedures, interventions and routine tasks. (3-19-07)
- e.** Selection and delegation of appropriate portions of treatment procedures, interventions and routine physical therapy tasks to the physical therapist assistants, physical therapy students, physical therapist assistant students, and supportive personnel. (3-19-07)
- f.** Performance of a re-evaluation when any change in a patient's condition occurs that is not consistent with the physical therapy treatment plan of care, patient's anticipated progress, and physical therapy treatment goals. (3-19-07)
- g.** Performance and documentation of a discharge evaluation and summary of the physical therapy treatment plan. (3-19-07)

02. Supervision of Physical Therapist Assistants. A physical therapist assistant shall be supervised by a physical therapist by no less standard than general supervision. (3-19-07)

a. A physical therapist assistant shall not change a procedure or intervention unless such change of procedure or intervention has been included within the treatment plan of care as set forth by a physical therapist. (3-19-07)

b. A physical therapist assistant may not continue to provide treatment as specified under a treatment plan of care if a patient's condition changes such that further treatment necessitates a change in the established treatment plan of care unless the physical therapist assistant has consulted with the supervising physical therapist prior to the patient's next appointment for physical therapy, and a re-evaluation is completed by the supervising physical therapist. (3-19-07)

c. ~~A patient re-evaluation must be performed and documented by the~~ The supervising physical therapist ~~a minimum of~~ shall provide direct personal contact with the patient and assess the plan of care on or before every ~~five ten~~ (510) visits or once a week if treatment is performed more than once per day ~~but no less often than once every sixty (60) days. The supervising therapist's assessment shall be documented in the patient record.~~ (3-19-07) ()

d. A physical therapist assistant may refuse to perform any procedure, intervention, or task delegated by a physical therapist when such procedure, intervention, or task is beyond the physical therapist assistant's skill level or scope of practice standards. (3-19-07)

e. A physical therapist shall not be required to co-sign any treatment related documents prepared by a physical therapist assistant, unless required to do so in accordance with law, or by a third-party. (3-19-07)

03. Supervision of Supportive Personnel. Any routine physical therapy tasks performed by supportive personnel shall require direct personal supervision. (3-19-07)

04. Supervision of Physical Therapy and Physical Therapist Assistant Students. Supervision of physical therapy students and physical therapist assistant students shall require direct supervision. (3-19-07)

a. A physical therapy student shall only be supervised by the direct supervision of a physical therapist. (3-19-07)

b. A physical therapy student shall be required to sign all treatment notes with the designation "SPT" after their name, and all such signatures shall require the co-signature of the supervising physical therapist. (3-19-07)

c. A physical therapist assistant student shall be required to sign all treatment notes with the designation "SPTA" after their name, and all such signatures shall require the co-signature of the supervising physical therapist or supervising physical therapist assistant. (3-19-07)

05. Supervision Ratios. (3-19-07)

a. At no time during the treatment of a patient or patients for physical therapy shall the number of physical therapist assistants providing such treatment be more than twice in number of such supervising physical therapist(s) providing physical therapy treatment at any physical therapy practice or site. (3-19-07)

b. At no time during the treatment of a patient or patients for physical therapy shall the number of supportive personnel performing routine physical therapy tasks be more than twice in number of such supervising physical therapist(s) or supervising physical therapist assistant(s) providing physical therapy treatment at any physical therapy practice or site. (3-19-07)

c. At no time during the treatment of a patient or patients for physical therapy shall the number of physical therapy students performing delegated supervised physical therapy tasks be more than twice in number of such supervising physical therapist(s) providing physical therapy treatment at any physical therapy practice or site. (3-19-07)

d. At no time during the treatment of a patient or patients for physical therapy shall the number of physical therapist assistant students performing delegated supervised physical therapy tasks be more than twice in number of such supervising physical therapist(s) or supervising physical therapist assistant(s) providing physical therapy treatment at any physical therapy practice or site. (3-19-07)

e. At no time during the treatment of a patient or patients for physical therapy shall the number of physical therapist assistants, physical therapy students, physical therapist assistants students, and supportive personnel, or a combination thereof, performing delegated supervised physical therapy or routine physical therapy tasks be more than three (3) times in number of such physical therapist(s) providing physical therapy treatment at any physical therapy practice or site; nor shall the number of physical therapist assistant students or supportive personnel, or a combination thereof, performing delegated and supervised physical therapy tasks or routine physical therapy tasks be more than twice in number of such physical therapist assistant(s) providing physical therapy treatment at any physical therapy practice or site. (3-19-07)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.14.01 - RULES OF THE STATE BOARD OF SOCIAL WORK EXAMINERS

DOCKET NO. 24-1401-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is acted on by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-3204, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 4, 2013 Idaho Administrative Bulletin, [Vol. 13-9, pages 186 through 188](#).

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cherie Simpson at 208-334-3233.

DATED this 28th day of October, 2013.

Tana Cory, Bureau Chief
Bureau of Occupational Licenses
700 W State St.
P O Box 83720
Boise, ID 83720-0063
Phone: 208-334-3233
Fax: 208-334-3945

**THE FOLLOWING NOTICE WAS PUBLISHED WITH
THE TEMPORARY AND PROPOSED RULE**

EFFECTIVE DATE: The effective date of the temporary rule is **June 19, 2013**.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Section 54-3204, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 18, 2013.

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

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

This rule change will allow experience obtained in any state to qualify for supervisor registration. The current rule affects the ability of those social workers moving to Idaho from other states to immediately qualify as a supervisor. The Board is also clarifying that the supervision rule only applies to those individuals in Idaho pursuing licensure. The Board does not have any jurisdiction over individuals practicing outside of Idaho.

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

The Board of Social Work Examiners is revising its supervisor registration rule to allow the experience obtained in other states to qualify for registration. Currently, only Idaho experience qualifies. The Board is also clarifying when postgraduate supervision is required.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rule being amended confers a benefit to potential supervisors and clarifies when post graduate supervision of an individual is necessary.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Cherie Simpson at 208 334-3233.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 25, 2013.

DATED this 9th day of August, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-1401-1301

211. SOCIAL WORK SUPERVISOR REGISTRATION (RULE 211).

Idaho licensed social workers shall be registered with the Board in order to provide postgraduate supervision for those individuals **in Idaho** pursuing licensure ~~in Idaho~~ as a clinical social worker. (4-4-13)()

01. Requirements for Registration. (3-14-05)

a. Document at least two (2) years experience as ~~an Idaho~~ licensed clinical social worker. (4-4-13)()

b. Have not been the subject of any disciplinary action for five (5) years prior to application for registration. (3-14-05)

c. Document fifteen (15) contact hours of education in clinical supervisor training as approved by the Board, or if previously registered as a supervisor with the Board, document six (6) hours of education in advanced supervisor training as approved by the Board. (4-4-13)

02. Registration. A supervisor applicant shall submit to the Bureau a completed application form as approved by the board. (3-14-05)

a. Upon receipt of a completed application verifying compliance with the requirements for registration as a supervisor, the applicant shall be registered as a supervisor. (3-14-05)

b. A supervisor's registration shall remain valid only so long as the individual's clinical social worker license remains current and in good standing. (4-4-13)

03. Renewal. Subject to the conditions in Paragraph 211.03.c., a supervisor's registration is valid for a term of five (5) years. To renew a supervisor registration, the registered supervisor must submit to the Board a complete application for registration renewal on forms approved by the Board and meet the following requirements: (4-4-13)

a. Hold an active Idaho clinical social worker license which has not been subject to discipline and is current and in good standing; and (4-4-13)

b. Document six (6) hours of continuing education in advanced supervisor training as approved by the Board and completed within the previous five (5) years. (4-4-13)

c. For supervisors registered prior to the effective date of this rule subsection 211.03., the following renewal requirements and conditions apply: (4-4-13)

i. A registered supervisor who has been registered for at least five (5) years prior to July 1, 2013 must submit a complete application for registration renewal and meet the renewal requirements by July 1, 2015. (4-4-13)

ii. A registered supervisor who has been registered for less than five (5) years prior to July 1, 2013 must submit a complete application for registration renewal and meet the renewal requirements by July 1, 2017. (4-4-13)

IDAPA 27 - BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-1207

NOTICE OF RULEMAKING - ADOPTION OF PENDING

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is acted on by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1717, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The original text of the proposed rule published in the October 2, 2013 Idaho Administrative Bulletin, [Vol. 13-10, pages 367 through 373](#).

These changes are non-substantive in nature and include grammar corrections, clarification of confusing language, and harmony of terms within IDAPA 27.01.01.

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

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

Minimal positive impact in the form of saved personnel time approving continuing pharmacy education.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Mark Johnston, Executive Director, at (208) 334-2356.

DATED this 1st day of November, 2013.

Mark Johnston, R.Ph.
Executive Director
Board of Pharmacy
1199 W. Shoreline Ln., Ste. 303
P. O. Box 83720
Boise, ID 83720-0067
Telephone: (208) 334-2356
FAX: (208) 334-3536

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-1717, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 16, 2013.

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

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

These rules would create harmony with 2013's House Bill No. 017 and other sections of Idaho Code, reduce the amount of and place more structure around Board approved continuing pharmacy education (CPE) thus requiring more CPE that is accredited with the Accreditation Counsel for Pharmacy Education or Continuing Medical Education, which are the two national agencies recognized by the federal Department of Education for such activities, mandate one (1) hour of CPE for all pharmacists engaged in the practice of sterile compounding, clarify that four (4) ounces is the maximum allowable quantity of a CV scheduled controlled substance that can be dispensed by a pharmacist without prescription, allow drugs to be stored and removed from a secured area adjacent to a pharmacy pursuant to many restrictions, and clarify that pharmacy structural security rules pertain to all pharmacies.

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

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

Minimal positive impact in the form of saved personnel time approving continuing pharmacy education.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notices of Intent to Promulgate Rules - Negotiated Rulemaking were published in the December 5, 2012 Idaho Administrative Bulletin, **Vol. 12-12**, page 62; January 2, 2013 Idaho Administrative Bulletin, **Vol. 13-1**, page 182; February 6, 2013 Idaho Administrative Bulletin, **Vol. 13-2**, page 28; March 6, 2013 Idaho Administrative Bulletin, **Vol. 13-3**, page 13; May 1, 2013 Idaho Administrative Bulletin, **Vol. 13-5**, page 83; July 3, 2013 Idaho Administrative Bulletin, **Vol. 13-7**, page 79; and August 7, 2013 Idaho Administrative Bulletin, **Vol. 13-8**, page 293.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Mark Johnston, Executive Director, at (208) 334-2356.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 23, 2013.

DATED this 30th day of August, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 27-0101-1207

029. PHARMACIST LICENSE OR REGISTRATION.

01. Practice in Idaho. All pharmacists practicing pharmacy in the state of Idaho must be licensed according to the Board's laws. (7-1-13)

02. Practice Into Idaho. Unless statutorily exempted, all pharmacists practicing pharmacy into the state of Idaho must be licensed or registered as follows: (7-1-13)

a. The following pharmacists must be licensed to provide centralized pharmacy services into Idaho: (7-1-13)

i. Pharmacists engaged in the independent practice of pharmacy across state lines as

defined by the Pharmacist Independent Practice Rule. (7-1-13)

ii. Pharmacists practicing from a central drug outlet that is not a pharmacy. (7-1-13)

iii. Pharmacists practicing from a remote office location. ()

b. The following pharmacists not licensed in Idaho must be registered to practice pharmacy into Idaho. (7-1-13)

i. The PIC or director of a nonresident central drug outlet or mail service pharmacy. (7-1-13)

ii. Pharmacists practicing from a pharmacy or its COE. (7-1-13)

(BREAK IN CONTINUITY OF SECTIONS)

035. PHARMACIST REGISTRATION TO PRACTICE PHARMACY INTO IDAHO.

To be registered to practice pharmacy into Idaho an applicant must submit an application in the manner and form prescribed by the Board including, but not limited to: (7-1-13)

01. Individual License Information. Current pharmacist licensure information in all other states, including each state of licensure and each license number; (7-1-13)

02. Facility License Information. The license or registration number of the facility ~~from~~ for which the applicant will be practicing. ~~(7-1-13)~~()

(BREAK IN CONTINUITY OF SECTIONS)

050. CPE: PROGRAM CRITERIA.

01. Board Approval of CPE Programs. The Board recognizes CPE program accreditation by ACPE and CME. CPE programs not accredited by either ACPE or CME must be approved by the Board. ~~Application for approval will require provision of the following information~~ A sponsoring organization, presenter or continuing education coordinator may apply to the Board for accreditation of a CPE program. An application must be submitted twenty-one (21) days in advance of the program and must include: ~~(3-21-12)~~()

a. The name of ~~provider or sponsor~~ the sponsoring organization, if applicable; ~~(3-21-12)~~()

b. The ~~type~~ title of ~~the~~ program offered; ~~(3-21-12)~~()

- c. The learning objectives and ~~Aa~~ description of the subject matter; ~~(3-21-12)~~()
- d. The ~~number of clock hours offered~~ method and materials for assessing the learning objectives; ~~(3-21-12)~~()
- e. The method of evaluating satisfactory completion of the program; ~~(3-21-12)~~()
- f. The dates, time schedule, number of clock hours and location of the program; and ~~(3-21-12)~~()
- g. The names and ~~qualifications~~ curriculum vitae or resume of instructors or other persons responsible for the delivery and content of the program; ~~and~~ ~~(3-21-12)~~()
- h. A copy of the materials to be offered to the participants and the program to be presented (electronic or hard copy), if applicable. ()

02. Postgraduate Education. A CPE program must consist of postgraduate education in one or more of the following general areas: (3-21-12)

- a. The socioeconomic and legal aspects of health care; (3-21-12)
- b. The properties and actions of drugs and dosage forms; or (3-21-12)
- c. The etiology, characteristics, and therapeutics of a disease state. (3-21-12)

03. Evidence of Satisfactory Completion. A CPE program must provide evidence of satisfactory completion by participants. (3-21-12)

04. Qualified Instruction. The program presenter must be qualified in the subject matter by education or experience. (3-21-12)

(BREAK IN CONTINUITY OF SECTIONS)

052. CPE: REQUIREMENTS.

Each pharmacist applicant for license renewal must annually complete fifteen (15) CPE hours. (4-4-13)

01. ACPE or CME. At a minimum, ~~eight~~ twelve (~~8~~12) of the CPE hours obtained must be all or a combination of ACPE or CME accredited programs. ACPE accredited activities must have a participant designation of "P" (for pharmacist) as the suffix of the ACPE universal program number. ~~(4-4-13)~~()

02. Pharmacy Law. One (1) of the CPE hours obtained must ~~be ACPE accredited or Board approved jurisprudence (pharmacy law) programs~~ address federal, state or local law effecting the practice of pharmacy. ~~(4-4-13)~~()

03. Board Approved. A maximum of ~~six~~ **three** (~~6~~**3**) of the CPE hours obtained may be Board-approved programs not accredited through ACPE or CME. (~~4-4-13~~)()

04. Live Attendance. Three (3) of the CPE hours obtained must be by attendance at live or synchronous online CPE programs. (4-4-13)

05. Immunizer Qualification. To maintain qualification to administer immunizations, a minimum of one (1) of the ACPE-approved CPE hours must be related to vaccines, immunizations, or their administration. (4-4-13)

06. Sterile Compounding Requirement. To engage in the practice of sterile compounding a minimum of one (1) of the CPE hours must be ACPE accredited and related to the practice of sterile compounding. ()

067. Carryover of Certain Unused Units. CPE hours accrued during June of a licensing period may be carried over into the next licensing period to the extent that a pharmacist's total CPE hours for the current licensing period exceed the total CPEs hours required by these rules. (4-4-13)

078. New Pharmacist Exemption. Recent pharmacist graduates applying for the first license renewal are not required to complete or certify the annual CPE requirements. (3-21-12)

~~0539. CPE.~~ **Requirements for Dual Licenses.** ()

~~01a. Idaho Licensee.~~ An Idaho-licensed pharmacist residing in another state must meet Idaho CPE requirements to be granted an Idaho license renewal. (~~3-21-12~~)()

~~02b. Approval.~~ CPE programs attended by an Idaho-licensed pharmacist for purposes of satisfying licensing requirements of another state must be accredited by either ACPE or CME or must be approved by the Board to also be recognized for purposes of renewal of the pharmacist's Idaho license. (~~3-21-12~~)()

0543. -- 059. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

111. PRESCRIPTION DRUG ORDER: MINIMUM REQUIREMENTS.

A prescription drug order must comply with applicable requirements of federal law and, except as differentiation is permitted for a drug order, must include at least the following: (3-21-12)

01. Patient's Name. The patient's name and: (3-21-12)

a. If for a controlled substance, the patient's full name and address; and (3-21-12)

- b.** If for an animal, the species. (3-21-12)
- 02. Date.** The date issued. (3-21-12)
- 03. Drug Information.** The drug name, strength, quantity, and if for a controlled substance, the dosage form. (3-21-12)
- 04. Directions.** The directions for use. (3-21-12)
- 05. Prescriber Information.** The name and, if for a controlled substance, the address and DEA registration number of the prescriber. (3-21-12)
- 06. Signature.** If paper, the pre-printed, stamped, or hand-printed name and written signature of the prescriber, or if statutorily allowed, the prescriber's agent's signature, and if electronic, the prescriber's electronic signature. (~~3-21-12~~)()

112. DRUG ORDER: MINIMUM REQUIREMENTS.

A drug order must comply with applicable requirements of federal law and must include at least the following:

- (3-21-12)
- 01. Patient's Name.** The patient's name. (3-21-12)
- 02. Date.** The date issued. (3-21-12)
- 03. Drug Information.** The drug name, strength, and route of administration. (3-21-12)
- 04. Directions.** The directions for use. (3-21-12)
- 05. Prescriber Information.** The name of the prescriber. (3-21-12)
- 06. Signature.** If written, the signature of the prescriber or if statutorily allowed, the prescriber's agent. (~~3-21-12~~)()

(BREAK IN CONTINUITY OF SECTIONS)

202. CONTROLLED SUBSTANCES: NON-PRESCRIPTION DISPENSING.

A Schedule V non-prescription controlled substance may be dispensed to a retail purchaser as permitted or restricted by these rules. (3-21-12)

- 01. Dispensing by a Technician Prohibited.** Technicians are prohibited from dispensing a non-prescription controlled substance even if under the direct supervision of a pharmacist, but may transact the sale and deliver the product after the pharmacist has fulfilled his professional and legal responsibilities. (3-21-12)

02. Restricted Quantity. No more than four (4) ounces of liquid containing a maximum of two hundred (200) milligrams of codeine per one hundred (100) milliliters or per one hundred (100) grams may be distributed at retail to the same purchaser in any forty-eight (48) hour period. ~~(3-21-12)~~()

03. Purchaser's Age. A purchaser of a non-prescription controlled substance must be at least eighteen (18) years of age. (3-21-12)

04. Identification Required for Purchase. The pharmacist must obtain positive identification as required by these rules that, if appropriate, includes proof of age of the purchaser of a non-prescription Schedule V controlled substance. (3-21-12)

05. Bound Record Book and Patient Signature Required. A bound record book must be used to document sales of non-prescription Schedule V controlled substances and must record the following: (3-21-12)

- a. The name and address of the purchaser; (3-21-12)
- b. The name and quantity of the controlled substance purchased; (3-21-12)
- c. The date of the purchase; (3-21-12)
- d. The name or initials of the pharmacist who dispensed the substance to the purchaser; and (3-21-12)
- e. The signature of the purchaser. (3-21-12)

(BREAK IN CONTINUITY OF SECTIONS)

604. PHARMACY PRODUCT STORAGE AND REMOVAL.

Prescription drugs, devices, and other products restricted to sale or dispensing by, or under the supervision of, a pharmacist must be stored in the pharmacy and must not be sold, delivered, or otherwise removed from a pharmacy unless a pharmacist is present, except: ()

01. Emergency Drug Access and Pharmacist Absence. ~~As~~ allowed by these rules for emergency access to an institutional pharmacy; ()

02. Institutional Facility Alternative Storage. In an institutional facility these restricted products may also be stored in an alternative designated area that is appropriately equipped to ensure compliance with drug product storage requirements, to provide adequate security and protection from diversion, and that otherwise complies with applicable requirements of these rules; ~~(3-21-12)~~()

03. Storage for Delivery. Filled prescriptions may be picked up for delivery from a

pharmacy when the pharmacy is closed for business if: ()

a. The prescriptions are placed in a secured delivery area equipped with adequate security, including an alarm or comparable monitoring system, to prevent unauthorized entry, theft and diversion;()

b. The secured delivery area has walls that extend to the roof *and* solid core or metal doors, and all doors and other access points must be equipped with locking devices and be constructed in a manner *so* that the hinge hardware is accessible only from inside the secured delivery area; ()

c. The secured delivery area appropriately safeguards product integrity in accordance with USP-NF requirements; ()

d. The secured delivery area is attached or located adjacent to the pharmacy that filled the prescriptions; ()

e. The PIC, or a pharmacist designated by the PIC, and the approved transport agent solely have access to the secure delivery area. Two (2) factor credentialing is required for entry, which must include two (2) of the following: ()

i. Something you know (a knowledge factor); ()

ii. Something you have (a hard token stored separately from the computer being accessed); and ()

iii. Something you are (biometric information); ()

f. The pharmacy has a means of recording the time of entry and the identity of all persons who access the secured delivery area; ()

g. The pharmacy maintains immediately retrievable records of all persons who have accessed the secured delivery area and each prescription stored and removed for delivery; ()

h. The pharmacy maintains written policies and procedures for secured delivery *area* storage and removal of prescriptions; and()

i. The PIC of a pharmacy that ships drugs by common carrier *must* require the common carrier to conduct criminal background checks on its employees who have access to the secured delivery area.()

04. Qualified Returns to the Secured Delivery Area. A pharmacist or a pharmacy, by means of its agent, may accept the return of the following drugs or devices to the secured delivery area: ()

a. Emergency kits; ()

b. Prescriptions that were unsuccessfully delivered by the pharmacy, a pharmacist, or its agent; and ()

c. Those deemed qualified for return pursuant to the Restricted Return of Drugs or Devices rule. ()

605. PHARMACY SECURITY.

01. Basic Security Standards. A pharmacy must be constructed and equipped with adequate security, and at least while closed, utilize an alarm or other comparable monitoring system to protect its equipment, records, and supply of drugs, devices, and other restricted sale items from unauthorized access, acquisition, or use. Pharmacies without an alarm or other monitoring system as of the effective date of this rule must comply with this rule upon completion of a structural remodel. (3-21-12)

02. Non-Institutional Pharmacy Security During Pharmacist Absence. A non-institutional pharmacy must be closed for business and secured during all times a pharmacist is not present except: (4-4-13)

a. If a technician or student pharmacist is on to duty, to allow brief pharmacist absences within the business establishment; or (4-4-13)

b. To perform professional services in the peripheral areas immediately outside of the pharmacy. (4-4-13)

03. Structural Security Requirements. If a pharmacy is located within an establishment that is open to the public for business at times when a pharmacist is not present, the pharmacy must be totally enclosed in a manner sufficient to provide adequate security for the pharmacy, as required by this rule and approved by the Board. All pharmacies must meet the following security requirements: (~~3-21-12~~)()

a. Pharmacy walls must extend to the roof or the pharmacy must be similarly secured from unauthorized entry. (3-21-12)

b. Solid core or metal doors are required for new or remodeled pharmacies after the effective date of this rule. (4-4-13)

c. Doors and other access points must be constructed in a manner that the hinge hardware is accessible only from inside of the pharmacy and must be equipped with locking devices. (3-21-12)

d. If used, a “drop box” or “mail slot” allowing delivery of prescription drug orders to the pharmacy during hours closed must be appropriately secured against theft, and the pharmacy hours must be prominently visible to the person depositing the prescription drug order. Prescriptions must not be accepted for delivery to the pharmacy or for depositing in the drop box by non-pharmacy employees of a retail establishment. (3-21-12)

04. Restricted Access to the Pharmacy. No one must be allowed entrance to the

closed and secured pharmacy unless under the direct supervision of a pharmacist or except as permitted by these rules for an institutional pharmacy. (3-21-12)

IDAPA 27 - BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-1301

NOTICE OF RULEMAKING - ADOPTION OF PENDING

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is acted on by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1717, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The original text of the proposed rule published in the October 2, 2013 Idaho Administrative Bulletin, [Vol. 13-10, pages 374 through 386](#).

In addition to non-substantive changes, such as changes to improve grammar, condense language, and clarify confusing language, these changes rename a subsection, add an exception to the definition of compounding, and expand who may initial certain documents.

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

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

The Board envisions requesting about ten thousand dollars (\$10,000) to send the Board's inspectors to sterile compounding training.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Mark Johnston, Executive Director, at (208) 334-2356.

DATED this 1st day of November, 2013.

Mark Johnston, R.Ph.
Executive Director
Board of Pharmacy
1199 W. Shoreline Ln., Ste. 303
P. O. Box 83720
Boise, ID 83720-0067
Telephone: (208) 334-2356
FAX: (208) 334-3536

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-1717, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 16, 2013.

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

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

The New England Compounding Center tragedy, whereby 52 Americans have died so far from tainted injectible compounded product, has highlighted the need for tighter compounding regulation. This rulemaking establishes standards for the compounding of drugs, including general compounding standards that regulate ingredients, prohibited acts, equipment, compromised drugs, and hazardous drugs, scope of practice that regulates compounding of commercially available drugs, anticipatory compounding, compounding and distributing for office use, compounding for research, and reconstitution exceptions, and drug compounding controls that regulates policies and procedures, compounding accuracy, certain records, and labeling. These rule changes also expand sterile product preparation rules, including defining products that require sterilization, compounding responsibilities, environmental controls, equipment, sterile hazardous drugs, documentation requirements, and policy and procedures.

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

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

The Board envisions requesting about ten thousand dollars (\$10,000) to send the Board's inspectors to sterile compounding training.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted under Docket No. 27-0101-1207. The Notices of Intent to Promulgate Rules - Negotiated Rulemaking were published in the December 5, 2012 Idaho Administrative Bulletin, **Vol. 12-12**, page 62; January 2, 2013 Idaho Administrative Bulletin, **Vol. 13-1**, page 182; February 6, 2013 Idaho Administrative Bulletin, **Vol. 13-2**, page 28; March 6, 2013 Idaho Administrative Bulletin, **Vol. 13-3**, page 13; May 1, 2013 Idaho Administrative Bulletin, **Vol. 13-5**, page 83; July 3, 2013 Idaho Administrative Bulletin, **Vol. 13-7**, page 79; and August 7, 2013 Idaho Administrative Bulletin, **Vol. 13-8**, page 293.

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

The New England Compounding Center tragedy, whereby 52 Americans have died so far from tainted injectible compounded product, has highlighted the need for tighter compounding regulation. The FDA's Compliance Policy Guidance for FDA Staff and Industry, Sec. 460.200, Pharmacy Compounding, Appendix A (Reissued May 29, 2002) has been incorporated by reference into these rules to prohibit the compounding of drugs for human use that were withdrawn or removed from the market for safety reasons.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Mark Johnston, Executive Director, at (208) 334-2356.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 23, 2013.

DATED this 30th day of August, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 27-0101-1301

004. INCORPORATION BY REFERENCE.

~~No documents have~~ FDA's Compliance Policy Guidance for FDA Staff and Industry, Sec. 460.200, Pharmacy Compounding, Appendix A (Reissued May 29, 2002) has been incorporated by reference into these rules. ~~(3-21-12)(_____)~~

(BREAK IN CONTINUITY OF SECTIONS)

010. DEFINITIONS AND ABBREVIATIONS (A -- I).

01. Accredited School or College of Pharmacy. A school or college that meets the minimum standards of the ACPE and appears on its list of accredited schools or colleges of pharmacy. (3-21-12)

02. ACPE. Accreditation Council for Pharmacy Education. (3-21-12)

03. Acute Care Hospital. A facility in which concentrated medical and nursing care is provided by, or under the supervision of, physicians on a twenty-four (24) hour basis to inpatients experiencing acute illnesses. (3-21-12)

04. ADS -- Automated Dispensing and Storage. A mechanical system that performs operations or activities, other than compounding or administration, relative to the storage, packaging, dispensing, or distribution of drugs and that collects, controls, and maintains transaction information. (3-21-12)

05. CDC. United States Department of Health and Human Services, Centers for Disease Control and Prevention. (3-21-12)

06. Central Drug Outlet. A resident or nonresident pharmacy, drug outlet or business entity employing or contracting pharmacists to perform centralized pharmacy services. (7-1-13)

07. Central Pharmacist. A pharmacist performing centralized pharmacy services. (7-1-13)

08. Central Pharmacy. A pharmacy performing centralized pharmacy services. (7-1-13)

09. Centralized Pharmacy Services. The processing by a central drug outlet or central pharmacist of a request from another pharmacy to fill, refill, or dispense a prescription drug order, perform processing functions, or provide cognitive or pharmaceutical care services. Each function may be performed by the same or different persons and at the same or different locations. (7-1-13)

10. Change of Ownership. A change of majority ownership or controlling interest of a drug outlet licensed or registered by the Board. (3-21-12)

11. Charitable Clinic or Center -- Authorized Personnel. A person designated in writing and authorized by the qualifying charitable clinic or center's medical director or consultant pharmacist to perform specified duties within the charitable clinic or center under the supervision of a pharmacist, physician, dentist, optometrist, physician assistant, or an advanced

- practice professional nurse with prescriptive authority. (3-21-12)
- 12. Chart Order.** A lawful drug order for a drug or device entered on the chart or a medical record of an inpatient or resident of an institutional facility. (3-21-12)
- 13. CME.** Continuing medical education. (3-21-12)
- 14. COE -- Central Order Entry.** A pharmacy that processes information related to the practice of pharmacy, engages solely in centralized prescription processing but from which drugs are not dispensed, is physically located outside the institutional pharmacy of a hospital, and is part of a hospital system. (3-21-12)
- 15. Collaborative Pharmacy Practice.** A pharmacy practice whereby one (1) or more pharmacists jointly agree to work under a protocol authorized by one (1) or more prescribers to provide patient care and DTM services not otherwise permitted to be performed by a pharmacist under specified conditions or limitations. (3-21-12)
- 16. Collaborative Pharmacy Practice Agreement.** A written agreement between one (1) or more pharmacists and one (1) or more prescribers that provides for collaborative pharmacy practice. (3-21-12)
- 17. Continuous Quality Improvement Program.** A system of standards and procedures to identify and evaluate quality-related events and to constantly enhance the efficiency and effectiveness of the structures and processes of a pharmacy system. (3-21-12)
- 18. Correctional Facility.** Any place used for the confinement of persons charged with or convicted of an offense or otherwise confined under a court order. (4-4-13)
- 19. CPE.** Continuing pharmacy education. (3-21-12)
- 20. DEA.** United States Drug Enforcement Administration. (3-21-12)
- 21. Distributor.** A supplier of drugs manufactured, produced, or prepared by others to persons other than the ultimate consumer. (3-21-12)
- 22. DME.** Durable medical equipment. (3-21-12)
- 23. Drug Order.** A prescription drug order issued in the unique form and manner permitted for a patient or resident of an institutional facility or as permitted for other purposes by these rules. Unless specifically differentiated, rules applicable to a prescription drug order are also applicable to a drug order. (3-21-12)
- 24. Drug Product Selection.** The act of selecting either a brand name drug product or its therapeutically equivalent generic. (3-21-12)
- 25. Drug Product Substitution.** Dispensing a drug product other than prescribed. (4-4-13)

26. DTM -- Drug Therapy Management. Selecting, initiating, or modifying drug treatment pursuant to a collaborative practice agreement. (3-21-12)

27. Emergency Drugs. Drugs required to meet the immediate therapeutic needs of one (1) or more patients that are not available from any other authorized source in sufficient time to avoid risk of harm due to the delay that would result from obtaining the drugs from another source. (3-21-12)

28. Executive Director. The Idaho State Board of Pharmacy executive director created by Sections 54-1713 and 54-1714, Idaho Code. (3-21-12)

29. FDA. United States Food and Drug Administration. (3-21-12)

30. Flavoring Agent. An additive used in food or drugs when the additive is used in accordance with the principles of good pharmacy practices and in the minimum quantity required to produce its intended effect. (3-21-12)

31. Floor Stock. Drugs or devices not labeled for a specific patient that are maintained at a nursing station or other department of an institutional facility, excluding the pharmacy, for the purpose of administering to patients of the facility. (3-21-12)

32. FPGEC. Foreign Pharmacy Graduate Examination Committee. (4-4-13)

33. Hazardous Drug. Any drug listed as such by the National Institute for Occupational Safety and Health or any drug identified by at least one of the following criteria: ()

a. Carcinogenicity; ()

b. Teratogenicity or developmental toxicity; ()

c. Reproductive toxicity in humans; ()

d. Organ toxicity at low doses in humans or animals; ()

e. Genotoxicity; or ()

f. New drugs that mimic existing hazardous drugs in structure or toxicity. ()

34. High Risk Sterile Product Preparation. A sterile drug product that is compounded from nonsterile components, containers, or equipment and requires terminal sterilization. ()

335. HIPAA. Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191). (3-21-12)

346. Hospital System. A hospital or hospitals and at least one (1) on-site institutional

pharmacy under common ownership. A hospital system may also include one (1) or more COE pharmacies under common ownership. (3-21-12)

357. Idaho State Board of Pharmacy or Idaho Board of Pharmacy. The terms Idaho State Board of Pharmacy, Idaho Board of Pharmacy, State Board of Pharmacy, and Board of Pharmacy are deemed synonymous and are used interchangeably to describe the entity created under the authority of Title 54, Chapter 17, Idaho Code. Unless specifically differentiated, “the Board” or “Board” also means the Idaho State Board of Pharmacy. (3-21-12)

368. Individually Identifiable Health Information. Information that is a subset of health information, including demographic information, collected from an individual and that: (3-21-12)

a. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (3-21-12)

b. Relates to the past, present, or future physical or mental health or condition of an individual; or the past, present, or future payment for the provision of health care to an individual that: (3-21-12)

i. Identifies the individual; or (3-21-12)

ii. With respect to which there is a reasonable basis to believe the information can be used to identify the individual. (3-21-12)

379. Institutional Pharmacy. A pharmacy located in an institutional facility. (3-21-12)

011. DEFINITIONS AND ABBREVIATIONS (J -- R).

01. LTCF -- Long-Term Care Facility. An institutional facility that provides extended health care to resident patients. (3-21-12)

02. Mail Service Pharmacy. A nonresident pharmacy that ships, mails, or delivers by any lawful means a dispensed legend drug to residents in this state pursuant to a legally issued prescription drug order and ensures the provision of corresponding related pharmaceutical care services required by law. (7-1-13)

03. MPJE. Multistate Pharmacy Jurisprudence Exam. (3-21-12)

04. MTM -- Medication Therapy Management. A distinct service or group of services that optimize therapeutic outcomes for individual patients. MTM services are independent of, but can occur in conjunction with, the provision or administration of a drug or a device and encompass a broad range of activities and responsibilities. The MTM service model in pharmacy practice includes the following five core elements: (3-21-12)

a. Medication therapy review; (3-21-12)

b. Personal medication record; (3-21-12)

- c.** Medication-related action plan; (3-21-12)
- d.** Intervention or referral, or both; (3-21-12)
- e.** Documentation and follow-up. (3-21-12)
- 05.** **NABP.** National Association of Boards of Pharmacy. (3-21-12)
- 06.** **NAPLEX.** North American Pharmacists Licensure Examination. (3-21-12)
- 07.** **NDC.** National Drug Code. (3-21-12)
- 08.** **Non-Institutional Pharmacy.** A pharmacy located in a drug outlet that is not an institutional facility. (3-21-12)
- 09.** **Parenteral Admixture.** The preparation and labeling of sterile products intended for administration by injection. (3-21-12)
- 10.** **Pharmaceutical Care Services.** A broad range of pharmacist-provided cognitive services, activities and responsibilities intended to optimize drug-related therapeutic outcomes for patients. Pharmaceutical care services may be performed independent of, or concurrently with, the dispensing or administration of a drug or device and encompasses services provided by way of DTM under a collaborative practice agreement, pharmacotherapy, clinical pharmacy practice, pharmacist independent practice, and MTM. Except as permitted pursuant to a collaborative practice agreement, nothing in these rules allows a pharmacist, beyond what is statutorily allowed, to engage in the unlicensed practice of medicine or to diagnose, prescribe, or conduct physical examinations. Pharmaceutical care services are not limited to, but may include one (1) or more of the following, according to the individual needs of the patient: (4-4-13)

 - a.** Performing or obtaining necessary assessments of the patient’s health status, including the performance of health screening activities that may include, but are not limited to, obtaining finger-stick blood samples; (3-21-12)
 - b.** Reviewing, analyzing, evaluating, formulating or providing a drug utilization plan; (3-21-12)
 - c.** Monitoring and evaluating the patient’s response to drug therapy, including safety and effectiveness; (3-21-12)
 - d.** Performing a comprehensive drug review to identify, resolve, and prevent drug-related problems, including adverse drug events; (3-21-12)
 - e.** Documenting the care delivered; (3-21-12)
 - f.** Communicating essential information or referring the patient when necessary or appropriate; (3-21-12)

- g.** Providing counseling education, information, support services, and resources applicable to a drug, disease state, or a related condition or designed to enhance patient compliance with therapeutic regimens; (3-21-12)
- h.** Conducting a drug therapy review consultation with the patient or caregiver; (3-21-12)
- i.** Preparing or providing information as part of a personal health record; (3-21-12)
- j.** Identifying processes to improve continuity of care and patient outcomes; (3-21-12)
- k.** Providing consultative drug-related intervention and referral services; (3-21-12)
- l.** Coordinating and integrating pharmaceutical care services within the broader health care management services being provided to the patient; and (3-21-12)
- m.** Other services as allowed by law. (3-21-12)
- 11. Pharmacist Extern.** A person enrolled in an accredited school or college of pharmacy who is pursuing a professional degree in pharmacy. (4-4-13)
- 12. Pharmacist Intern.** A person who has successfully completed a course of study at an accredited school or college of pharmacy, has received a professional degree in pharmacy, and is obtaining practical experience under the supervision of a pharmacist. (3-21-12)
- 13. Pharmacy Operations.** Activities related to and including the preparation, compounding, distributing, or dispensing of drugs or devices from a pharmacy. (3-21-12)
- 14. PHI -- Protected Health Information.** Individually identifiable health information that is: (3-21-12)
- a.** Transmitted by electronic media (as defined by the HIPAA Privacy Rule at 45 CFR 160.103); (3-21-12)
- b.** Maintained in electronic media; and (3-21-12)
- c.** Transmitted or maintained in any other form or medium. (3-21-12)
- d.** PHI excludes individually identifiable health information in: (3-21-12)
- i.** Education records covered by the Family Education Right and Privacy Act, as amended (20 U.S.C. Section 1232g); (3-21-12)
- ii.** Records described at 20 U.S.C. Section 1232g(a)(4)(B)(iv); and (3-21-12)
- iii.** Employment records held by a covered entity (as defined by the HIPAA Privacy Rule at 45 CFR 160.103) in its role as an employer. (3-21-12)

15. **PIC.** Pharmacist-in-charge. (3-21-12)
16. **PMP.** Prescription Monitoring Program. (3-21-12)
17. **Prepackaging.** The act of transferring a drug, manually or using an automated system, from a manufacturer's original container to another container prior to receiving a prescription drug order or prior to distributing a sterile product as allowed by these rules. (~~3-21-12~~)()
18. **Prescriber.** An individual currently licensed, registered, or otherwise authorized to prescribe and administer drugs in the course of professional practice. (3-21-12)
19. **Prescriber Drug Outlet.** A drug outlet in which prescription drugs or devices are dispensed directly to patients under the supervision of a prescriber, except where delivery is accomplished only through on-site administration or the provision of drug samples. (3-21-12)
20. **Readily Retrievable.** Records are considered readily retrievable if they are able to be completely and legibly produced upon request within seventy-two (72) hours. (3-21-12)
21. **Reconstitution.** The process of adding a dilute to a powdered medication to prepare a solution or suspension, according to the product's labeling or the manufacturer's instructions. ()
- ~~22.~~ **Relative Contraindication.** A condition that renders a particular treatment or procedure inadvisable, but not prohibitive. (3-21-12)
- ~~23.~~ **Remote Dispensing Site.** A licensed pharmacy staffed by one or more certified technicians at which telepharmacy services are provided through a supervising pharmacy. (3-21-12)
- ~~24.~~ **Remote Office Location.** A secured area that is restricted to authorized personnel, adequately protects private health information, and shares a secure common electronic file or a private, encrypted connection with a pharmacy, from which a pharmacist who is contracted or employed by a central drug outlet performs centralized pharmacy services. (7-1-13)
- ~~25.~~ **Retail Non-Pharmacy Drug Outlet.** A retail outlet that sells non-prescription drugs or devices that is not a pharmacy. (3-21-12)
- ~~26.~~ **Retail Pharmacy.** A community or other pharmacy that sells prescription drugs at retail and is open to the public for business. (3-21-12)
- ~~27.~~ **R.N.** Registered nurse. (3-21-12)
28. **USP 795.** The current edition of the United States Pharmacopeia-National Formulary, Chapter 795. ()
29. **USP 797.** The current edition of the United States Pharmacopeia-National

Formulary, Chapter 797. ()

(BREAK IN CONTINUITY OF SECTIONS)

231. -- 239~~8~~. (RESERVED)

239. COMPOUNDING DRUG PRODUCTS.

01. Application. These rules apply to any person, including any business entity, authorized to engage in the practice of non-sterile compounding, sterile compounding and sterile prepackaging of drug products in or into Idaho. ()

a. USP. Strict application of or adherence to the guidelines of USP 795 and USP 797 is not mandated; however, it is expected that all persons and business entities will strive to practice in accordance with those guidelines that apply to their practice settings and in all situations comply with the spirit of USP 797 and USP 795. ()

b. Manufacturing. Any compounding that is not permitted herein is considered manufacturing. ()

02. General Compounding Standards. ()

a. Certificate of Analysis. A COA issued by a firm located in the United States must be obtained for all active ingredients procured for compounding and retained for a period of not less than three (3) years from the date the container is emptied. If a COA is not available from the vendor, one must be procured from a laboratory located in the United States. COAs are not required if the active ingredient utilized is designated USP-NF. If the product is not designated as USP-NF, then the following minimum information is required on the COA:()

i. Product name: ()

ii. Lot number: ()

iii. Expiration date; and ()

iv. Assay. ()

b. Prohibited Compounding. Compounding any drug for human use that the FDA, in its Compliance Policy Guidance for FDA Staff and Industry, Sec. 460.200 Pharmacy Compounding, Appendix A (Reissued May 29, 2002), has identified as prohibited for compounding or withdrawn or removed from the market for safety reasons is prohibited. ()

c. Equipment. Equipment and utensils must be of suitable design and composition and cleaned, sanitized, or sterilized as appropriate prior to use. ()

d. Disposing Compromised Drugs. When the correct identity, purity, strength, and sterility of ingredients and components cannot be confirmed (in cases of, for example, unlabeled syringes, opened ampules, punctured stoppers of vials and bags, and containers of ingredients with incomplete labeling) or when the ingredients and components do not possess the expected appearance, aroma, and texture, they must be disposed of immediately. ()

e. Hazardous Drugs. Drug outlets must ensure the storage area has sufficient general exhaust ventilation to dilute and remove any airborne contaminants and use a ventilated cabinet designed to reduce worker exposures while preparing hazardous drugs. When asepsis is not required, a Class I BSC, powder containment hood or an isolator intended for containment applications may be sufficient. A ventilated cabinet that re-circulates air inside the cabinet or exhausts air back into the room environment is prohibited, unless the hazardous drugs in use will not volatilize while they are being handled. Additionally, a drug outlet that prepares hazardous drugs must: ()

i. Clearly identify prepared doses of hazardous drugs, label them with proper precautions, and dispense them in a manner to minimize risk of hazardous spills; ()

ii. Comply with applicable local, state, and federal laws in the disposal of hazardous waste; and ()

iii. Include procedures for handling hazardous spills in the policies and procedures manual. ()

iv. Supplies necessary for handling hazardous spills and disposal of wastes must be available and maintained in the area at all times. ()

03. Scope of Practice. A pharmacist may compound a drug product in the usual course of professional practice for an individual patient pursuant to an established prescriber/patient/pharmacist relationship and a valid prescription drug order. ()

a. Commercially Available Products. Compounding a drug product that is commercially available is prohibited, provided however, that a pharmacist may compound a drug product that is essentially a copy of an available FDA-approved drug product if: ()

i. Pursuant to a valid pharmacist/patient/prescriber relationship and valid prescription drug order, it is medically warranted to provide an alternate ingredient, dosage form, or strength of significance; or ()

ii. Commercial product is not reasonably available in the market in time to meet the patient's needs. ()

b. Anticipatory Compounding. A pharmacist may compound limited quantities of a drug product prior to receiving a valid prescription drug order based on a history of receiving valid prescription drug orders generated solely within an established pharmacist/patient/prescriber relationship. ()

c. Office Use. A pharmacist may distribute non-patient specific drug products in the absence of a valid prescription drug order to licensed practitioners to administer (and not for resale) to their patients in the course of their professional practice. The quantity shall be limited to five percent (5%) of the total number of compounded or sterile prepackaged drug products dispensed and distributed on an annual basis by the pharmacy, except that this limit shall not apply to nuclear pharmacies. ()

d. Research. A drug may be compounded for the purpose of, or incident to, research, teaching, or chemical analysis and not for resale or dispensing. ()

e. Exceptions. Compounding does not include reconstituting of a nonsterile drug or a sterile drug for immediate administration or the addition of a flavoring agent to a drug product. ()

04. Drug Compounding Controls.()

a. Policies and Procedures. In consideration of the applicable provisions of USP 795 concerning pharmacy compounding of non-sterile preparations, USP 797 concerning sterile preparations, Chapter 1075 of the USP-NF concerning good compounding practices, and Chapter 1160 of the USP-NF concerning pharmaceutical calculations, policies and procedures for the compounding or sterile prepackaging of drug products must ensure the safety, identity, strength, quality, and purity of the finished product, and must include any of the following that are applicable to the scope of compounding being performed:()

- i. Appropriate packaging, handling, transport, and storage requirements;()
- ii. Accuracy and precision of calculations, measurements, and weighing;()
- iii. Determining ingredient identity, quality, and purity;()
- iv. Labeling accuracy and completeness;()
- v. Beyond use date assignment;()
- vi. Auditing for deficiencies, including routine environmental sampling, quality and accuracy testing, and maintaining inspection and testing records;()
- vii. Maintaining environmental quality control;()
- viii. Safe limits and ranges for strength of ingredients, pH, bacterial endotoxins, and particulate matter; and()

b. Accuracy. Components, including but not limited to, bulk drug substances, used in the compounding or sterile prepackaging of drug products must be accurately weighed, measured, or subdivided, as appropriate. The amount of each active ingredient contained within a compounded drug product must not vary from the labeled potency by more than the drug

product's acceptable potency range listed in the USP-NF monograph for that product. If USP-NF does not publish a range for a particular drug product, the active ingredients must not contain less than ninety percent (90%) and not more than one hundred ten percent (110%) of the potency stated on the label. If any drug potency analysis is conducted, records must be maintained in a readily retrievable manner.()

c. Non-Patient Specific Records. Except for drug products that are being compounded for direct administration, a production record of drug products compounded or sterile prepackaged for office use or prepared in anticipation of receiving prescription drug orders, solely as permitted herein, must be prepared and kept for each drug product prepared, including: ()

- i. Production date;()
- ii. Beyond use date;()
- iii. List and quantity of each ingredient;()
- iv. Internal control or serial number; and()

v. Initials or unique identifier of all persons involved in the process or the compounder responsible for the accuracy of these processes.()

d. Labeling. The label affixed to the container of a compounded or sterile prepackaged drug product that is:()

- i. Dispensed must comply with the standard prescription drug labeling requirements. ()
- ii. Distributed in the absence of a patient specific prescription drug order, solely as permitted herein, must contain the following information:()

- (1) The name of each drug included;()
- (2) The strength or concentration of each drug included;()
- (3) If applicable, the name and concentration of the base or diluents;()
- (4) If applicable, the dosage form or route of administration;()
- (5) The total quantity of the drug product;()
- (6) The expiration or beyond use date;()

(7) The initials or unique identifier of the compounder responsible for the accuracy of the drug product;()

(8) The statement “not for resale;” and()

(9) Handling, storage or drug specific instructions, cautionary information, and warnings as required or deemed appropriate for proper use and patient safety.()

240. STERILE PRODUCT PREPARATION.

01. Application. In addition to all other applicable rules in this chapter, including the rules governing Compounding Drug Products, these rules apply to all persons, including any business entity, engaged in the practice of sterile compounding and sterile prepackaging. ()

02. Dosage Forms Requiring Sterility. The sterility of compounded biologics, diagnostics, drugs, nutrients, and radiopharmaceuticals must be maintained or the compounded drug product must be sterilized when prepared in the following dosage forms: ()

a. Aqueous bronchial and nasal inhalations, except sprays intended to treat bronchial mucosa only; ()

b. Baths and soaks for live organs and tissues; ()

c. Injections (for example, colloidal dispersions, emulsions, solutions, suspensions); ()

d. Irrigations for wounds and body cavities; ()

e. Ophthalmic drops and ointments; and ()

f. Tissue implants. ()

03. Compounder Responsibilities. Compounders and sterile prepackagers are responsible for ensuring that sterile products are accurately identified, measured, diluted, and mixed and are correctly purified, sterilized, packaged, sealed, labeled, stored, dispensed, and distributed, as well as prepared in a manner that maintains sterility and minimizes the introduction of particulate matter; ()

a. Unless following manufacturer’s guidelines or another reliable literature source, opened or partially used packages of ingredients for subsequent use must be properly stored as follows; ()

i. Opened or entered (such as needle-punctured) single-dose containers, such as bags, bottles, syringes, and vials of sterile products and compounded sterile products shall be used within one (1) hour if opened in non-sterile conditions, and any remaining contents must be discarded; ()

ii. Single-dose vials needle-punctured in a sterile environment may be used up to six (6) hours after initial needle puncture; ()

- iii. Opened single-dose ampules shall not be stored for any time period; and ()
- iv. Multiple-dose containers (for example, vials) that are formulated for removal of portions on multiple occasions because they contain antimicrobial preservatives, may be used for up to twenty-eight (28) days after initial opening or entering, unless otherwise specified by the manufacturer; ()
- b. Water-containing compounded sterile products that are non-sterile during any phase of the compounding procedure must be sterilized within six (6) hours after completing the preparation in order to minimize the generation of bacterial endotoxins; ()
- c. Food, drinks, and materials exposed in patient care and treatment areas shall not enter ante-areas, buffer areas, or segregated areas where components and ingredients of sterile products are prepared. ()

014. Environmental Controls. Except when prepared for immediate administration, the environment for the preparation of sterile products in a drug outlet must be in an isolated area, designed to avoid unnecessary traffic and airflow disturbances, and equipped to accommodate aseptic techniques and conditions. (3-21-12)

- a. Hoods and aseptic environmental control devices must be certified for operational efficiency as often as recommended by the manufacturer or at least every ~~twelve~~ six (126) months or if relocated. (~~3-21-12~~)()
- b. ~~Pre~~Filters must be inspected and replaced in accordance with the manufacturer's recommendations. (~~3-21-12~~)()

025. Sterile Product Preparation Equipment. A drug outlet in which sterile products are prepared must be equipped with at least the following: (3-21-12)

- a. Protective apparel including non-vinyl gloves, gowns, and masks unless the PIC or director can provide aseptic isolator manufacturer's written documentation that any component of garbing is not required; (~~3-21-12~~)()
- b. A sink with hot and cold water in close proximity to the hood; (3-21-12)
- c. A refrigerator for proper storage of additives and finished sterile products prior to delivery when necessary; (3-21-12)
- d. An appropriate laminar airflow hood or other aseptic environmental control device such as a laminar flow biological safety cabinet; (~~3-21-12~~)()
- ~~e. A separate vertical flow biohazard safety hood, if hazardous materials are prepared; and~~ (~~3-21-12~~)
- ~~f. Supplies necessary for handling both hazardous and biohazardous spills and disposal of wastes must be available and maintained in the area at all times.~~ (~~3-21-12~~)

036. ~~Cytotoxic Sterile Hazardous Drugs Preparation Equipment.~~ A drug outlet in which cytotoxic Sterile hazardous drugs are prepared must also: (3-21-12)

~~a. Be equipped with and prepared the drugs~~ in a vented dedicated class II biological safety cabinet or a barrier isolator of appropriate design to meet the personnel exposure limits described in product material safety data sheets; (3-21-12)()

~~b. Require appropriate containment techniques;~~ (3-21-12)

~~c. Clearly identify prepared doses of cytotoxic drugs, label them with proper precautions, and dispense them in a manner to minimize risk of cytotoxic spills;~~ (3-21-12)

~~d. Comply with applicable local, state, and federal laws in the disposal of cytotoxic waste; and~~ (3-21-12)

~~e. Include procedures for handling cytotoxic spills in the policies and procedures manual.~~ (3-21-12)

047. Documentation Requirements. The following documentation must also be maintained by a drug outlet in which sterile products are prepared: (3-21-12)

a. Justification of expiration beyond use dates chosen assigned, pursuant to direct testing or extrapolation from reliable literature sources; (3-21-12)()

b. ~~Employee~~ Training records, ensuring that personnel are adequately skilled, educated, and instructed; (3-21-12)()

c. ~~Technique a~~ Audits; and appropriate for the risk of contamination for the particular sterile product including; (3-21-12)()

i. Visual inspection to ensure the absence of particulate matter in solutions, the absence of leakage from bags and vials, and the accuracy of labeling with each dispensing;()

ii. Initial hand hygiene and garbing competency; ()

iii. Media-fill test procedures (or equivalent), aseptic technique, and practice related competency evaluation at least annually by each compounder or sterile prepackager; ()

iv. Environmental sampling testing at least upon registration of a new drug outlet, following the servicing or re-certification of facilities and equipment, or in response to identified problems with end products, staff techniques or patient-related infections, or every six (6) months, including; ()

(1) Total particle counts; ()

(2) Viable air sampling; ()

(3) Gloved fingertip sampling; ()

- (4) Surface sampling; ()
- v. Sterility testing of high risk batches of more than twenty-five (25) identical packages (ampules, bags, vials, etc.) before dispensing or distributing; ()
- d. Temperature, logged daily; ()
- e. Beyond use date and accuracy testing, when appropriate; and ()
- ~~df.~~ Measuring, mixing, sterilizing and purification ~~E~~equipment inspection, monitoring, cleaning, and maintenance to ensure accuracy and effectiveness for their intended use. ~~(3-21-12)~~()
- 058. Policies and Procedures.** Policies and procedures appropriate to the practice setting must be adopted by a drug outlet ~~compounding~~ preparing sterile pharmaceutical products and must: ~~(3-21-12)~~
- ~~a.~~ ~~Be designed and sufficiently detailed to protect the health and safety of persons preparing or receiving sterile products; and~~ ~~(3-21-12)~~
- ~~b.~~ Include a continuous quality improvement program for monitoring personnel qualifications and training in sterile technique, ~~product storage, stability standards, and infection control.~~ including; ~~(3-21-12)~~()
- a. Antiseptic hand cleansing; ()
- b. Disinfection of non-sterile compounding surfaces; ()
- c. Appropriately selecting and donning protective garb; ()
- d. Maintaining or achieving sterility of sterile products while maintaining the labeled strength of active ingredients; ()
- e. Manipulating sterile products aseptically, including mixing, diluting, purifying, and sterilizing in the proper sequence; ()
- f. Choosing the sterilization method, pursuant to the risk of a contamination of particular compounded sterile product; and ()
- g. Inspecting for quality standards before dispensing or distributing. ()

IDAPA 27 - BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-1302

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2014 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is acted on by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1717, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule published in the October 2, 2013 Idaho Administrative Bulletin, [Vol. 13-10, pages 387 and 388](#).

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the proposed rule, contact Mark Johnston, Executive Director, at (208) 334-2356.

DATED this 1st day of November, 2013.

Mark Johnston, R.Ph.
Executive Director
Board of Pharmacy
1199 W. Shoreline Ln., Ste. 303
P. O. Box 83720
Boise, ID 83720-0067
Telephone: (208) 334-2356
FAX: (208) 334-3536

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-1717, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 16, 2013.

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

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

This rulemaking updates the list of acceptable forms of identification required to receive controlled substance prescriptions, to include those issued in compliance with the Western Hemisphere Travel Initiative (WHTI). The rulemaking extends the acceptable forms of positive identification to obtain controlled substance prescriptions to include Enhanced Drivers Licenses (EDLs), Nexus Cards, and PASS Cards.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rule is simple in nature.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Mark Johnston, Executive Director, at (208) 334-2356.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 23, 2013.

DATED this 30th day of August, 2013.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 27-0101-1302

200. CONTROLLED SUBSTANCES: POSITIVE IDENTIFICATION REQUIRED.

A potential recipient of a controlled substance must first be positively identified or the controlled substance must not be dispensed. (3-21-12)

01. Positive Identification Presumed. Positive identification is presumed and presentation of identification is not required if dispensing directly to the patient and if: (3-21-12)

- a.** The controlled substance will be paid for, in whole or in part, by an insurer; or (3-21-12)
- b.** The patient is being treated at an institutional facility or is housed in a correctional facility. (4-4-13)
- c.** The filled prescription is delivered to the patient's residence either by mail, common carrier, or an employee of the pharmacy. (4-4-13)

02. Personal Identification. Presentation of identification is also not required if the individual receiving the controlled substance is personally and positively known by a pharmacy or prescriber drug outlet staff member who is present and identifies the individual and the personal identification is documented by recording: (3-21-12)

- a.** The recipient's name (if other than the patient); (3-21-12)
- b.** A notation indicating that the recipient was known to the staff member; and (3-21-12)
- c.** The identity of the staff member making the personal identification. (3-21-12)

03. Acceptable Identification. The identification presented must include an unaltered photograph and signature and acceptable forms include: ()

- a.** A valid U.S. state or U.S. military driver's license or identification card; and ()
- b.** A Western Hemisphere Travel Initiative (WHTI) compliant document (i.e.,

Enhanced Driver's License (EDL) or Nexus Air Card); ()

c. ~~A~~ valid passport; and (3-21-12)()

d. A U.S. passport card (PASS Card). ()

04. Identification Documentation. Documentation of the recipient's identification must be permanently linked to the record of the dispensed controlled substance and must include: (3-21-12)

a. A copy of the identification presented; or (3-21-12)

b. A record that includes: (3-21-12)

i. The recipient's name; (3-21-12)

ii. A notation of the type of identification presented; (3-21-12)

iii. The ~~state, military branch, or other~~ government entity that issued the identification; and (3-21-12)()

iv. The unique identification number ~~of the driver's license, identification card, or passport.~~ (3-21-12)()