HEALTH & WELFARE COMMITTEE

ADMINISTRATIVE RULES REVIEW

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2010 Legislative Session

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

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16.02.02 - RULES OF THE EMERGENCY MEDICAL SERVICES (EMS) PHYSICIAN COMMISSION

DOCKET NO. 16-0202-0902

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is January 1, 2010. This rule has been adopted by the agency and is now pending review by the 2010 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 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Sections 56-1013A and 56-1023, Idaho Code, and Senate Bill 1108, 2009.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the temporary 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 "Incorporation by Reference" section of these rules was revised with the updated edition number of the EMS Physician Commission Standards Manual. This Standards Manual is a "scope of practice" manual that governs the medications, devices, and clinical interventions that EMS personnel can use to treat patients at emergency scenes and in ambulances. In addition, a link to the online version of the Standards Manual was added as recommended by Legislative Services.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions that have been made to the pending rule. 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 Book 1 of the October 7, 2009, Idaho Administrative Bulletin, Vol. 09-10, pages 305 through 315.

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.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule and the amendment to temporary rule, contact Dia Gainor at (208) 334-4000.

DATED this 18th day of November, 2009.

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THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective dates of the temporary rule are July 1, 2009, and October 1, 2009.

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 56-1013A and 56-1017, Idaho Code, and Senate Bill 1108a, 2009.

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 Wednesday, October 21, 2009.

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

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

The following changes are being made in this rulemaking:

1. **The "Incorporation by Reference" section of these rules was revised with the updated edition number of the EMS Physician Commission Standards Manual. This revision to rule ensures that the most recent edition of the manual has the force and effect of law. To best protect the public's health and safety, the Emergency Medical Services (EMS) Physician Commission has amended their Standards Manual that is incorporated by reference in this chapter of rules. This Standards Manual is a "scope of practice" manual that governs the medications, devices, and clinical interventions that EMS personnel can use to treat patients at**

emergency scenes and in ambulances.

2. **In addition, to keep the rule aligned with changes being made to the incorporated manual and eliminate duplication between the rule and the manual, the text of the rule was amended. The list in rule of required elements for the EMS medical supervision plan was deleted. This list of required elements is found in the Standards Manual. Any updates to the list will be made in the manual.**

3. **Finally, the chapter was amended to align it with changes related to EMS made to Idaho statute under Senate Bill 1108a (2009).**

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(a) and (b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate as it is necessary to protect public health, safety, and welfare, and to comply with amendments made to governing law under Senate Bill 1108a, passed by the 2009 Legislature.

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. N/A

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because the content of the proposed updates to the EMS Physician Commission Standards Manual already represents extensive input from stakeholders gathered during 2008 and 2009.

NOTE: The EMS Physician Commission is itself a representative body of emergency medicine physicians and citizens with EMS experience from across the state.

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

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 Wednesday, October 28, 2009.

DATED this 14th day of September, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

000. LEGAL AUTHORITY.
Under Sections 56-1013A and 56-1017, Idaho Code, the Idaho Emergency Medical Services (EMS) Physician Commission is authorized to promulgate these rules for the purpose of establishing standards for scope of practice and medical supervision for ~~*certified*~~ licensed personnel, air medical, ambulance services, and nontransport agencies licensed by the Department of Health and Welfare. ~~*(4-2-08)*~~( )

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission." (4-2-08)

02. Scope. The scope of these rules is to define the allowable scope of practice, acts, and duties that can be performed by persons ~~*certified*~~ licensed as emergency medical services personnel by the Department of Health and Welfare Emergency Medical Services (EMS) Bureau and to define the required level of supervision by a physician. ~~*(4-2-08)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

003. ADMINISTRATIVE APPEALS AND INVESTIGATIONS.

01. Administrative Appeals. Provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings," govern administrative appeals. (4-2-08)

02. Physician Complaint Investigations. The provisions of the rules of the Board of Medicine, IDAPA 22.01.14, "Rules Relating to Complaint Investigation," govern investigation of complaints regarding physicians. (4-2-08)

03. EMS Personnel and EMS Agency Complaint Investigations. The provisions of IDAPA 16.02.03, "Rules Governing Emergency Medical Services," govern investigation of complaints regarding ~~*certified*~~ licensed EMS personnel and EMS Agencies. ~~*(4-2-08)*~~( )

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 20~~*07*~~*10*-~~*13*~~*31*, and hereby incorporates this Standards Manual by reference. Copies of the manual may be obtained *on the internet at: www.emspc.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. ~~*(4-2-08)(10-1-09)T*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS REQUESTS.

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." (4-2-08)

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. (4-2-08)

03. EMS Complaints. The provisions of IDAPA 16.02.03, "Rules Governing Emergency Medical Services," govern the confidentiality of the investigation of complaints regarding ~~*certified*~~ licensed EMS personnel. ~~*(4-2-08)*~~( )

007. -- 009. (RESERVED).

010. DEFINITIONS.
In addition to the applicable definitions in Section 56-1012, Idaho Code, and IDAPA 16.02.03, "Rules Governing Emergency Medical Services," the following terms are used in this chapter as defined below: (4-2-08)

01. ~~*Certification*~~ License. A license issued by the EMS Bureau to an individual for a specified period of time indicating that minimum standards corresponding to one (1) of several levels of EMS proficiency have been met. ~~*(4-2-08)*~~( )

02. ~~*Certified*~~ Licensed EMS Personnel. Individuals who possess a valid ~~*certification*~~ license issued by the EMS Bureau. ~~*(4-2-08)*~~( )

03. Credentialed EMS Personnel. Individuals who are authorized to provide medical care by the EMS medical director, hospital supervising physician, or medical clinic supervising physician. (4-2-08)

04. Credentialing. The local process by which ~~*certified*~~ 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. ~~*(4-2-08)*~~( )

05. Designated Clinician. A licensed Physician Assistant (PA) or Nurse Practitioner designated by the EMS medical director, hospital supervising physician, or medical clinic supervising physician who is responsible for direct (on-line) medical supervision of ~~*certified*~~ licensed EMS personnel in the temporary absence of the EMS medical director. ~~*(4-2-08)*~~( )

06. Direct (On-Line) Supervision. Contemporaneous instructions and directives about a specific patient encounter provided by a physician or designated clinician to ~~*certified*~~ licensed EMS personnel who are providing medical care. ~~*(4-2-08)*~~( )

07. 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. (4-2-08)

08. Emergency Medical Services (EMS) Bureau. The Emergency Medical Services (EMS) Bureau of the Idaho Department of Health and Welfare. (4-2-08)

09. Emergency Medical Services (EMS) Physician Commission. The Idaho Emergency Medical Services Physician Commission as created under Section 56-1013A, Idaho Code, hereafter referred to as "the Commission." (4-2-08)

10. EMS Agency. An organization licensed by the EMS Bureau to provide emergency medical services in Idaho. (4-2-08)

11. EMS Medical Director. A physician who supervises the medical activities of ~~*certified*~~ licensed personnel affiliated with an EMS agency. ~~*(4-2-08)*~~( )

12. 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. (4-2-08)

13. Hospital Supervising Physician. A physician who supervises the medical activities of ~~*certified*~~ licensed EMS personnel while employed or utilized for delivery of services in a hospital. ~~*(4-2-08)*~~( )

14. Indirect (Off-Line) Supervision. The medical supervision, provided by a physician, to ~~*certified*~~ licensed EMS personnel who are providing medical care including EMS system design, education, quality management, patient care guidelines, medical policies, and compliance. ~~*(4-2-08)*~~( )

15. Medical Clinic. A place devoted primarily to the maintenance and operation of facilities for outpatient medical, surgical, and emergency care of acute and chronic conditions or injury. (4-2-08)

16. Medical Clinic Supervising Physician. A physician who supervises the medical activities of ~~*certified*~~ licensed EMS personnel while employed or utilized for delivery of services in a medical clinic. ~~*(4-2-08)*~~( )

17. Medical Supervision. The advice and direction provided by a physician, or under the direction of a physician, to ~~*certified*~~ licensed EMS personnel who are providing medical care, including direct and indirect supervision. ~~*(4-2-08)*~~( )

18. Medical Supervision Plan. The written document describing the provisions for medical supervision of ~~*certified*~~ licensed EMS personnel. ~~*(4-2-08)*~~( )

19. 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." (4-2-08)

20. Out-of-Hospital. Any setting outside of a hospital, including inter-facility transfers, in which the provision of emergency medical services may take place. (4-2-08)

21. Physician. In accordance with Section 54-1803, Idaho Code, ~~A~~a person who holds a current active license issued by the Board of Medicine to practice medicine and surgery, ~~or~~ osteopathic medicine ~~or~~ and surgery, or osteopathic medicine in Idaho and is in good standing with no restriction upon, or actions taken against, his license. ~~(4-2-08)~~( )

22. Physician Assistant. A person who meets all the applicable requirements to practice as a licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants." (4-2-08)

011. -- 094. (RESERVED).

095. GENERAL PROVISIONS.

01. Practice of Medicine. This chapter does not authorize the practice of medicine or any of its branches by a person not licensed to do so by the Board of Medicine. (4-2-08)

02. Patient Consent. The provision or refusal of consent for individuals receiving emergency medical services is governed by Title 39, Chapter 45, Idaho Code. (4-2-08)

03. System Consistency. All EMS medical directors, hospital supervising physicians, and medical clinic supervising physicians must collaborate to ensure EMS agencies and ~~certified~~ licensed EMS personnel have protocols, policies, standards of care, and procedures that are consistent and compatible with one another. ~~(4-2-08)~~( )

096. -- 099. (RESERVED).

100. GENERAL DUTIES OF EMS PERSONNEL.

01. General Duties. General duties of EMS personnel include the following: (4-2-08)

a. ~~Certified~~ Licensed EMS personnel must possess a valid ~~certification~~ license issued by the EMS Bureau equivalent to or higher than the scope of practice authorized by the EMS medical director, hospital supervising physician, or medical clinic supervising physician. ~~(4-2-08)~~( )

b. ~~Certified~~ Licensed EMS personnel must only provide patient care for which they have been trained, based on curricula or specialized training approved according to IDAPA 16.02.03, "Rules Governing Emergency Medical Services," or additional training approved by the hospital or medical clinic supervising physician. ~~(4-2-08)~~( )

c. ~~Certified~~ Licensed EMS personnel must not perform a task or tasks within their scope of practice that have been specifically prohibited by their EMS medical director, hospital supervising physician, or medical clinic supervising physician. ~~(4-2-08)~~( )

d. ~~*Certified*~~ Licensed EMS personnel that possess a valid credential issued by the EMS medical director, hospital supervising physician, or medical clinic supervising physician are authorized to provide services when representing an Idaho EMS agency, hospital, or medical clinic and under any one (1) of the following conditions: ~~*(4-2-08)*~~( )

i. When part of a documented, planned deployment of personnel resources approved by the EMS medical director, hospital supervising physician, or medical clinic supervising physician; or (4-2-08)

ii. When, in a manner approved by the EMS medical director, hospital supervising physician, or medical clinic supervising physician, administering first aid or emergency medical attention in accordance with Section 5-330 or 5-331, Idaho Code, without expectation of remuneration; or (4-2-08)

iii. When participating in a training program approved by the EMS Bureau, the EMS medical director, hospital supervising physician, or medical clinic supervising physician. (4-2-08)

02. Scope of Practice. (4-2-08)

a. The Commission maintains an "EMS Physician Commission Standards Manual" that: (4-2-08)

i. Establishes the scope of practice of ~~*certified*~~ licensed EMS personnel; and ~~*(4-2-08)*~~( )

ii. Specifies the type and degree of medical supervision for specific skills, treatments, and procedures by level of EMS ~~*certification*~~ licensure. ~~*(4-2-08)*~~( )

b. The Commission will consider the United States Department of Transportation's National EMS Scope of Practice Model when preparing or revising the standards manual described in Subsection 100.02.a. of this rule; (4-2-08)

c. The scope of practice established by the EMS Physician Commission determines the objectives of applicable curricula and specialized education of ~~*certified*~~ licensed EMS personnel. ~~*(4-2-08)*~~( )

d. The scope of practice does not define a standard of care, nor does it define what should be done in a given situation; (4-2-08)

e. ~~*Certified*~~ Licensed EMS personnel must not provide out-of-hospital patient care that exceeds the scope of practice established by the Commission; ~~*(4-2-08)*~~( )

f. ~~*Certified*~~ Licensed EMS personnel must be credentialed by the EMS medical director, hospital supervising physician, or medical clinic supervising physician to be authorized for their scope of practice; ~~*(4-2-08)*~~( )

g. The credentialing of ~~*certified*~~ licensed EMS personnel affiliated with an EMS agency, in accordance with IDAPA 16.02.03, "Rules Governing Emergency Medical Services,"

must not exceed the licensure level of that EMS agency; and *(4-2-08)*( )

h. The patient care provided by ~~*certified*~~ licensed EMS personnel must conform to the Medical Supervision Plan as authorized by the EMS medical director, hospital supervising physician, or medical clinic supervising physician. ~~*(4-2-08)*~~( )

101. -- 199. (RESERVED).

200. EMS MEDICAL DIRECTOR, HOSPITAL SUPERVISING PHYSICIAN, AND MEDICAL CLINIC SUPERVISING PHYSICIAN QUALIFICATIONS.
The EMS Medical Director, Hospital Supervising Physician, and Medical Clinic Supervising Physician must: (4-2-08)

01. Accept Responsibility. Accept responsibility for the medical direction and medical supervision of the activities provided by ~~*certified*~~ licensed EMS personnel. ~~*(4-2-08)*~~( )

02. Maintain Knowledge of EMS Systems. Obtain and maintain knowledge of the contemporary design and operation of EMS systems. (4-2-08)

03. Maintain Knowledge of Idaho EMS. Obtain and maintain knowledge of Idaho EMS laws, regulations, and standards manuals. (4-2-08)

201. -- 299. (RESERVED).

300. EMS MEDICAL DIRECTOR, HOSPITAL SUPERVISING PHYSICIAN, AND MEDICAL CLINIC SUPERVISING PHYSICIAN RESPONSIBILITIES AND AUTHORITY.

01. Documentation of Written Agreement. The EMS medical director must document a written agreement with the EMS agency to supervise ~~*certified*~~ licensed EMS personnel and provide such documentation to the EMS Bureau annually or upon request. ~~*(4-2-08)*~~( )

02. Approval for EMS Personnel to Function. (4-2-08)

a. The explicit approval of the EMS medical director, hospital supervising physician, or medical clinic supervising physician is required for ~~*certified*~~ licensed EMS personnel under his supervision to provide medical care. ~~*(4-2-08)*~~( )

b. The EMS medical director, hospital supervising physician, or medical clinic supervising physician may credential ~~*certified*~~ licensed EMS personnel under his supervision with a limited scope of practice relative to that allowed by the EMS Physician Commission, or with a limited scope of practice corresponding to a lower level of EMS ~~*certification*~~ licensure. ~~*(4-2-08)*~~( )

03. Restriction or Withdrawal of Approval for EMS Personnel to Function. (4-2-08)

a. The EMS medical director, hospital supervising physician, or medical clinic supervising physician can restrict the scope of practice of ~~*certified*~~ licensed EMS personnel under his supervision when such personnel fail to meet or maintain proficiencies established by the EMS medical director, hospital supervising physician, or medical clinic supervising physician, or the Idaho EMS Bureau. ~~*(4-2-08)*~~( )

b. The EMS medical director, hospital supervising physician, or medical clinic supervising physician can withdraw approval of ~~*certified*~~ licensed EMS personnel to provide services, under his supervision, when such personnel fail to meet or maintain proficiencies established by the EMS medical director, hospital supervising physician, or medical clinic supervising physician, or the EMS Bureau. ~~*(4-2-08)*~~( )

c. The EMS medical director, hospital supervising physician, or medical clinic supervising physician must report in writing such restriction or withdrawal of approval within fifteen (15) days of the action to the EMS Bureau in accordance with Section 39-1393, Idaho Code. (4-2-08)

04. Review Qualifications of EMS Personnel. The EMS medical director, hospital supervising physician, or medical clinic supervising physician must document the review of the qualification, proficiencies, and all other EMS agency, hospital, and medical clinic affiliations of EMS personnel prior to credentialing the individual. (4-2-08)

05. Document EMS Personnel Proficiencies. The EMS medical director, hospital supervising physician, or medical clinic supervising physician must document that the capabilities of ~~*certified*~~ licensed EMS personnel are maintained on an ongoing basis through education, skill proficiencies, and competency assessment. ~~*(4-2-08)*~~( )

06. Develop and Implement a Performance Assessment and Improvement Program. The EMS medical director must develop and implement a program for continuous assessment and improvement of services provided by ~~*certified*~~ licensed EMS personnel under their supervision. ~~*(4-2-08)*~~( )

07. Review and Update Procedures. The EMS medical director must review and update protocols, policies, and procedures at least every two (2) years. (4-2-08)

08. Develop and Implement Plan for Medical Supervision. The EMS medical director, hospital supervising physician, or medical clinic supervising physician must develop, implement and oversee a plan for supervision of ~~*certified*~~ licensed EMS personnel as described in Subsection 400.06 of these rules. ~~*(4-2-08)*~~( )

09. Access to Records. The EMS medical director must have access to all relevant agency, hospital, or medical clinic records as permitted or required by statute to ensure responsible medical supervision of ~~*certified*~~ licensed EMS personnel. ~~*(4-2-08)*~~( )

301. -- 399. (RESERVED).

400. PHYSICIAN SUPERVISION IN THE OUT-OF-HOSPITAL SETTING.

01. Medical Supervision Required. In accordance with Section 56-1011, Idaho Code, ~~*certified*~~ licensed EMS personnel must provide emergency medical services under the supervision of a designated EMS medical director. ~~*(4-2-08)*~~( )

02. Designation of EMS Medical Director. The EMS agency must designate a physician for the medical supervision of ~~*certified*~~ licensed EMS personnel affiliated with the EMS agency. ~~*(4-2-08)*~~( )

03. Delegated Medical Supervision of EMS Personnel. The EMS medical director can designate other physicians to supervise the ~~*certified*~~ licensed EMS personnel in the temporary absence of the EMS medical director. ~~*(4-2-08)*~~( )

04. Direct Medical Supervision by Physician Assistants and Nurse Practitioners. The EMS medical director can designate Physician Assistants (PA) and Nurse Practitioners for purposes of direct medical supervision of ~~*certified*~~ licensed EMS personnel under the following conditions: ~~*(4-2-08)*~~( )

a. A designated physician is not present in the anticipated receiving health care facility; and (4-2-08)

b. The Nurse Practitioner, when designated, must have a preexisting written agreement with the EMS medical director describing the role and responsibilities of the Nurse Practitioner; or (4-2-08)

c. The physician supervising the PA, as defined in IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants," authorizes the PA to provide direct (on-line) supervision; and (4-2-08)

d. The PA, when designated, must have a preexisting written agreement with the EMS medical director describing the role and responsibilities of the PA related to supervision of EMS personnel. (4-2-08)

e. Such designated clinician must possess and be familiar with the medical supervision plan, protocols, standing orders, and standard operating procedures authorized by the EMS medical director. (4-2-08)

05. Indirect Medical Supervision by Non-Physicians. Non-physicians can assist the EMS medical director with indirect medical supervision of ~~*certified*~~ licensed EMS personnel. ~~*(4-2-08)*~~( )

06. Medical Supervision Plan. The medical supervision of ~~*certified*~~ licensed EMS personnel must be provided in accordance with a documented medical supervision plan that includes direct, indirect, on-scene, educational, and proficiency standards components. ~~*The EMS medical director is responsible for developing, implementing, and overseeing the medical supervision plan that must consist of the following elements:*~~ The requirements for the medical supervision plan are found in the Idaho EMS Physician Commission Standards Manual that is incorporated by reference under Section 004 of these rules. ~~*(4-2-08)*~~( )

~~***a.*** *Certified EMS personnel credentialing that includes all of the following:* *(4-2-08)*~~

~~*i. EMS Bureau certification;* *(4-2-08)*~~

~~*ii. Affiliation to the EMS agency;* *(4-2-08)*~~

~~*iii. An EMS agency orientation as prescribed by the EMS agency that includes:* *(4-2-08)*~~

~~*(1) EMS agency policies;* *(4-2-08)*~~

~~*(2) EMS agency procedures;* *(4-2-08)*~~

~~*(3) Medical treatment protocols;* *(4-2-08)*~~

~~*(4) Radio communications procedures;* *(4-2-08)*~~

~~*(5) Hospital/facility destination policies;* *(4-2-08)*~~

~~*(6) Other unique system features; and* *(4-2-08)*~~

~~*iv. Successful completion of an EMS agency evaluation.* *(4-2-08)*~~

~~***b.*** *Indirect (off-line) supervision that includes all of the following:* *(4-2-08)*~~

~~*i. Written standing orders and treatment protocols including direct (online) supervision criteria;* *(4-2-08)*~~

~~*ii. Initial and continuing education in addition to those required by the EMS Bureau;* *(4-2-08)*~~

~~*iii. Methods of assessment and improvement;* *(4-2-08)*~~

~~*iv. Periodic assessment of psychomotor skill proficiency;* *(4-2-08)*~~

~~*v. Provisions for medical supervision of and defining the patient care provided by certified EMS personnel who are present for a multiple or mass causality incident, disaster response, or other significant event involving response of certified EMS personnel;* *(4-2-08)*~~

~~*vi. Defining the response when certified EMS personnel discover a need for EMS while not on duty;* *(4-2-08)*~~

~~*vii. The credentialing of certified EMS personnel for emergency response;* *(4-2-08)*~~

~~*viii. The appropriate level of emergency response based upon dispatch information provided by the designated Public Safety Answering Point(s);* *(4-2-08)*~~

ix. Triage, treatment, and transport guidelines; (4-2-08)

x. Scene management for multiple EMS agencies anticipated to be on scene concurrently; (4-2-08)

xi. Criteria for determination of patient destination; (4-2-08)

xii. Criteria for utilization of air medical services in accordance with IDAPA 16.02.03, "Rules Governing Emergency Medical Services," Section 415; (4-2-08)

xiii. Policies and protocols for patient refusal, "treat and release," Physician Orders for Scope of Treatment (POST) or other valid Do Not Resuscitate (DNR) orders, and determination of death and other predictable patient non-transport scenarios; (4-2-08)

xiv. Criteria for cancellation or modification of EMS response; (4-2-08)

xv. Equipment authorized for patient care; (4-2-08)

xvi. Medical communications guidelines; and (4-2-08)

xvii. Methods and elements of documentation of services provided by certified EMS personnel. (4-2-08)

c. *Direct (on-line) supervision: (4-2-08)*

i. Is accomplished by concurrent communication with the EMS medical director, other physicians designated by the EMS medical director, or designated clinicians who must be available twenty-four (24) hours a day seven (7) days a week. (4-2-08)

ii. The EMS medical director will develop and implement procedures in the event of on-scene supervision by: (4-2-08)

(1) The EMS medical director or other physician(s) designated by the EMS medical director; (4-2-08)

(2) A physician with a pre-existing relationship with the patient; and (4-2-08)

(3) A physician with no pre-existing relationship with the patient who is present for the duration of treatment on scene or transportation. (4-2-08)

iii. Direct supervision of certified EMS personnel by other persons is prohibited except in the manner described in the medical supervision plan. (4-2-08)

d. *The EMS medical director in collaboration with the course medical director or course coordinator, will define standards of supervision and training for students of state-approved training programs placed for clinical practice and training. (4-2-08)*

07. Out-of-Hospital Medical Supervision Plan Filed with EMS Bureau. The

agency EMS medical director must file the medical supervision plan, including identification of the EMS medical director and any designated clinicians to the EMS Bureau in a form described in the standards manual. (4-2-08)

a. The agency EMS medical director must inform the EMS Bureau of any changes in designated clinicians or the medical supervision plan within thirty (30) days of the change(s). (4-2-08)

b. The EMS Bureau must provide the Commission with the medical supervision plans annually and upon request. (4-2-08)

c. The EMS Bureau must provide the Commission with the identification of EMS Medical directors and designated clinicians annually and upon request. (4-2-08)

401. -- 499. (RESERVED).

500. PHYSICIAN SUPERVISION IN HOSPITALS AND MEDICAL CLINICS.

01. Medical Supervision Required. In accordance with Section 56-1011, Idaho Code, ~~*certified*~~ licensed EMS personnel must provide emergency medical services under the supervision of a designated hospital supervising physician or medical clinic supervising physician. ~~*(4-2-08)*~~( )

02. Level of ~~*Certification*~~ Licensure Identification. The ~~*certified*~~ licensed EMS personnel employed or utilized for delivery of services within a hospital or medical clinic, when on duty, must at all times visibly display identification specifying their level of EMS ~~*certification*~~ licensure. ~~*(4-2-08)*~~( )

03. Credentialing of ~~*Certified*~~ Licensed EMS Personnel in a Hospital or Medical Clinic. The hospital or medical clinic must maintain a current written description of acts and duties authorized by the hospital supervising physician or medical clinic supervising physician for credentialed EMS personnel and must submit the descriptions upon request of the Commission or the EMS Bureau. ~~*(4-2-08)*~~( )

04. Notification of Employment or Utilization. The ~~*certified*~~ licensed EMS personnel employed or utilized for delivery of services within a hospital or medical clinic must report such employment or utilization to the EMS Bureau within thirty (30) days of engaging such activity. ~~*(4-2-08)*~~( )

05. Designation of Supervising Physician. The hospital or medical clinic administration must designate a physician for the medical supervision of ~~*certified*~~ licensed EMS personnel employed or utilized in the hospital or medical clinic. ~~*(4-2-08)*~~( )

06. Delegated Medical Supervision of EMS Personnel. The hospital supervising physician or medical clinic supervising physician can designate other physicians to supervise the ~~*certified*~~ licensed EMS personnel during the periodic absence of the hospital supervising physician or medical clinic supervising physician. ~~*(4-2-08)*~~( )

07. Direct Medical Supervision by Physician Assistants and Nurse Practitioners. The hospital supervising physician, or medical clinic supervising physician can designate Physician Assistants (PA) and Nurse Practitioners for purposes of direct medical supervision of ~~*certified*~~ licensed EMS personnel under the following conditions: ~~*(4-2-08)*~~( )

a. The Nurse Practitioner, when designated, must have a preexisting written agreement with the hospital supervising physician or medical clinic supervising physician describing the role and responsibilities of the Nurse Practitioner; or (4-2-08)

b. The physician supervising the PA, as defined in IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants," authorizes the PA to provide supervision; and (4-2-08)

c. The PA, when designated, must have a preexisting written agreement with the hospital supervising physician or medical clinic supervising physician describing the role and responsibilities of the PA related to supervision of EMS personnel. (4-2-08)

d. Such designated clinician must possess and be familiar with the medical supervision plan, protocols, standing orders, and standard operating procedures authorized by the hospital supervising physician or medical clinic supervising physician. (4-2-08)

08. On-Site Contemporaneous Supervision. ~~*Certified*~~ Licensed EMS personnel will only provide patient care with on-site contemporaneous supervision by the hospital supervising physician, medical clinic supervising physician, or designated clinicians. ~~*(4-2-08)*~~( )

09. Medical Supervision Plan. The medical supervision of ~~*certified*~~ licensed EMS personnel must be provided in accordance with a documented medical supervision plan. The hospital supervising physician or medical clinic supervising physician is responsible for developing, implementing, and overseeing the medical supervision plan, and must submit the plan(s) upon request of the Commission or the EMS Bureau. ~~*(4-2-08)*~~( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.02.10 - IDAHO REPORTABLE DISEASES

DOCKET NO. 16-0210-0901

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 39-605, 39-906, 39-1003, 39-1603, 54-1119, 56-1003, and 56-1005 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 Department is amending the proposed rule based on comments received during the comment period to clarify: (1) Preventing spread of health hazards from dead human bodies; and (2) Reporting requirements for rabies - human, animal, and post-exposure prophylaxis (rPEP).

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 2, 2009, Idaho Administrative Bulletin, Vol. 09-9, pages 99 through 112.

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 state general funds due to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Kathryn Turner at (208) 334-5939.

DATED this 19th day of November, 2009.

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

THE FOLLOWING NOTICE 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 39-605, 39-906, 39-1003, 39-1603, 54-1119, 56-1003, and 56-1005 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 16, 2009.

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 this proposed rulemaking:

Idaho Code requires the Department to provide rules that govern the reporting, control, and prevention of reportable diseases and conditions and requirements to prevent transmission of health hazards from dead human bodies. These rules are being amended to protect the health and safety of the public by:

1. **Adding requirements for disposition of dead human bodies that may pose a health hazard from communicable diseases or hazardous substances;**
2. **Providing clarification of the reporting requirements and restrictions for the following diseases: cryptosporidiosis, hemolytic-uremic syndrome (HUS), mumps, rabies, prion diseases, and West Nile virus;**
3. **Adding reporting requirements for cases of novel influenza A virus; and**
4. **Updating the authority, scope, definitions, and incorporation by reference sections of 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.

There is no anticipated fiscal impact to state general funds due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because these rule changes are being made to protect the health of Idaho citizens.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Kathryn Turner at (208) 334-5939.

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 23, 2009.

DATED this 27th day of July, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

000. LEGAL AUTHORITY.
Sections 39-605, 39-1003, 39-1603, and 56-1005, Idaho Code, grant authority to the Board of Health and Welfare to adopt rules protecting the health of the people of Idaho. Section 39-906, Idaho Code, provides for the Director to administer rules adopted by the Board of Health and Welfare. Section 39-4505(2), Idaho Code, gives the Director authority to promulgate rules regarding the identification of blood- or body fluid-transmitted viruses or diseases. Section 56-1003, Idaho Code, gives the Director the authority to adopt rules protecting the health of the people of Idaho and to recommend rules to the Board of Health and Welfare. Section 54-1119, Idaho Code, authorizes the Director to promulgate rules regarding the handling of dead human bodies as needed to preserve and protect the public health. ~~*(4-2-08)*~~( )

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.02.10, "Idaho Reportable Diseases." (4-2-08)

02. Scope. These rules contain the official requirements governing the reporting, control, and prevention of reportable diseases and conditions and requirements to prevent transmission of health hazards from dead human bodies. The purpose of these rules is to identify, control, and prevent the transmission of reportable diseases and conditions within Idaho. ~~*(4-2-08)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

004. DOCUMENTS INCORPORATED BY REFERENCE.
The documents referenced in Subsections 004.01 through 004.06 of this rule are used as a means of further clarifying these rules. These documents are incorporated by reference and are available at the Idaho State Law Library or at the Department's main office listed in Section 005 of these rules. (4-2-08)

01. Guideline for Isolation Precautions in Hospitals. Siegel, J.D., et al., "Guideline for Isolation Precautions in Hospitals." Health Care Infection Control Practices Advisory Committee, Atlanta, GA: Centers for Disease Control and Prevention, 2007. (4-2-08)

02. Case Definitions for Infectious Conditions Under Public Health Surveillance, 2010. Morbidity and Mortality Weekly Report, ~~*May 2, 1997, Vol. 46, No. RR-10*~~ 2010 Edition. Centers for Disease Control and Prevention. Division of Integrated Surveillance Systems and Services at http://www.cdc.gov/ncphi/disss/nndss/phs/infdis.htm. ~~*(4-2-08)*~~( )

03. Human Rabies Prevention -- United States, 1999. Morbidity and Mortality Weekly Report, January 8, 1999, Vol. 48, RR-1. Centers for Disease Control and Prevention. (4-2-08)

04. Updated U.S. Public Health Service Guidelines for the Management of ~~*Health Care Worker*~~ Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis. Morbidity and Mortality Weekly Report, ~~*May 15, 1998, Vol. 47, RR-7*~~ September 30, 2005, Vol. 54, RR09. Centers for Disease Control and Prevention. These guidelines are found at http://aidsinfo.nih.gov/contentfiles/HealthCareOccupExpoGL.pdf. ~~*(4-2-08)*~~( )

05. Compendium of Animal Rabies Control, 200~~7~~8. National Association of State Public Health Veterinarians, Inc., Morbidity and Mortality Weekly Report, April 6, 2007, Vol. 58, RR-3. Centers for Disease Control and Prevention. This document is found at http://www.nasphv.org/. ~~*(4-2-08)*~~( )

06. Standards for Cancer Registries, Volume II, Data Standards and Data Dictionary. North American Association of Central Cancer Registries, Twelfth Edition, Record Layout Version 11.2, April 2007. (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

011. DEFINITIONS L THROUGH Z.
For the purposes of this chapter, the following definitions apply. (4-2-08)

01. Laboratory Director. A person who is directly responsible for the operation of a licensed laboratory or his designee. (4-2-08)

02. Laboratory. A medical diagnostic laboratory which is inspected, licensed, or approved by the Department or licensed according to the provisions of the Clinical Laboratory Improvement Act by the United States Health Care and Financing Administration. Laboratory may also refer to the Idaho State Public Health Laboratory, and to the United States Centers for Disease Control and Prevention. (4-2-08)

03. Livestock. Livestock includes cattle, swine, horses, mules, asses, native and non-native ungulates, and other animals determined by the Department. (4-2-08)

04. Medical Record. Hospital or medical records are all those records compiled for the purpose of recording a medical history, diagnostic studies, laboratory tests, treatments, or rehabilitation. Access will be limited to those parts of the record which will provide a diagnosis, or will assist in identifying contacts to a reportable disease or condition. Records specifically exempted by statute are not reviewable. (4-2-08)

05. Outbreak. An outbreak is an unusual rise in the incidence of a disease. An outbreak may consist of a single case. (4-2-08)

06. Personal Care. The service provided by one (1) person to another for the purpose of feeding, bathing, dressing, assisting with personal hygiene, changing diapers, changing bedding, and other services involving direct physical contact. (4-2-08)

07. Physician. A person legally authorized to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine in Idaho as defined in Section 54-1803, Idaho Code. (4-2-08)

08. Quarantine. The restriction placed on the entrance to and exit from the place or premises where an infectious agent or hazardous material exists. The place of quarantine will be designated by the Director or Health District Board. (4-2-08)

09. Rabies Post-Exposure Prophylaxis (rPEP). The administration of a rabies vaccine series with or without the antirabies immune globulin, depending on pre-exposure vaccination status, following a documented or suspected rabies exposure, as described in "Human Rabies Prevention--United States, 1999," incorporated in Section 004 of these rules. (4-2-08)

10. Rabies-Susceptible Animal. Any animal capable of being infected with the rabies virus. (4-2-08)

11. Residential Care Facility. A commercial or non-profit establishment organized and operated to provide a place of residence for three (3) or more individuals who are not members of the same family, but live within the same household. Any restriction for this type of facility is included under restrictions for a health care facility. (4-2-08)

12. Restriction. (4-2-08)

a. To limit the activities of a person to reduce the risk of transmitting a communicable disease. Activities of individuals are restricted or limited to reduce the risk of disease transmission until such time that they are no longer considered a health risk to others. (4-2-08)

b. A food employee who is restricted must not work with exposed food, clean equipment, utensils, linens, and unwrapped single-service or single-use articles. A restricted employee may still work at a food establishment as outlined in the IDAPA 16.02.19, "The Idaho Food Code." (4-2-08)

13. Restrictable Disease. A restrictable disease is a communicable disease, which if left unrestricted, may have serious consequences to the public's health. The determination of whether a disease is restrictable is based upon the specific environmental setting and the likelihood of transmission to susceptible persons. (4-2-08)

14. Severe Reaction to Any Immunization. Any serious or life-threatening condition which results directly from the administration of any immunization against a communicable

disease. (4-2-08)

15. Significant Exposure to Blood or Body Fluids. Significant exposure is defined as a percutaneous injury, contact of mucous membrane or non-intact skin, or contact with intact skin when the duration of contact is prolonged or involves an extensive area, with blood, tissue, or other body fluids as defined in "Updated U.S. Public Health Service Guidelines for the Management of ~~*Health Care Worker*~~ Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis," incorporated in Section 004 of these rules. ~~*(4-2-08)*~~( )

16. Standard Precautions. Methods used to prevent transmission of all infectious agents, as described in the "Guideline for Isolation Precautions in Hospitals," incorporated in Section 004 of these rules. (4-2-08)

17. State Epidemiologist. A person employed by the Department to serve as a statewide epidemiologist or his designee. (4-2-08)

18. Suspected Case. A person diagnosed with or thought to have a particular disease or condition by a licensed physician or other health care provider. The suspected diagnosis may be based on signs and symptoms, or on laboratory evidence, or both criteria. Suspected cases of some diseases are reportable as described in Section 050 of these rules. (4-2-08)

19. Vaccination of an Animal Against Rabies. Vaccination of an animal by a licensed veterinarian with a rabies vaccine licensed or approved for the animal species and administered according to the specifications on the product label or package insert as described in the "Compendium of Animal Rabies Control, 200~~7~~8," incorporated in Section 004 of these rules. ~~*(4-2-08)*~~( )

20. Veterinarian. Any licensed veterinarian as defined in Section 54-2103, Idaho Code. (4-2-08)

21. Waterborne Outbreak. An outbreak is when two (2) or more persons experience a similar illness after ingesting water from a common supply and an epidemiological analysis implicates the water as the source of the illness. (4-2-08)

22. Working Day. A working day is from 8 a.m. to 5 p.m., Monday through Friday, excluding state holidays. (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

050. REPORTABLE OR RESTRICTABLE DISEASES, CONDITIONS AND REPORTING REQUIREMENTS.
Reportable diseases and conditions must be reported to the Department or Health District by those required under Section 020 of these rules. The table below identifies the reportable and restrictable diseases and conditions, the timeframe for reporting, and the person or facility required to report.

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	**Section in Rule**	**Reporting Timeframe**	**Restrictable for DC = Day Care FS = Food Service HC = Health Care Facility S = School**	**Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)**
Acquired Immune Deficiency Syndrome (AIDS), (including CD-4 lymphocyte counts <200 cells/mm3 blood or < 14%)	100	Within 3 working days	None	
Amebiasis	110	Within 3 working days	DC, FS, HC	~~*Day Care Facility*~~ Food Service Facility
Anthrax (*Bacillus anthracis*)	120	Immediately	None	
Biotinidase Deficiency	130	Within 1 working day (in newborn screening)	None	
Botulism	140	Immediately	None	
Brucellosis (*Brucella* species)	150	Within 1 working day	None	
Campylobacteriosis (*Campylobacter* species)	160	Within 3 working days	DC, FS, HC	~~*Day Care Facility*~~ Food Service Facility
Cancer	170	Report to Cancer Data Registry of Idaho within 180 days of diagnosis or recurrence (including suspected cases)	None	
Chancroid	180	Within 3 working days	None	
Chlamydia trachomatis Infections	190	Within 3 working days	HC - ophthalmica neonatorum only	
Cholera (*Vibrio cholerae*)	200	Within 1 working day	FS, HC, DC	Food Service Facility
Congenital Hypothyroidism	210	Within 1 working day (in newborn screening)	None	
Conjunctivitis	080, 090	No reporting required	DC, S	
Cryptosporidiosis (*Cryptosporidium* species)	220	Within 3 working days	FS, HC, DC	
Cutaneous Fungal Infections	080, 090	No reporting required	DC, S	
Diarrhea (until common communicable diseases have been ruled out)	085	No reporting required	FS	

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	**Section in Rule**	**Reporting Timeframe**	**Restrictable for DC = Day Care FS = Food Service HC = Health Care Facility S = School**	**Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)**
Diphtheria (*Corynebacterium diphtheriae*)	230	Immediately	DC, FS, HC, S	~~*Day Care Facility*~~ School
Encephalitis, Viral or Aseptic	240	Within 3 working days	None	
Escherichia coli O157:H7 and other Shiga-Toxin Producing *E. coli* (STEC)	250	Within 1 working day	DC, FS, HC	~~*Day Care Facility*~~ Food Service Facility School
Extraordinary Occurrence of Illness, including Clusters	260	Within 1 working day	None	
Fever	085	No reporting required	FS	
Food Poisoning, Foodborne Illness, and Waterborne Illnesses	270	Within 1 working day	None	
Galactosemia	280	Within 1 working day (in newborn screening)	None	
Giardiasis (*Giardia lamblia*)	290	Within 3 working days	DC, FS, HC	~~*Day Care Facility*~~ Food Service Facility
Haemophilus influenzae Invasive Disease	300	Within 1 working day	DC, S	~~*Day Care Facility*~~ School
Hantavirus Pulmonary Syndrome	310	Within 1 working day	None	
Hemolytic-Uremic Syndrome (HUS) or Thrombotic thrombocytopenic purpura-HUS (TTP-HUS)	320	Within 1 working day	None	
Hepatitis A	330	Within 1 working day	DC, FS, HC	~~*Day Care Facility*~~ Food Service Facility
Hepatitis B	340	Within 1 working day	None	
Hepatitis C	350	Within 3 working days	None	
Human Immunodeficiency Virus (HIV)	360	Within 3 working days	None	
Human T-Lymphotropic Virus	370	Within 3 working days	None	
Jaundice	085	No reporting required	FS	

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	**Section in Rule**	**Reporting Timeframe**	**Restrictable for DC = Day Care FS = Food Service HC = Health Care Facility S = School**	**Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)**
Lead Levels of Ten Micrograms or more per Deciliter of Whole Blood (ug/dL)	380	Within 3 working days	None	
Legionellosis	390	Within 3 working days	None	
Leprosy (Hansen's Disease)	400	Within 3 working days	None	
Leptospirosis	410	Within 3 working days	None	
Listeriosis (*Listeria* species)	420	Within 3 working days	None	
Lyme Disease	430	Within 3 working days	None	
Malaria (*Plasmodium* species)	440	Within 3 working days	None	
Maple Syrup Urine Disease	450	Within 1 working day (in newborn screening)	None	
Measles (Rubeola)	460	Within 1 working day	DC, HC, S	~~*Day Care Facility*~~ School
Meningitis, Viral or Aseptic	470	Within 3 working days	None	
Methicillin-resistant *Staphylococcus aureus* (MRSA) Invasive Disease	475	Within 3 working days	None	**Note:** Only Laboratory Directors need to report.
Methicillin-resistant *Staphylococcus aureus* (MRSA) Non-Invasive Disease	475, 080, 090	No reporting required	DC, FS, HC, S	
Mumps	480	Within 3 working days	DC, S, HC	~~*Day Care Facility*~~ School
Myocarditis, Viral	490	Within 3 working days	None	
Neisseria gonorrhoeae Infections	500	Within 3 working days	None	
Neisseria meningitidis Invasive Disease	510	Within 1 working day	DC, HC, S	~~*Day Care Facility*~~ School
Norovirus	520	Within 1 working day	DC, FS, HC, S	
Novel Influenza A Virus	522	Within 1 working day	DC, FS, HC, S	
Pediculosis	080, 090	No reporting required	DC, S	
Pertussis (*Bordetella pertussis*)	530	Within 1 working day	DC, HC, S	~~*Day Care Facility*~~ School

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	**Section in Rule**	**Reporting Timeframe**	**Restrictable for DC = Day Care FS = Food Service HC = Health Care Facility S = School**	**Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)**
Phenylketonuria (PKU)	540	Within 1 working day (in newborn screening)	None	
Plague (*Yersinia pestis*)	550	Immediately	HC, S	~~*Day Care Facility*~~ School
Pneumococcal Invasive Disease in Children less than Eighteen (18) Years of Age *(Streptococcus pneumoniae)*	560	Within 3 working days	DC, S	~~*Day Care Facility*~~ School
Pneumocystis Pneumonia (PCP)	570	Within 3 working days	None	
Poliomyelitis	580	Within 1 working day	DC	~~*Day Care Facility*~~ School
Psittacosis	590	Within 3 working days	None	
Q Fever	600	Within 1 working day	None	
Rabies - Human, ~~*and*~~ Animal, and Post-Exposure Prophylaxis (rPEP)	610	Immediately (human), Within 1 working day (animal or rPEP)	None	
Relapsing Fever, Tick-borne and Louse-borne	620	Within 3 working days	None	
Respiratory Syncytial Virus (RSV)	630	Within 1 working day	None	**Note:** Only Laboratory Directors need to report.
Reye Syndrome	640	Within 3 working days	None	
Rocky Mountain Spotted Fever	650	Within 3 working days	None	
Rubella (including Congenital Rubella Syndrome)	660	Within 1 working day	DC, HC, S	~~*Day Care Facility*~~ School
Salmonellosis (including Typhoid Fever) (*Salmonella* species)	670	Within 1 working day	DC, FS, HC	~~*Day Care Facility*~~ Food Service Facility
Scabies	080, 090	No reporting required	DC, S	
Severe Acute Respiratory Syndrome (SARS)	680	Within 1 working day	DC, S	~~*Day Care Facility*~~ School
Severe Reaction to Any Immunization	690	Within 1 working day	None	

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	**Section in Rule**	**Reporting Timeframe**	**Restrictable for DC = Day Care FS = Food Service HC = Health Care Facility S = School**	**Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)**
Shigellosis (*Shigella* species)	700	Within 1 working day	DC, FS, HC, S	~~*Day Care Facility*~~ Food Service Facility School
Smallpox	710	Immediately	DC, HC, S	~~*Day Care Facility*~~ School
Sore Throat with Fever	085	No reporting required	FS	
Staphylococcal Infections other than MRSA	080, 085, 090	No reporting required	DC, FS, S	
Streptococcal Pharyngeal Infections	080, 090	No reporting required	DC, S	
Streptococcus pyogenes (Group A Strep), Invasive or Resulting in Rheumatic Fever	720	Within 3 working days	DC, HC, S	~~*Day Care Facility*~~ School
Syphilis	730	Within 3 working days	None	
Taeniasis	085	No reporting required	FS	
Tetanus	740	Within 3 working days	None	
Toxic Shock Syndrome	750	Within 3 working days	None	
Transmissible Spongiform Encephalopathies (TSE), including Creutzfeldt-Jakob Disease (CJD) and Variant CJD (vCJD)	760	Within 3 working days	None	
Trichinosis	770	Within 3 working days	None	
Tuberculosis (*Mycobacterium tuberculosis*)	780	Within 3 working days	DC, FS, HC, S	~~*Day Care Facility*~~ School Food Service Facility
Tularemia (*Francisella tularensis*)	790	Immediately; Identification of *Francisella tularensis* - within 1 working day	None	
Uncovered and Open or Draining Skin Lesions with Pus, such as a Boil or Open Wound	085	No reporting required	FS	
Varicella (chickenpox)	080, 090	No reporting required	DC, S	

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	**Section in Rule**	**Reporting Timeframe**	**Restrictable for DC = Day Care FS = Food Service HC = Health Care Facility S = School**	**Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)**
Vomiting (until noninfectious cause is identified)	085	No reporting required	FS	
West Nile Virus (WNV)	800	Within 3 working days	None	
Yersiniosis (*Yersinia enterocolitica* and *Yersinia pseudotuberculosis*)	810	Within 3 working days; Identification of *Yersinia pestis* - immediately	FS	

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

(BREAK IN CONTINUITY OF SECTIONS)

066. -- 06~~9~~7. (RESERVED).

068. PREVENTING SPREAD OF HEALTH HAZARDS FROM DEAD HUMAN BODIES.

01. Embalming. ( )

a. The Division of Public Health Administrator or Health District Director may order a dead human body to be embalmed or prohibit embalming to prevent the spread of infectious or communicable diseases or exposure to hazardous substances. ( )

b. The dead human body of a person suspected of or confirmed as having a viral hemorrhagic fever at the time of death must not be embalmed, but wrapped in sealed leak-proof material and cremated or buried. ( )

02. Burial. The Division of Public Health Administrator or Health District Director may order a dead human body to be buried or cremated, or prohibit burial or cremation, and may specify a time frame for final disposition to prevent the spread of infectious or communicable diseases or exposure to hazardous substances. *As required in Section 39-268, Idaho Code, all orders of cremation will be approved by the coroner and the coroner will be notified of prohibitions of cremation ordered by the Administrator or Director.* *( )*

03. Notification of Health Hazard. Any person authorized to release a dead human body of a person suspected of or confirmed as having a prion disease, a viral hemorrhagic fever, other infectious health hazard, or contaminated with a hazardous substance, must notify the

person taking possession of the body and indicate necessary precautions on a written notice to accompany the body. *( )*

069. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

220. CRYPTOSPORIDIOSIS.

01. Reporting Requirements. Each case of cryptosporidiosis must be reported to the Department or Health District within three (3) working days of identification. (4-2-08)

02. Investigation. Each reported case must be investigated to determine the extent of the outbreak and identify the source of the infection. (4-2-08)

03. Restrictions - Day Care Facility. A fecally incontinent person excreting *Cryptosporidium ~~parvum~~* must not attend a day care facility. A person excreting *Cryptosporidium ~~parvum~~* must not provide personal care in a day care facility, unless an exemption is obtained from the Department or Health District. This restriction will be withdrawn when: *~~(4-2-08)~~*( )

a. At least two (2) approved fecal specimens collected at least twenty-four (24) hours apart fail to show *Cryptosporidium* upon testing by a licensed laboratory; or (4-2-08)

b. Diarrhea has ceased for twenty-four (24) hours. (4-2-08)

04. Restrictions - Food Service Facility. A symptomatic person excreting *Cryptosporidium ~~parvum~~* is restricted from working as a food employee. *~~(4-2-08)~~*( )

05. Restrictions - Health Care Facility. A person excreting *Cryptosporidium ~~parvum~~* must not provide personal care in a custodial institution, or health care facility while fecally incontinent, unless an exemption is obtained from the Department or Health District. This restriction will be withdrawn when: *~~(4-2-08)~~*( )

a. At least two (2) approved fecal specimens collected at least twenty-four (24) hours apart fail to show *Cryptosporidium* upon testing by a licensed laboratory; or (4-2-08)

b. Diarrhea has ceased for twenty-four (24) hours. (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

320. HEMOLYTIC-UREMIC SYNDROME (HUS).

01. Reporting Requirements. Each case of hemolytic-uremic syndrome (HUS) or thrombotic thrombocytopenic purpura-HUS (TTP-HUS) must be reported to the Department or

Health District within one (1) working day. ~~*(4-2-08)*~~( )

02. Investigation. Each case of HUS or TTP-HUS must be investigated to confirm the diagnosis, determine the etiologic agent including *E. coli* O157:H7, non-O157 Shiga-toxin producing *E. coli*, or other enteric pathogens, and determine the source of infection.
~~*(4-2-08)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

480. MUMPS.

01. Reporting Requirements. Each case of mumps must be reported to the Department or Health District within three (3) working days of identification. (4-2-08)

02. Investigation. Each reported case of mumps must be investigated to determine the immunization history or if the cause for an outbreak is unusual. (4-2-08)

03. Restrictions. A person with mumps must be restricted from day care, school, or work for ~~*nine*~~ five (~~9~~5) days after the onset of parotid swelling. ~~*(4-2-08)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

521. RESERVED.

522. NOVEL INFLUENZA A VIRUS.

01. Reporting Requirements. ( )

a. Each detection of a novel influenza A virus must be reported to the Department or Health District within one (1) working day of identification by the laboratory director. ( )

b. Each probable or confirmed case of a novel influenza A infection resulting in hospitalization must be reported to the Department or Health District within one (1) working day of the event. ( )

02. Investigation. Any case of a novel influenza A infection may be investigated to determine severity and recommend measures to prevent spread. ( )

03. Restrictions. A person diagnosed with novel influenza A virus infection must be restricted from day care, school, or work for twenty-four (24) hours after the fever is resolved. Fever must be absent without the aid of fever-reducing medicine. ( )

52~~1~~3. -- 529. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

610. RABIES - HUMAN, ~~*AND*~~ ANIMAL, AND POST-EXPOSURE PROPHYLAXIS (rPEP).

01. Reporting Requirements. (4-2-08)

a. Each case or suspected case of rabies in humans must be reported to the Department or Health District immediately, at the time of identification, day or night. (4-2-08)

b. Each case ~~*or suspected case*~~ of rabies in animals must be reported to the Department or Health District ~~*and the Idaho Department of Agriculture*~~ within one (1) working day of identification. Each case of rabies in animals must also be reported to the Department of Agriculture as required in IDAPA 02.04.03, "Rules Governing Animal Industries."~~*(4-2-08)*~~( )

c. Each instance of rabies post-exposure prophylaxis (rPEP) series initiation must be reported to the Department or Health District within one (1) working day. (4-2-08)

02. Investigation. (4-2-08)

a. Each reported case or suspected case of rabies in humans must be investigated to confirm the diagnosis, identify the source and other persons or animals that may have been exposed to the source, and identify persons who may need to undergo ~~*prophylaxis with rabies immune globulin and rabies vaccine*~~ rPEP. ~~*(4-2-08)*~~( )

b. Each suspected or confirmed case of rabies in animals will be investigated to determine if potential human or animal exposure has occurred and identify persons who may need to under go rPEP. ( )

~~*b*~~**c.** Each reported rPEP series initiation must be investigated to determine if additional individuals require rPEP and identify the source of possible *rabies* exposure. ~~*(4-2-08)*~~( )

03. Handling of Report. The Health District must notify the Department and the Idaho Department of Agriculture within one (1) working day of each reported case of this disease. (4-2-08)

04. Management of Exposure to Rabies. All exposures to a suspected or confirmed rabid animal must be managed under the guidelines in the "Compendium of Animal Rabies Control, 2008," incorporated by reference in Section 004 of these rules. In the event that a human or animal case of rabies occurs, any designated representative of the Department, Health District, or Idaho Department of Agriculture, will establish such isolation and quarantine of animals *involved* as deemed necessary to protect the public health. ~~*(4-2-08)*~~( )

a. The handling of a rabies-susceptible animal that has bitten a person must be as follows: (4-2-08)

i. Any livestock which has bitten a person must be managed by the Idaho

Department of Agriculture. *(4-2-08)*

ii. Any healthy domestic dog, cat, or ferret that has bitten a person must be observed for ten (10) days following the bite under the supervision of a licensed veterinarian or other person designated by the Idaho Department of Agriculture, Health District, or the Department. Such observation must be within an enclosure or with restraints deemed adequate to prevent contact with any member of the public or other animals. (4-2-08)

iii. It is the animal owner's responsibility to carry out the quarantine of the biting animal and to follow instructions provided for the quarantine of the animal. (4-2-08)

iv. Any domestic dog, cat, or ferret that has not been vaccinated against rabies by a licensed veterinarian and can not be quarantined, must be destroyed by a means other than shooting in the head. The head must be submitted to an approved laboratory for rabies analysis. (4-2-08)

v. Rabies ~~S~~susceptible animals other than domestic dogs, cats, ferrets, or livestock must be destroyed and the head submitted to an approved laboratory for rabies analysis, unless an exemption is given by the Department or Health District. ~~*(4-2-08)*~~(____)

vi. No person will destroy, or allow to be destroyed, the head of a rabies-susceptible animal that has bitten a person without authorization from the Department or Health District. (4-2-08)

b. The handling of a rabies-susceptible animal that has not bitten a person, but has within the past one hundred eighty (180) days been bitten, mouthed, mauled by, or closely confined in the same premises with a known rabid animal must be as follows: (4-2-08)

i. Any domestic dog, cat, ferret, or livestock which has not been vaccinated as recommended by the American Veterinary Medical Association, must be placed in quarantine for a period of six (6) months under the observation of a licensed veterinarian or a person designated by the Idaho Department of Agriculture, Health District, or the Department and vaccinated according to the Rabies Compendium. An animal with current vaccinations, including livestock, should be revaccinated immediately with an appropriate rabies vaccine and quarantined for forty-five (45) days. These provisions apply only to animals for which an approved rabies vaccine is available. (4-2-08)

ii. The quarantine of such animal must be within an enclosure deemed adequate by a person designated by the Idaho Department of Agriculture, the Department, or Health District to prevent contact with any person or rabies-susceptible animal. (4-2-08)

iii. The owner of the animal is financially responsible for the cost of isolating and quarantining the animal and for specimen collection and testing. (4-2-08)

iv. Destruction of such animal is permitted as an alternative to quarantine. (4-2-08)

c. Any rabies-susceptible animal other than domestic dogs, cats, ferrets, or livestock that are suspected of having rabies, or which have been in close contact with an animal known to

be rabid, must be destroyed. The animal must be tested by an approved laboratory for rabies if a person has been bitten or has had direct contact with the animal which might result in the person becoming infected unless an exemption is granted by the Department or Health District.
(4-2-08)( )

05. City or County Authority. Nothing in these rules is intended or will be construed to limit the power of any city or county in its authority to enact more stringent requirements to prevent the transmission of rabies. (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

760. TRANSMISSIBLE SPONGIFORM ENCEPHALOPATHIES (TSE), INCLUDING CREUTZFELDT-JAKOB DISEASE (CJD) AND VARIANT CJD (VCJD).

01. Reporting Requirements. Each case or suspected case of transmissible spongiform encephalopathy (TSE), including Creutzfeldt-Jakob disease (CJD) and variant CJD (vCJD) must be reported to the Department or Health District within three (3) working days of identification. *(4-2-08)*( )

02. Investigation. Each reported case of transmissible spongiform encephalopathy (TSE) must be investigated to determine the cause and confirm the diagnosis. (4-2-08)

03. Autopsy. The state epidemiologist may order an autopsy for suspected CJD or vCJD *cases* deaths as per Section 39-277, Idaho Code. *(4-2-08)*( )

(BREAK IN CONTINUITY OF SECTIONS)

800. WEST NILE VIRUS (WNV).

01. Reporting Requirements. Each case *or suspected case* of West Nile virus (WNV) infection must be reported to the Department or Health District within three (3) working days of identification. *(4-2-08)*( )

02. Investigation. Each reported case of WNV infection must be investigated to confirm the diagnosis, review any travel history, review any blood donations, and identify the most likely source of infection including exposure to vectors, blood transfusion, or organ receipt. (4-2-08)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.02.12 - RULES GOVERNING PROCEDURES AND TESTING TO BE PERFORMED ON NEWBORN INFANTS

DOCKET NO. 16-0212-0901

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 of the legislature, this agency requests that the effective date of July 1, 2010, be inserted into the language of the concurrent resolution rather than have the rule become effective upon adoption of 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 39-906, 39-909, and 39-910, 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:

This rulemaking updated this chapter of rule to reflect the latest reference materials incorporated, and to update some sections to reflect currently accepted medical practices for newborn screening.

Based on comment to the rule by the Department, the legal authority section was revised. This rule chapter is under the authority of the Board of Health; however, based on statute, it is also under the authority of the Director of the Department of Health and Welfare. A reference to the Director's authority is being added to the legal authority section. Also, a legal term in the authority section is being changed to a more appropriate term. Finally, based on comment to the rule, the term "preventable diseases," was restored to reflect the currently codified text.

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 2, 2009, Idaho Administrative Bulletin, Vol. 09-9, pages 113 through 119.

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, either positive or negative, to the state general fund due to the approval of these rule changes.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions

concerning the pending rule, contact Dieuwke Spencer at (208) 334-0670.

DATED this 19th day of November, 2009.

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

THE FOLLOWING NOTICE 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 39-906, 39-909, and 39-910, 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 16, 2009.

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 rule change is necessary to update this chapter of rule to reflect the latest reference materials incorporated, and to update some sections to reflect currently accepted medical practices for newborn screening.

The reference to the latest edition of the Clinical and Laboratory Standards Institute's newborn screening manual and the newborn screening specimen collection requirements for current medical practices are both being updated. A new section of rule is being added to clearly outline the acceptable uses and storage of newborn screening specimens.

Additionally, this chapter is being updated to conform to the formatting and plain language standards required by the Department.

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 Idaho Newborn Screening Program is funded through provider payments. There will be no fiscal impact, positive or negative, to the state general fund due to the approval of these rule changes.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because these changes are not of a controversial nature.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Dieuwke Spencer at (208) 334-0670.

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 23, 2009.

DATED this 23rd day of July, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

IDAPA 16,
TITLE 02
CHAPTER 12

16.02.12 - RULES GOVERNING PROCEDURES AND TESTING TO BE PERFORMED ON NEWBORN INFANTS

000. LEGAL AUTHORITY.
The Idaho Legislature has given the Board of Health and Welfare ~~*legislative power*~~ *and the Director of the Department authority* to promulgate rules governing the testing of newborn infants for phenylketonuria and other preventable diseases and governing the instillation of an ophthalmic preparation in the eyes of the newborn to prevent Ophthalmia Neonatorum, ~~*pursuant to*~~ *under* Sections 39-906, 39-909, and 39-910 ~~*and 39-911*~~, Idaho Code. ~~*(5-3-03)*~~*( )*

001. TITLE AND SCOPE.

01. Title. These rules are to be cited in full as Idaho Department of Health and Welfare Rules, IDAPA 16.02.12, "~~*Rules Governing*~~ Procedures and Testing to ~~*B*~~be Performed on Newborn Infants." ~~*(5-3-03)*~~*( )*

02. Scope. These rules specify the tests and procedures that must be performed on newborn infants for early detection of ~~*mental retardation, developmental disabilities, blood amino acid levels*~~ metabolic disorders, endocrine disorders, hemoglobin disorders, cystic fibrosis, and prevention of infant blindness. ~~*(5-3-03)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

003. ADMINISTRATIVE APPEALS.
~~*All contested cases shall be*~~ Administrative appeals are governed by the provision of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings."
~~*(5-3-03)*~~( )

004. INCORPORATION BY REFERENCE.
~~*Pursuant to*~~ Under Section 67-5229, Idaho Code, this chapter incorporates by reference the following document. ~~*(5-3-03)*~~( )

01. Document. "Blood Collection on Filter Paper for ~~*Neonatal*~~ Newborn Screening Programs; Approved Standard," ~~*Third*~~ Fifth Edition. ~~*National Committee for Clinical Laboratory Standards*~~ Clinical and Laboratory Standards Institute, ~~*1997*~~ 2007. ISBN 1-56238-~~*334-5*~~644-1.
~~*(5-3-03)*~~( )

02. Availability. This document is available through the ~~*National Committee for Clinical Laboratory Standards*~~ Clinical and Laboratory Standards Institute, 940 West Valley Road, Suite 1400, Wayne, PA 19087-1898, telephone 610-688-0100. ~~*(5-3-03)*~~( )

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS AND STREET ADDRESS.
~~*The state office of the Department of Health and Welfare is located at 450 W. State St., Boise, ID 83720-0036, telephone number 208-334-5930. The office hours are 8 a.m. to 5 p.m. Monday through Friday.*~~ ~~*(5-3-03)*~~

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 St., 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 found at http://www.healthandwelfare.idaho.gov. ( )

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

~~*These rules have been promulgated according to the provisions of Title 67, Chapter 52, Idaho Code, and are public records. Any disclosure of information obtained by the Department is subject to the restrictions contained in Idaho Department of Health and Welfare Rules, IDAPA 16.05.01, "Use and Disclosure of Department Records," and Section 9-338 et seq., Idaho Code.*~~ ~~*(5-3-03)*~~

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.
The following definitions will apply in the interpretation and enforcement of this chapter: (5-3-03)

01. Department. The Idaho Department of Health and Welfare. (5-3-03)

02. Dried Blood Specimen. A blood specimen obtained from an infant by means of skin puncture, not by means of venipuncture or any other method, that is placed on special filter paper ~~*kits*~~ and allowed to dry. ~~*(5-3-03)*~~( )

03. Hyperalimentation. The administration of an amount of nutrients beyond minimum normal requirements of the appetite, in an attempt to replace nutritional deficiencies. ( )

0~~3~~4. Laboratory. A medical or diagnostic laboratory certified according to the provisions of the Clinical Laboratory Improvement Amendments of 1988 by the United States Department of Health and Human Services. (5-3-03)

0~~4~~5. Newborn Screening. Newborn screening means a laboratory procedure performed on dried blood specimens from newborns to detect those at risk for the diseases specified in Subsection 100.01 of these rules. (5-3-03)

0~~5~~6. Person Responsible for Registering Birth of Child. The person responsible for preparing and filing the certificate of birth is defined in Section 39-255, Idaho Code. (5-3-03)

0~~6~~7. Test Kit. The materials provided by the laboratory for the purposes of dried blood specimen collection and submission of specimens for newborn screening laboratory procedures. (5-3-03)

011. -- 0~~9~~4~~9~~9. (RESERVED).

050. USE AND STORAGE OF DRIED BLOOD SPECIMENS.

01. Use of Dried Blood Specimens. Dried blood specimens will be used for the purpose of testing the infant from whom the specimen was taken, for congenital birth defects. Limited use of specimens for routine calibration of newborn screening laboratory equipment and quality assurance is permissible. ( )

02. Prohibited Use of Dried Blood Specimens. Dried blood specimens may not be used for any purpose other then those described in Section 050.01 of this rule without the express written consent of the parent(s) or guardian(s) of the infant from whom the specimen was collected. ( )

03. Storage of Dried Blood Specimens. Dried blood specimens may be stored at the testing facility for a period not to exceed eighteen (18) months. Acceptable use of stored specimens will be for re-testing the specimen in the event of a symptomatic diagnosis or death of the infant during the storage period. ( )

051. -- 099. (RESERVED).

100. DUTIES OF THE ADMINISTRATOR OF THE RESPONSIBLE INSTITUTION AND THE PERSON REQUIRED TO REGISTER THE BIRTH OF A CHILD.

01. Conditions for Which Infants Will Be Tested. All infants born in Idaho ~~*shall*~~ must be tested for at least the following conditions: ~~*(5-3-03)*~~( )

a. Biotinidase deficiency; (5-3-03)

b. Congenital hypothyroidism; (5-3-03)

c. Galactosemia; (5-3-03)

d. Maple syrup urine disease; and (5-3-03)

e. Phenylketonuria. (5-3-03)

02. Blood Specimen Collection. (5-3-03)

a. The dried blood specimen collection procedures ~~*shall*~~ must follow the ~~*National Committee for Clinical Laboratory Standards, "Blood Collection on Filter Paper for Neonatal Screening Programs; Approved Standard-Third Edition," 1997*~~ document listed in Subsection 004.01 of these rules. ~~*(5-3-03)*~~( )

b. For ~~*premature*~~ infants~~, in-hospital~~ admitted to the neonatal intensive care unit (NICU), the initial dried blood specimen for newborn screening ~~*shall*~~ must be obtained ~~*between forty-eight (48) hours of age and ten (10) days of age*~~ upon admission to the NICU. ~~*(5-3-03)*~~( )

c. For non-premature infants, in-hospital, the initial dried blood specimen for newborn screening ~~*shall*~~ must be obtained between ~~*forty-eight*~~ twenty-four (~~*48*~~24) and forty-eight (48) hours of age ~~*and five (5) days of age*~~. ~~*(5-3-03)*~~( )

d. For newborns transferred from one hospital to another, the originating hospital ~~*shall*~~ must assure that the dried blood specimen is drawn. If the newborn is too premature or too sick to have a dried blood specimen drawn for screening prior to transfer and a dried blood specimen is not obtained, the originating hospital ~~*shall be responsible for clearly*~~ must document~~*ing*~~ this, and notify~~*ing*~~ the hospital to which the newborn is being transferred that a dried blood specimen for newborn screening has not been obtained. ~~*(5-3-03)*~~( )

e. Prior to the discharge of an infant from the institution where initial newborn care or specialized medical care was rendered, the Administrator ~~*shall*~~ of the institution must assure that an adequate dried blood specimen has been collected regardless of the time the infant is discharged from the institution. ~~*(5-3-03)*~~( )

f. For births occurring outside of a hospital, the birth attendant ~~*shall be*~~ is responsible for assuring that an acceptable dried blood specimen is properly collected for newborn screening as stipulated in Section 100 of these rules. ~~*(5-3-03)*~~( )

g. Newborns who require a blood transfusion, hyperalimentation, or dialysis ~~*shall*~~ must have a dried blood specimen collected for screening prior to ~~*transfusion or dialysis*~~ these procedures. ~~*(5-3-03)*~~( )

h. If a dried blood specimen cannot be obtained for newborn screening before transfusion, hyperalimentation, or dialysis, the ~~*physician shall*~~ hospital must ensure that a repeat dried blood specimen is obtained at the appropriate time when the specimen will reflect the infant's own metabolic processes and phenotype. ~~*(5-3-03)*~~( )

i. ~~*Infants from whom the dried blood specimen has been collected for newborn screening less than forty-eight (48) hours after birth shall*~~ All infants must be retested. A test kit ~~*shall*~~ must be given to the parents or responsible party at the time of discharge from the institution where initial newborn care was rendered, with instructions to have a second dried blood specimen collected. ~~*In such cases t*~~The preferred time for sample collection is ~~*after five (5) but before*~~ between ten (10) and fifteen (15) days of age. ~~*(5-3-03)*~~( )

03. Specimen Data Card. The person obtaining the newborn screening specimen must complete the demographic information card attached to the sample kit. The First Specimen Card must include the infant's mother's date of birth, address, and phone number. Both the First and Second Specimen's Card must include the items listed in 100.03.a. through 100.03.k. of this rule, optional fields may be completed as needed. ( )

a. Name of the infant; ( )

b. Whether the birth was a single or multiple-infant birth; ( )

c. Name of the infant's mother; ( )

d. Gender of the infant; ( )

e. Method of feeding the infant; ( )

f. Name of the birthing facility; ( )

g. Date and time of the birth; ( )

h. Date and time the specimen was obtained; ( )

i. Name of the attending physician or other attendant; ( )

j. Date specimen was collected; and ( )

k. Name of person collecting the specimen. ( )

03~~.~~4. Specimen Mailing. Within twenty-four (24) hours after collection, the dried blood specimen ~~*shall*~~ must be mailed to the laboratory by first class mail or its equivalent, except when mailing service is not available. When mailing service is not available on weekends and holidays, dried blood specimens ~~*shall*~~ must be mailed to the laboratory on the first available mail pick-up day. The preferred method of mailing, following a weekend or holiday, is by expedited mail service. ~~*(5-3-03)*~~( )

04~~.~~5. Record Keeping. Maintain a record of all dried blood specimens collected for newborn screening. This record ~~*shall*~~ must indicate ~~*the*~~: ( )

a. ~~*n*~~Name of the infant~~,~~; ( )

b. ~~*n*~~Name of the attending physician or other attendant~~,~~; ( )

c. ~~*d*~~Date specimen was collected~~,~~; and ( )

d. ~~*n*~~Name of person collecting specimen. ~~*(5-3-03)*~~( )

05~~.~~6. Collection Protocol. Ensure that a protocol for collection and submission for newborn screening of adequate dried blood specimens has been developed, documented, and implemented. Individual responsibilities ~~*shall*~~ must be clearly defined and documented. The attending physician ~~*shall*~~ must request that the test be done. The hospital may make an appropriate charge for this service. ~~*(5-3-03)*~~( )

06~~.~~7. Responsibility for Recording Specimen Collection. (5-3-03)

a. The administrator of the responsible institution, or his designee, ~~*shall be responsible for recording*~~ must record on the birth certificate whether the dried blood specimen for newborn screening has been collected. ~~*(5-3-03)*~~( )

b. When a birth occurs outside a hospital, the person responsible for registering the

birth of the child ~~*shall also be responsible for recording*~~ must record on the birth certificate whether the dried blood specimen for newborn screening has been collected and submitted within twenty-four (24) hours following collection. ~~*(5-3-03)*~~( )

0~~7~~8. Fees. The Department ~~*shall*~~ will provide access to newborn screening laboratory services. If the administration of the responsible institution or the person required to register the birth of a child chooses to utilize this service, the Department ~~*shall*~~ will collect a fee equal to the cost of the test kit, analytical, and diagnostic services provided by the laboratory. The fees ~~*shall*~~ must be remitted to the Department before the laboratory provides the test kit to those responsible for ensuring the infant is tested according to these rules. ~~*(5-3-03)*~~( )

101. -- 199. (RESERVED).

200. LABORATORY DUTIES.

01. Participation in Centers for Disease Control and Prevention (CDC) Newborn Screening Quality Assurance Program. All laboratories receiving dried blood specimens for newborn screening on infants born in Idaho ~~*shall*~~ must participate in the Newborn Screening Quality Assurance Program operated by the CDC. ~~*(5-3-03)*~~( )

02. Specimen Processing. Dried blood specimens for newborn screening must be processed within twenty-four (24) hours of receipt by the laboratory or before the close of the next business day. (5-3-03)

03. Result Notification. Normal test results may be reported by mail to the submitter. Other results must be reported in accordance with Section 300 of these rules. (5-3-03)

201. -- 299. (RESERVED).

300. FOLLOW-UP FOR UNSATISFACTORY SPECIMENS, PRESUMPTIVE POSITIVE RESULTS AND POSITIVE CASES.

01. Follow-Up for Unsatisfactory Specimens. (5-3-03)

a. The laboratory will immediately report any unsatisfactory dried blood specimens to the submitting institution which originated the dried blood specimen or to the healthcare provider responsible for the newborn's care, with an explanation of the results. The laboratory will request a repeat dried blood specimen for newborn screening from the institution or individual submitting the original sample, or from the responsible provider. ~~*(5-3-03)*~~( )

b. Upon notification from the laboratory, the health care provider responsible for the newborn's care at the time of the report will cause another dried blood specimen to be appropriately forwarded to the laboratory for screening. (5-3-03)

02. Follow-Up of Presumptive Positive Results. The laboratory will report positive or suspicious results on an infant's dried blood specimen to the attending physician or midwife, or, if there is none or the physician or midwife is unknown, to the person who registered the infant's birth, and make recommendations on the necessity of follow-up testing. (5-3-03)

03. Positive Case Notification. Confirmed positive cases of biotinidase deficiency, congenital hypothyroidism, galactosemia, maple syrup urine disease, and phenylketonuria must be reported as described in IDAPA 16.02.10, "Idaho Reportable Diseases." (5-3-03)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.01 - ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

DOCKET NO. 16-0301-0901

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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, 56-209, 56-236, 56-237, 56-238, 56-239, 56-240, 56-242, 56-250, 56-253, 56-255, and 56-257, Idaho Code; and Public Law 111-8, Sections 601 and 602, "Afghan Allies Protection Act of 2009"; H.R.1, "American Recovery and Reinvestment Act of 2009"; and "Children's Health Insurance Program (CHIP) Reauthorization Act of 2009," Sections 113 (deemed newborn definition) and 221 (citizenship documentation for deemed newborns and tribal members).

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 pending rule is being adopted as proposed. The complete text of the proposed rule was published in the July 1, 2009 Idaho Administrative Bulletin, Vol. 09-7, pages 30 through 39.

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 total estimated impact of this rulemaking is $891,200, of which $185,700 would be from the state general fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Kathy McGill at (208) 334-4934.

DATED this 17th day of September, 2009.

Tamara Prisock
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THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective dates of the temporary rule are March 11, 2009, April 1, 2009, and July 1, 2009.

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, 56-209, 56-236, 56-237, 56-238, 56-239, 56-240, 56-242, 56-250, 56-253, 56-255, and 56-257, Idaho Code; and Public Law 111-8, Sections 601 and 602, "Afghan Allies Protection Act of 2009"; H.R.1, "American Recovery and Reinvestment Act of 2009"; and "Children's Health Insurance Program (CHIP) Reauthorization Act of 2009," Sections 113 (deemed newborn definition) and 221 (citizenship documentation for deemed newborns and tribal members).

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 15, 2009.

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 rulemaking is being proposed due to several changes in federal requirements. The changes in federal statute create the following changes to the Department's rules dealing with eligibility for services:

1. **Extend the Afghani special immigrant benefits to eight months. (Effective March 11, 2009)**

2. **Amend deemed newborn (a newborn child deemed eligible for Medicaid for the first year of his life) to remain eligible regardless of mother's eligibility or whether living with birth mother. (Effective April 1, 2009)**

3. **Align citizenship and identification documentation requirements with federal regulations for deemed newborns and tribal members. (Effective April 1, 2009)**

4. **Exclude income as required and defined in federal law. (Effective July 1, 2009)**

5. **Delete the reporting requirements and income test from Transitional Medicaid. (Effective July 1, 2009)**

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 for the following reasons:

This rulemaking is necessary to meet deadlines in federal regulation and confers a benefit to participants receiving Medicaid.

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:

The total estimated impact of this rulemaking is $891,200, of which $185,700 would be from the state general fund.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 67-5220, negotiated rulemaking was not conducted because this rule is being written to comply with federal regulations.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Kathy McGill at (208) 334-4934.

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 22, 2009.

DATED this 29th day of May, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

220. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.
To be eligible, an individual must be a member of one (1) of the following groups: (3-30-07)

01. U.S. Citizen. A U.S. Citizen; (3-30-07)

02. U.S. National, National of American Samoa or Swain's Island. A U. S. national, or a national of American Samoa or Swain's Island. (3-30-07)

03. 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)

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

05. Veteran of the U.S. Armed Forces. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) who were 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)

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

07. Non-Citizen Entering On or After August 22, 1996. A non-citizen who entered the U.S. on or after August 22, 1996, and who is: (3-30-07)

a. 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. 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. 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. An Amerasian immigrant admitted into the U.S. under 8 U.S.C. 1612(b)(2)(A)(i)(V), and can be eligible for seven (7) years from the date of entry; or (3-30-07)

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 their date of entry; (3-30-07)

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

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

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

11. 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; and (3-30-07)

12. 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: (3-30-07)

a. Is under the age of eighteen (18) years; or (3-30-07)

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 (3-30-07)

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 (3-30-07)

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

13. Afghan Special Immigrants. An Afghan special immigrant, as defined in Public Law 110-161, who has special immigration status after December 26, 2007, is eligible for ~~*six*~~ eight (~~*6*~~8) months from the date they enter into the U.S. as a special immigrant or the date they convert to the special immigrant status. ~~*(5-8-09)*~~(____)

14. Iraqi Special Immigrants. An Iraqi special immigrant, as defined in Public Law 110-181, who has special immigration status after January 28, 2008, is eligible for eight (8) months from the date they enter the U.S. as a special immigrant or the date they convert to the special immigrant status. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

222. LEVELS OF CITIZENSHIP DOCUMENTATION.

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; (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 document issued by a federally-recognized Indian tribe proving membership, enrollment in, or affiliation with such tribe. ( )

02. Documents Accepted as Secondary Level Proof of U.S. Citizenship but Not Identity. The following documents are accepted as proof of U.S. citizenship if the proof in Subsection 222.01 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 222.05 or Section 223 of these rules to establish both citizenship and identity. (3-30-07)

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; (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. Certification of birth abroad, Form FS-545; (4-2-08)

k. Verification 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)

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 Subsection 222.05 or Section 223 of these rules to establish both citizenship and identity. (3-30-07)

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; or (3-30-07)

b. 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. (3-30-07)

c. Religious record recorded in the U.S. within three (3) months of birth showing the birth occurred in the U.S. and showing whether 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. (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 105.01 through 105.03 of these rules 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 Subsection 222.05 or Section 223 of these rules to establish both citizenship and identity. (3-30-07)

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 for participants sixteen (16) years of age or older and was created at least five (5) years before the application for Medicaid. For children under sixteen (16) years of age, the document must have been created near the time of birth; (4-2-08)

~~*i. Seneca Indian tribal census record;* (3-30-07)~~

i~~i~~. Bureau of Indian Affairs tribal census records of the Navajo Indians; (3-30-07)

ii~~i~~. U.S. State vital Statistics official notification of birth registration; (3-30-07)

iv~~i~~ii. A delayed U.S. public birth record that is 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~~i~~. Medical (clinic, doctor, or hospital) record; (3-30-07)

vi~~i~~. Institutional admission papers from a nursing facility, skilled care facility or other institution; or (3-30-07)

vii~~i~~. Bureau of Indian Affairs roll of Alaska Natives. (4-2-08)

c. 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)

05. Documents Accepted for Proof of Identity but Not Citizenship. The following documents are accepted as proof of identity. They are not proof of citizenship and must be used in combination with at least one (1) document listed in Subsections 222.01 through 222.04 of this rule to establish both citizenship and identity. (3-30-07)

a. A state-issued driver's license bearing the individual's picture or other identifying information such as name, age, gender, race, height, weight, or eye color; (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 222.05.a. of this rule; (3-30-07)

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; or *(3-30-07)*( )

g. *Certificate of Degree of Indian blood; or* *(3-30-07)*

h. *Native American Indian or Alaska Native Tribal document with a photograph or other personal identifying information relating to the individual.* *(3-30-07)*

ig. Identity affidavits are acceptable proof of identity for individuals living in a residential care facility. (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

225. INDIVIDUALS CONSIDERED AS MEETING THE U.S. CITIZENSHIP AND IDENTITY DOCUMENTATION REQUIREMENTS.
The individuals listed in Subsections 225.01 through 225.05 of this rule meet the U.S. citizenship and identity requirements and are not required to provide documentation of citizenship and identity. (4-2-08)

01. Supplemental Security Income (SSI) Recipients. (4-2-08)

02. Social Security Disability Income (SSDI) Recipients. (4-2-08)

03. Individuals Determined by SSA to be Entitled to Receive Medicare. (4-2-08)

04. Adoptive or Foster Care Children Receiving Assistance Under Title IV-B or Title IV-E of the Social Security Act. (4-2-08)

05. Individuals Deemed Eligible for Medicaid as a Waived Newborn Under Section 530 of these Rules. ( )

(BREAK IN CONTINUITY OF SECTIONS)

385. INCOME EXCLUDED BY FEDERAL LAW.
Income excluded by federal law is not counted in determining income available to the participant. *The following kinds of income are excluded by federal law:* *(3-30-07)*( )

~~**01. Agent Orange Settlement Funds**. Payments made to veterans from the Agent Orange Settlement Fund. (3-30-07)~~

~~**02. Alaska Native Claims**. Tax-exempt portions of payments made in accordance with the Alaska Native Claims Settlement Act, PL 92-203. (3-30-07)~~

~~**03. AmeriCorps**. AmeriCorps payments for child care allowances and educational awards, other than stipends or living allowances, are excluded. (3-30-07)~~

~~**04. Child Nutrition Benefits**. The value of supplemental food assistance received under the Child Nutrition Act of 1966, as amended, and the food service program for children under the National School Fund Act, as amended, (PL 92-433 and PL 93-150). These are the WIC program and school lunch program. (3-30-07)~~

~~**05. Commodities and Food Stamps**. The value of U.S. Department of Agriculture donated commodities and Food Stamps. (3-30-07)~~

~~**06. Disaster Relief**. Assistance paid under the Disaster Relief Act of 1974 and aid provided under any federal statute for a President-declared disaster and comparable disaster assistance provided by states, local government and disaster assistance organizations. (3-30-07)~~

~~**07. Elderly Nutritional Benefits**. Any benefits received under Title VII, Nutritional Program for the Elderly, of the Older Americans Act of 1965. (3-30-07)~~

~~**08. Foster Care and Adoption Assistance Payment**. Foster care payments paid by the Department are excluded. Adoption Assistance payments paid by federal, state or local agencies are excluded. (3-30-07)~~

~~**09. Garnishments**. Income garnished by court order is not available and is excluded. (3-30-07)~~

~~**10. Home Energy Assistance**. PL 100-203 excludes Home Energy Assistance. The aid must be provided based on need certified by the Department. (3-30-07)~~

~~**11. Home Produce**. The value of home produce used by the family. (3-30-07)~~

~~**12. Housing Subsidies**. The value of government rent or housing subsidies or both, if the participant receives both. (3-30-07)~~

~~**13. HUD Family Self Sufficiency Escrow Account**. Interest earned on an escrow account established by HUD for families participating in the Family Self-Sufficiency Program established by Section 544 of the National Affordable Housing Act. (3-30-07)~~

~~**14. Income Tax Refunds and Earned Income Tax Credit (EITC) Payments**. Income tax refunds are excluded from income, but counted as a resource. Earned Income Tax Credit payments, or the advance payment of the EITC, is excluded. (3-30-07)~~

~~***15. Indian Payments**. Payments distributed to or held in trust for members of any Indian tribe issued under PL 92-254, PL 93-134, or PL 94-540. Payments distributed to certain Indian tribes, including the Shoshone Bannock Tribe of Fort Hall, Idaho, referenced under Section 5 of PL 94-114, effective October 10, 1975. Per capita judgment funds paid to members of the Blackfoot Tribe of the Blackfoot Indian Reservation, Montana and the Gros Ventre Tribe of the Fort Belknap Reservation, Montana. Per capita funds held in trust by the Secretary of the Interior for tribal members paid under PL 98-64. Effective January 1, 1994, up to two thousand dollars ($2,000) of payments derived from interests of individual Indians in trust or restricted lands are excluded by Section 8 of the PL 93-134 as amended by PL 103-66. (3-30-07)*~~

~~***16. Loans**. A bona fide loan is not available income. (3-30-07)*~~

~~***17. Low Income Energy Assistance**. Money paid to families under the Low Income Energy Assistance Act of 1981 under 42 U.S.C. 8624(f) is excluded. (3-30-07)*~~

~~***18. Radiation Exposure Compensation Act**. Payments made to individuals under this act are excluded. (3-30-07)*~~

~~***19. Relocation Assistance**. Payments received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, contained in 42 U.S.C. Subsection 4636 of the U.S. Code, and relocation payments paid to civilians of World War II per Public Law 100-383. (3-30-07)*~~

~~***20. SSI Income or AABD Income**. Income and resources of a person who has been determined eligible for, or is receiving SSI or AABD, is excluded. (3-30-07)*~~

~~***21. Senior Volunteer Programs**. Payments for supportive services or out-of-pocket expenses made to individual volunteers serving as foster grandparents, Vista volunteers, senior health aids, or senior companions and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and any other program under Title II and Title III of the Domestic Volunteer Service Act of 1973, Section 418, PL 93-113, and 93-143. This Federal Code is contained in Titles 5 and 42 of the U.S. Code. (3-30-07)*~~

~~***22. Spina Bifida**. Spina bifida allowances paid to children of Vietnam veterans. (3-30-07)*~~

~~***23. Third Party Deposits to a Checking Account**. Third party deposits to a participant's checking account are excluded if the deposit is solely for the use of the third party and the participant receives no benefit from the deposit. (3-30-07)*~~

~~***24. Utility Reimbursement Payments**. Utility reimbursement payments made to persons living in housing subsidized by HUD. (3-30-07)*~~

~~***25. Work Related Payments**. Payments made by an employer for work-related expenses are excluded. Work-related expenses include travel and per diem. (3-30-07)*~~

(BREAK IN CONTINUITY OF SECTIONS)

422. -- 424. (RESERVED).

~~***423. TRANSITIONAL MEDICAID REPORTING REQUIREMENT.***~~
~~*To continue to receive Transitional Medicaid for months seven (7) through twelve (12), the family must complete and return three (3) quarterly reports. Each report must include the family gross earnings, expenses for dependent care needed for employment, and any change to the family composition. Proof of monthly earnings and dependent care expenses must be provided with each report.* (5-8-09)~~

~~***424. INCOME TESTS FOR TRANSITIONAL MEDICAID.***~~

~~***01. Income Test**. The family's reported earnings, less dependant care expenses necessary for employment, must not exceed one-hundred and eighty-five percent (185%) of the FPG for the family size.* (5-8-09)~~

~~***02. Good Cause for Lack of Earnings**. Good cause for lack of earnings includes, but is not limited to:* (4-2-08)~~

~~***a.** Family crisis.* (4-2-08)~~

~~***b.** Court required appearance or incarceration.* (4-2-08)~~

~~***c.** Loss of transportation where no other means of transportation is readily accessible.* (4-2-08)~~

~~***d.** Loss of child care arrangements.* (4-2-08)~~

~~***e.** Involuntary loss of employment.* (4-2-08)~~

~~***f.** Illness.* (4-2-08)~~

(BREAK IN CONTINUITY OF SECTIONS)

525. CONTINUOUS HEALTH CARE ASSISTANCE ELIGIBILITY FOR CHILDREN UNDER AGE NINETEEN.
Children under age nineteen (19), who are found eligible in an initial determination or a 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. (3-30-07)

01. Reasons Continuous Eligibility Ends. Continuous eligibility for children stops for one (1) of the following reasons: (3-30-07)

a. The child is no longer an Idaho resident; or (3-30-07)

b. The child dies; or (3-30-07)

c. The participant requests closure; or (3-30-07)

d. The child turns nineteen (19) years of age as defined in Subsection 010.05 of these rules. (3-30-07)

02. Children Not Eligible for Continuous Eligibility. Children are not eligible for continuous eligibility for one (1) of the following reasons: (3-30-07)

a. A child is approved for emergency medical services; (5-8-09)

b. A child is approved for pregnancy-related services; (5-8-09)

c. A child is an Afghan special immigrant and is approved for ~~*six*~~ eight (~~6~~8) months; or ~~*(5-8-09)*~~( )

d. A child is an Iraqi special immigrant and is approved for eight (8) months. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

530. NEWBORN CHILD DEEMED ELIGIBLE FOR MEDICAID.
A child is deemed eligible for Medicaid for his first year of life if: (4-2-08)

01. Mother Filing an Application. The child is born to a mother who files an application for medical assistance, and (4-2-08)

02. Mother Is Eligible for Medicaid. The mother is ~~*at or below one hundred thirty-three (133%) FPG and is*~~ eligible for Medicaid in the newborn's birth month. This includes a mother ~~*with income at or below one hundred thirty-three (133%) of poverty*~~ who qualifies for coverage ~~*of*~~ only for the delivery because of her alien status. ~~*(4-2-08)*~~( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.04 - RULES GOVERNING THE FOOD STAMP PROGRAM IN IDAHO

DOCKET NO. 16-0304-0903

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 56-203, Idaho Code; also Public Law 111-8, Subsection 602(b)(8), "Afghan Allies Protection Act of 2009"; 2008 Federal Farm Bill, P.L. 110-234, Section 4105 "State Option to Expand Simplified Reporting"; 7 CFR 273.9(d)(3)(x) re: attendant meals deduction; and 7 CFR 273.9(d)(6)(ii)(C) re: Telephone Utility Allowance.

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 pending rule is being adopted as proposed. The complete text of the proposed rule was published in the Wednesday, September 2, 2009, Idaho Administrative Bulletin, Vol. 09-9, pages 121 through 138.

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 impact to the state general fund as a result of this rulemaking. Food stamp benefits are 100% federally-funded. The necessary programming changes to the new eligibility system (IBES) have already been made and were funded as part of the EPICS Replacement Project.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Darlene Rydalch at (208) 528-5811.

DATED this 6th day of November, 2009.

Tamara Prisock
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THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective dates of the temporary rule are March 11, 2009, and October 1, 2009.

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 Public Law 111-8, Subsection 602(b)(8), "Afghan Allies Protection Act of 2009"; 2008 Federal Farm Bill, P.L. 110-234, Section 4105 "State Option to Expand Simplified Reporting"; 7 CFR 273.9(d)(3)(x) re: attendant meals deduction; and 7 CFR 273.9(d)(6)(ii)(C) re: Telephone Utility Allowance.

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 16, 2009.

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 reference to Public Law 111-8,"Afghan Allies Protection Act of 2009," is being added to this chapter to align it with recent changes in federal statute. The effect of this addition will be to extend Afghani immigrant benefits from six months to eight months.

In addition, the following changes are being made to the chapter:

1. **Reporting requirements for households that have all elderly or disabled members are being simplified. This will make reporting easier for participants, improve program compliance, reduce errors, and save Department staff time.**

2. **The meals deduction for attendants of elderly or disabled Food Stamp participants is no longer correct and is being updated. Making this correction will help elderly and disabled participants get the correct deduction counted against their income and help the Department avoid quality control errors.**

3. **The Department's new eligibility system makes provision for a 4th utility allowance category - the Telephone Utility Allowance (TUA). The TUA is being added to these rules since many households have phone services as their only utility expense. Currently, they receive no utility deduction, so adding the TUA will allow them to receive some credit for this type of expense.**

4. **The definition of the Farm Bill mentions the year 2002, but as the Farm Bill is reauthorized approximately every 5 years this is outdated; therefore, a more generic definition is being added to replace it.**

5. **The citation from CFR for the formula used in the new eligibility system for prorating Food Stamps benefits is being added.**

6. **Also, other minor corrections and changes are being made to clarify existing text.**

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 since some of the changes are being made to comply with deadlines in amendments to governing law or federal programs; some changes also confer benefits to food stamp 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: 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 impact to the state general fund as a result of this rulemaking. Food stamp benefits are 100% federally-funded. The necessary programming changes to the new eligibility system (IBES) have already been made and were funded as part of the EPICS Replacement Project.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because the rule changes are being made to align with changes in federal statute and the Code of Federal Regulations (CFR) and to confer benefits to food stamp participants.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Darlene Rydalch at (208) 528-5811.

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 Wednesday, September 23, 2009.

DATED this 20th day of July, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

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

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

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

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

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

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

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

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

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

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

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

11. Categorical Eligibility. There are two (2) types of categorically eligible households: (6-1-09)T

a. Categorically Eligible Household. If all household members receive or are authorized to receive a monthly cash payment through TAFI, AABD, or SSI, the household is

categorically eligible. A categorically eligible household is exempt from resource, gross, and net income eligibility standards. (6-1-09)T

b. Expanded Categorically Eligible Household. If a household receives a TANF-funded non-cash or in-kind service, it is categorically eligible. An expanded categorically eligible household must meet the gross and net income standards for its household size. An expanded categorically eligible household is exempt from resource standards. (6-1-09)T

12. Certification Determination. Actions necessary to determine household eligibility including interviews, verification, approval, denial, field investigation, analysis and corrective action necessary to insure prompt, efficient and correct certifications. (6-1-94)

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

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

~~***15. Change Reporting Household (CR)**. A household in which all members are elderly or disabled. (4-11-06)~~

16~~5~~. Client. A person entitled to or receiving Food Stamps. (6-1-94)

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

18~~7~~. Desk Review. A desk review is a recertification that may or may not include talking to the participant. (4-11-06)

19~~8~~. Disqualified Household Members. Individuals required to be excluded from participation in the Food Stamp Program are Disqualified Household Members. These include: (6-1-94)

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

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

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

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

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

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

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

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

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

~~20~~19. Documentation. The method used to record information establishing eligibility. The information must sufficiently explain the action taken and the proof and how it was used. (6-1-94)

2~~1~~0. **Drug Addiction or Alcoholic Treatment Program**. Any drug addiction or alcoholic treatment rehabilitation program conducted by a private nonprofit organization or institution or a publicly operated community mental health center under Part B of Title XIX of the Public Health Service Act (42 USC 300x, et seq.). Indian reservation based centers may qualify if FCS requirements are met and the program is funded by the National Institute on Alcohol Abuse under Public Law 91-616 or was transferred to Indian Health Service funding. (4-6-05)

011. DEFINITIONS E THROUGH L.
For the Food Stamp Program, the following definitions apply: (4-11-06)

01. EBT Handbook. Idaho Department of Health and Welfare Rules, IDAPA 16.03.20, "Rules Governing Electronic Benefit Transfer (EBT) of Public Assistance, Food Stamps, and Child Support." (7-1-98)

02. Electronic Benefit Transfer. A method of issuing Food Stamps to an eligible household. (7-1-98)

03. Eligible Foods. Any food or food product for human consumption excluding alcohol, tobacco, and hot foods and hot food products ready for immediate consumption. Eligible foods include: (6-1-94)

a. Garden seeds and plants to grow food for human consumption. (6-1-94)

b. Meals prepared for the elderly at a communal dining facility. (6-1-94)

c. Meals prepared and delivered by an authorized meal delivery service. (6-1-94)

d. Meals served to a narcotics addict or alcoholic who participate and reside in a rehabilitation center program. (6-1-94)

e. Meals prepared and served by an authorized group living center to blind or disabled residents who receive benefits under Titles I, II or X, XIV, XVI of the Social Security

Act. (6-1-94)

f. Meals prepared and served at a shelter for battered women and children to eligible residents. (6-1-94)

g. Meals prepared and served by an authorized public or private nonprofit establishment to homeless Food Stamp participants. (6-1-94)

04. Eligible Household. A household living in a Idaho and meeting the eligibility criteria in these rules. (4-11-06)

05. Emancipated Minor. A person, age fourteen (14) but under age eighteen (18), who has been married or whose circumstances show the parent and child relationship has been renounced such as a child in the military service. (6-1-94)

06. Enumeration. The requirement that each household member provide the Department either their Social Security Number (SSN) or proof that they have applied. (6-1-94)

07. Exempt. A household member who is not required to register for or participate in the JSAP program is exempt. A household member who is not required to register for work is exempt. (6-1-94)

~~***08. Farm Bill**. Public Law 107-171, "Farm Security and Rural Investment Act of 2002."* (4-6-05)~~

08. Extended Certification Household (EC). A household in which all members are elderly or disabled, and no one has earned income. ( )

09. Fair Hearing. A fair hearing in an appeal of a Department decision. See Section 003 of these rules for appeals. (4-11-06)

10. Federal Fiscal Year. The federal fiscal year (FFY) is from October 1 to September 30. (6-1-94)

11. Field Office. A Department of Health and Welfare service delivery site. (4-6-05)

12. Food Assistance. The Department's Food Stamp Program or Food Distribution Program. (6-1-94)

13. Food and Nutrition Service (FNS). The Food and Nutrition Service of the U.S. Department of Agriculture. This is the federal entity that administers the Food Stamp program. (4-11-06)

14. Group Living Arrangement. A public or private nonprofit residential setting serving no more than sixteen (16) residents. The residents are blind or disabled and receiving benefits under Title II or XVI of the Social Security Act, certified by the Department under regulations issued under Section 1616(e) of the Social Security Act, or under standards determined by the Secretary of USDA to be comparable to Section 1616(e) of the Social Security

Act. (6-1-94)

15. Homeless Person. A person: (6-1-94)

a. Who has no fixed or regular nighttime residence. (6-1-94)

b. Whose primary nighttime residence is a temporary accommodation for not more than ninety (90) days in the home of another individual or household. (7-1-98)

c. Whose primary nighttime residence is a temporary residence in a supervised public or private shelter providing temporary residence for homeless persons. (6-1-94)

d. Whose primary nighttime residence is a temporary residence in an institution which provides temporary residence for people who are being transferred to another institution. (6-1-94)

e. Whose primary nighttime residence is a temporary residence in a public or private place which is not designed or customarily used as sleeping quarters for people. (6-1-94)

16. Homeless Meal Provider. A public or private nonprofit establishment or a profit making restaurant which provides meals to homeless people. The establishment or restaurant must be approved by the Department and authorized as a retail food store by FCS. (7-1-98)

17. Identification Card. The card identifying the bearer as eligible to receive and use Food Stamps. (4-11-06)

18. Inadvertent Household Error Claim (IHE). A claim resulting from an overissuance, caused by the household's misunderstanding or unintended error. A household error claim pending an intentional program violation decision. (6-1-94)

19. Income and Eligibility Verification System (IEVS). A system of information acquisition and exchange for income and eligibility verification which meets Section 1137 of the Social Security Act requirements. (6-1-94)

20. Indian General Assistance. The general assistance program administered by the Bureau of Indian Affairs. (6-1-94)

21. Institution of Higher Education. Any institution which normally requires a high school diploma or equivalency certificate for enrollment. These institutions include colleges, universities, and business, vocational, technical, or trade schools at the post-high school level. (7-1-97)

22. Institution of Post Secondary Education. Educational institutions normally requiring a high school diploma or equivalency certificate for enrollment, or admits persons beyond the age of compulsory school attendance. The institution must be legally authorized by the state and provide a program of training to prepare students for gainful employment. (4-11-06)

23. Legal Noncitizen. A qualified alien under 8 USC Section 1641(b). (4-6-05)

24. Limited Utility Allowance (LUA). Utility deduction given to a food stamp household that has a cost for more than one (1) utility. This includes electricity and fuel for purposes other than heating or cooling, water, sewage, well and septic tank installation and maintenance, telephone, and garbage or trash collection. (4-11-06)

012. DEFINITIONS M THROUGH Z.
For the Food Stamp Program, the following definitions apply: (4-11-06)

01. Migrant Farmworker Household. A migrant farmworker household has a member who travels from community to community to do agricultural work. (4-6-05)

02. Minimum Utility Allowance (MUA). Utility deduction given to a food stamp household that has a cost for one (1) utility that is not heating, cooling, or telephone.
~~*(4-11-06)*~~( )

03. Nonexempt. A household member who must register for and participate in the JSAP program. A household member who must register for work. (6-1-94)

04. Nonprofit Meal Delivery Service. A political subdivision or a private nonprofit organization, which prepares and delivers meals, authorized to accept Food Stamps. (6-1-94)

05. Overissuance. The amount Food Stamps issued exceeds the Food Stamps a household was eligible to receive. (6-1-94)

06. Parental Control. Parental control means that an adult household member has a minor in the household who is dependent financially or otherwise on the adult. Minors, emancipated through marriage, are not under parental control. Minors living with children of their own are not under parental control. (4-6-05)

07. Participant. A person who receives Food Stamp benefits. (4-6-05)

08. Program. The Food Stamp Program created under the Food Stamp Act and administered in Idaho by the Department. (6-1-94)

09. Public Assistance. Public assistance means Temporary Assistance for Families in Idaho (TAFI), and Aid to the Aged, Blind, and Disabled (AABD). (4-6-05)

10. Recertification. A recertification is a process for determining ongoing eligibility for Food Stamps. (4-11-06)

11. Retail Food Store. A retail food store, for Food Stamp purposes means: (6-1-94)

a. An establishment, or recognized department of an establishment, or a house-to-house food trade route, whose food sales volume is more than fifty percent (50%) staple food items for home preparation and consumption. (6-1-94)

b. Public or private communal dining facilities and meal delivery services. (6-1-94)

c. Private nonprofit drug addict or alcohol treatment and rehabilitation programs. (6-1-94)

d. Public or private nonprofit group living arrangements. (6-1-94)

e. Public or private nonprofit shelters for battered women and children. (6-1-94)

f. Private nonprofit cooperative food purchasing ventures, including those whose members pay for food prior to the receipt of the food. (6-1-94)

g. A farmers' market. (6-1-94)

h. An approved public or private nonprofit establishment which feeds homeless persons. The establishment must be approved by FCS. (7-1-98)

12. Sanction. A penalty period when an individual is ineligible for Food Stamps. (3-30-07)

13. Seasonal Farmworker Household. A seasonal farmworker household has a member who does agricultural work of a seasonal or other temporary nature. (4-6-05)

~~***14. Simplified Reporting Household (SR)**. All households except those in which all members are elderly or disabled.* *(4-11-06)***~~

15~~4~~. Spouse. Persons who are living together, married or free to marry, and are holding themselves out as man and wife. (4-6-05)

16~~5~~. Standard Utility Allowance (SUA). Utility deduction given to a food stamp household that has a cost for heating or cooling. (4-11-06)

17~~6~~. State. Any of the fifty (50) States, the District of Columbia, Puerto Rico, Guam, the Northern Mariana Islands and the Virgin Islands of the United States. (6-1-94)

18~~7~~. State Agency. The Idaho Department of Health and Welfare. (6-1-94)

19~~8~~. Student. An individual between the ages of eighteen (18) and fifty (50), physically and mentally fit, and enrolled at least half-time in an institution of higher education. (6-1-94)

~~20~~19. Supplemental Security Income (SSI). Monthly cash payments under Title XVI of the Social Security Act. Payments include state or federally administered supplements. (4-11-06)

2~~1~~0. Systematic Alien Verification for Entitlements (SAVE). The federal automated system that provides immigration status needed to determine an applicant's eligibility for many public benefits, including Food Stamps. (4-11-06)

21. Telephone Utility Allowance (TUA). Utility deduction given to a Food Stamp

household that has a cost for telephone services and no other utilities. ( )

22. Timely Notice. Notice that is mailed at least ten (10) days before the effective date of an action taken by the Department. (4-6-05)

23. Twelve Month Contact. For households that have a twenty-four (24) month certification period, Department staff contact the household during the twelfth month of the certification period for the purpose of determining continued eligibility. (4-6-05)

24. Tribal General Assistance. Cash, excluding in-kind assistance, financed by federal, state or local government and provided to cover living expenses or other basic needs. This cash is intended to promote the health and well-being of recipients. (4-11-06)

25. Verification. The proof obtained to establish the accuracy of information and the household's eligibility. (6-1-94)

26. Verified Upon Receipt. Food stamp benefits are adjusted on open food stamp cases when information is received from "verified upon receipt" sources. Information "verified upon receipt" is received from a manual query or automated system match with the Social Security Administration or Homeland Security query for citizenship status. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

014. ABBREVIATIONS I THROUGH Z.
For the purposes of the Food Stamp Program, the following abbreviations are used. (4-11-06)

01. ICCP. Idaho Child Care Program. (4-11-06)

02. ICSES. Idaho Child Support Enforcement System. (4-11-06)

03. IEVS. Income and Eligibility Verification Systems. (6-1-94)

04. IHE. Inadvertent household error. (6-1-94)

05. INS. Immigration and Naturalization Service, in 2003, became the United States Citizenship and Immigration Service (USCIS), a Division of Homeland Security. (4-11-06)

06. INA. Immigration and Nationality Act. (4-6-05)

07. IPV. Intentional program violation. (6-1-94)

08. IRS. Internal Revenue Service. (6-1-94)

09. JSAP. Job Search Assistance Program. (6-1-94)

10. **LUA**. Limited utility allowance. (4-11-06)

11. **MUA**. Minimum utility allowance. (4-11-06)

12. **NADA**. National Automobile Dealer's Association. (4-11-06)

13. **PA**. Public Assistance. (6-1-94)

14. **RSDI**. Retirement, Survivors, Disability Insurance received from SSA. (6-1-94)

15. **SAVE**. Systematic Alien Verification for Entitlements. (4-11-06)

16. **SAW**. Special Agricultural Worker. (6-1-94)

17. **SDX**. State Data Exchange. (6-1-94)

18. **SQC**. State Quality Control. (6-1-94)

19. **SRS**. Self Reliance Specialist. (7-1-98)

20. **SUA**. Standard utility allowance. (4-11-06)

21. **SSA**. Social Security Administration. (6-1-94)

22. **SSI**. The Federal Supplemental Security Income Program for the aged, blind or disabled. (6-1-94)

23. **SSN**. Social Security number. (6-1-94)

24. **SWICA**. State Wage Information Collection Agency. (6-1-94)

25. **TAFI**. Temporary Assistance for Families in Idaho. (7-1-98)

26. **TOP**. Treasury Offset Program. (3-15-02)

27. **T~~*PQY*~~UA**. ~~*Third Party Query*~~ Telephone Utility Allowance. ~~*(6-1-94)*~~( )

28. **UI**. Unemployment Insurance. (6-1-94)

29. **USDA**. United States Department of Agriculture. (6-1-94)

30. **VA**. The Veterans Administration. (6-1-94)

31. **WIA**. The Workforce Investment Act. (3-15-02)

32. **WIC**. The special supplemental Food Program for Women, Infants, and Children. (6-1-94)

(BREAK IN CONTINUITY OF SECTIONS)

204. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.
To be eligible for Food Stamps, an individual must meet the requirements specified in 7 CFR 273.4, "Citizenship and alien status~~;~~." ~~*in accordance with Public Law 107-171 "Farm Security and Rural Investment Act of 2002," Title IV - Nutrition Programs, Subtitle D - Miscellaneous, Section 4401, regarding the partial restoration of benefits to legal immigrants: and regarding special immigrants, Public Law 110-161, effective December 26, 2007, and Public Law 110-181, effective January 28, 2008.*~~ In addition, special immigrants from Iraq and Afghanistan have limited eligibility per Public Laws 110-161, 110-181, and 111-8, Subsection 602(b)(8).
~~*(5-8-09)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

~~***221. DETERMINATION OF HOUSEHOLD COMPOSITION FOR CHANGE REPORTING HOUSEHOLDS.***~~
~~*Household composition must be determined at application, recertification, and when changes are reported.* *(4-6-05)*~~

22~~2~~1. DETERMINATION OF HOUSEHOLD COMPOSITION ~~*FOR SIMPLIFIED REPORTING HOUSEHOLDS*~~.
Household composition must be determined at application, twelve-month (12) contact, recertification, and when a reported change in household members would result in an increase in the food stamp benefits. ~~*(4-11-06)*~~( )

22~~3~~2. -- 225. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

323. LUMP SUM RESOURCES.
Nonrecurring lump sum payments are ~~*counted as*~~ considered a resource in the month received, unless excluded under these rules. A household ~~*using simplified reporting*~~ is not required to report changes in resources during a certification period. ~~*A household using change reporting must report the lump sum payment to the Department within ten (10) days of receiving the payment, if their resource limit is exceeded because of the lump sum. If the lump sum along with other resources exceeds the resource limit, that change reporting household is not eligible for Food Stamps. The Food Stamp case must be closed after timely notice. The household may spend resources down under the limit in the month the lump sum was received. If resources are spent down below the resource limit, the household continues to be eligible for Food Stamps. The household must still report receipt of the lump sum payment within ten (10) days.*~~ Some lump sum

payments are listed below: *~~(3-30-07)~~*( )

01. Retroactive Payments. Retroactive payments from: (6-1-94)

a. Social Security. (6-1-94)

b. SSI. (6-1-94)

c. Public Assistance. (6-1-94)

d. Railroad Retirement Benefits. (6-1-94)

e. Unemployment Compensation Benefits. (6-1-94)

f. Child Support. (3-30-07)

02. Insurance. Insurance settlements. (6-1-94)

03. Refunds. Income tax refunds, rebates, or credits. (6-1-94)

04. Property Payments. Lump sum payment from sale of property. Contract payments from the sale of property are counted as income. (6-1-94)

05. Security Deposits. Refunds of security deposits on rental property or utilities. (6-1-94)

06. Disability Pension. Annual adjustment payments in VA disability pensions. (6-1-94)

07. Vacation Pay. Vacation pay, withdrawn in one lump sum by a terminated employee. (6-1-94)

08. Military Bonus. Military re-enlistment bonuses. (6-1-94)

09. Readjustment Pay. Job Corps readjustment pay. (6-1-94)

10. Severance Pay. Severance pay, paid in one (1) lump sum to a former employee. (6-1-94)

11. TAFI One-Time Cash Payment. The one-time TAFI cash diversion payment. (4-5-00)

(BREAK IN CONTINUITY OF SECTIONS)

389. REPORTING RESOURCES.

Households receiving food stamps must report resource changes at each recertification or twelve (12) month contact. ~~*Change reporting households must also report when cash on hand, stocks, bonds, or money in a financial institution reaches or exceeds the resource limit. A household must report if it obtains a vehicle.* *(4-2-08)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

535. MEDICAL EXPENSES.
Medical expenses over thirty-five dollars ($35), for elderly or disabled household members, are deducted from the household income. 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. Guide Dog. Expenses incurred buying and caring for any animal trained and routinely used to help a disabled person. Expenses include costs for dog food, training, and veterinarian services. (4-6-05)

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. ~~*One hundred nineteen dollars ($119)*~~ An amount equal to the maximum Food Stamp allotment for a one (1) person household per month ~~*are*~~ is deducted if the household provides most of the attendant's meals. ~~*(4-6-05)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

542. COSTS ALLOWED FOR SHELTER DEDUCTION.

Shelter costs are current charges for the shelter occupied by the household. Shelter costs include costs for the home temporarily not occupied because of employment or training away from home or illness. The costs allowed for the shelter deduction are listed below: (6-1-94)

01. House Payments. Mortgages, second mortgages, mortgage fees, home equity loans, and land payments. (4-6-05)

02. Rent. Rent and space rent. (6-1-94)

03. Homeless Shelter Deduction. The homeless shelter deduction is allowed for homeless households with some shelter expenses. It is established by FNS and may be found under http://www.fns.usda.gov/fsp/government/cola.htm. This deduction must not be used in combination with other costs allowed for shelter deduction. (4-11-06)

04. Condominium Fees. The entire condominium fee, including fees for maintenance of the structure and the grounds. (3-30-01)

05. Loan Payments. Loan repayments for the purchase of a mobile or motor home, including interest. (6-1-94)

06. Taxes And Insurance. Property taxes, state and local assessments, and insurance on the property. This also includes insurance on a vehicle used as a residence. (3-30-07)

07. Utilities. Only one (1) utility allowance (SUA, LUA, ~~*or*~~ MUA, or TUA) may be used for a household. The costs used to determine the utility allowance are: heating, cooling,

cooking fuel, electricity, the basic service fee for one (1) telephone (including wire maintenance fees, subscriber line charges, relay center surcharges, 911 fees, and basic service for a cellular phone), water, sewer, garbage and trash collection, well installation and maintenance, septic tank system installation and maintenance, and fees for initial utility installation. One-time deposits cannot be included. ~~*(4-6-05)*~~( )

08. Vehicle Payments. Payments for vehicles used as the primary residence for the household. (6-1-94)

09. Costs for Home Repairs. Nonreimbursable costs to repair a home damaged or destroyed by a natural disaster such as a fire or flood or earthquake. (6-1-94)

10. Home Temporarily Not Occupied. Shelter costs for the home temporarily not occupied because of employment, training away from home, illness, or abandonment caused by a natural disaster or casualty loss. This shelter cost may be in addition to the shelter cost for the home the household currently occupies. To receive the shelter deduction for a vacated home: (4-6-05)

a. The household must intend to return; (4-6-05)

b. Current occupants must not be claiming Food Stamp shelter costs; and (4-6-05)

c. The home must not be leased or rented. (6-1-94)

543. UTILITY ALLOWANCES.
The shelter deduction is computed using one (1) of ~~*three*~~ four (~~3~~4) utility allowances: Standard Utility Allowance (SUA). Limited Utility Allowance (LUA), ~~*or*~~ the Minimum Utility Allowance (MUA), or the Telephone Utility Allowance (TUA). Utility allowances are not prorated.
~~*(4-6-05)*~~( )

01. Standard Utility Allowance (SUA). (4-6-05)

a. Primary heating or cooling system. The household must have a primary heating or cooling cost to qualify for the SUA. The heating or cooling costs must be separate from rent or mortgage payments. This includes households in private rental housing, billed by their landlords for individual usage or charged a flat rate, separately from rent. If not billed regularly for heating or cooling costs, the household must be otherwise Food Stamp eligible between billing periods. (4-6-05)

b. Cooling costs. If the household claims cooling costs, the household must have either an air conditioning system or a room air conditioner to qualify for the SUA. (3-15-02)

c. Heating costs. If the household claims heating costs, the household must have expenses for heat. Households buying wood for their primary source of heat may get the SUA. Cutting their own wood for the primary source of heat does not qualify a household for the SUA. Supplemental heat sources such as space heaters, electric blankets, cook stoves and a secondary heat source such as a fireplace do not qualify households for the SUA. (4-6-05)

d. LIHEAP. If the household receives LIHEAP assistance, it is automatically eligible for the SUA. (4-11-06)

e. Energy Assistance Excluded From Income. If the household gets direct or indirect energy assistance that is excluded from income, the household gets the SUA if the amount of the expense exceeds the amount of the assistance. (3-15-02)

f. Energy Assistance Not Excluded From Income. If a household gets energy assistance that is not excluded from income, the household must also have out-of-pocket heating or cooling costs to get the SUA. (3-15-02)

g. Occupied and Unoccupied Home. A household with both an occupied home and an unoccupied home, is limited to one (1) SUA. (3-15-02)

02. Limited Utility Allowance (LUA). The household must be billed for more than one (1) utility that is not for heating or cooling. Water, sewer, and trash are considered one (1) utility cost regardless of how they are billed. If the household is billed for rural trash pickup, this can be counted as a separate utility. (4-6-05)

03. Minimum Utility Allowance (MUA). The household must be billed for one (1) utility that is not for heating, ~~*or*~~ cooling, or telephone service. ~~*(4-6-05)*~~( )

04. Telephone Utility Allowance (TUA). The household must be billed for telephone service and have no other verified utility expenses. ( )

(BREAK IN CONTINUITY OF SECTIONS)

563. FOOD STAMP PRORATING FORMULA.
~~*Determine t*~~The prorated Food Stamp amount ~~*using the steps listed in Subsections 563.01 through 563.05*~~ is determined per 7 CFR 273.10(a)(1)(iii)(B). ~~*(7-1-97)*~~

~~***01. Step 1**. Subtract the application date (1 through 30) from 31. If the application date is the thirty-first day of the month, use thirty (30).* (7-1-97)~~

~~***02. Step 2**. Divide the amount in Step 1 by thirty (30).* (7-1-97)~~

~~***03. Step 3**. Multiply the monthly Food Stamp benefit by the amount in Step 2.* (7-1-97)~~

~~***04. Step 4**. If the difference in Step 3 ends in one (1) through ninety-nine ($.99) cents, round down to the lower dollar.* (7-1-97)~~

~~***05. Step 5.*~~ If the amount ~~*in Step 4 is*~~ for the initial month~~*, and*~~ is less than ten dollars ($10), benefits must not be issued. ~~*(7-1-97)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

565. FOOD STAMP BENEFITS FOR CATEGORICALLY ELIGIBLE HOUSEHOLD.
Categorically eligible households with one (1) or two (2) household members are eligible to get ~~*at least ten dollars ($10)*~~ an allotment amount of Food Stamps that is equal to at least eight percent (8%) of the maximum monthly one (1) person allotment, regardless of net income. Categorically eligible households with three (3) or more household members are eligible for Food Stamps, but do not get Food Stamps if the net income is too high. ~~*(10-1-94)*~~( )

566. -- 57~~1~~2. (RESERVED).

~~***572. HOUSEHOLD COMPOSITION CHANGES FOR CHANGE REPORTING HOUSEHOLDS.***~~
~~*Change reporting food stamp households must report changes in household composition. Any change reported is effective for the month after it is reported, allowing for timely notice. (4-2-08)*~~

573. ACTING ON HOUSEHOLD COMPOSITION CHANGES ~~*FOR SIMPLIFIED REPORTING HOUSEHOLDS*~~.
Changes in household composition are not required to be reported ~~*for simplified reporting households*~~. If a ~~*simplified reporting*~~ 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. 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 recertification or twelve-month (12) contact. ~~*(4-11-06)*~~( )

(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. ~~*(4-11-06)*~~( )

~~***01. Student Residing in a Change Reporting Household****. Changes in household composition are required to be reported for change reporting households. Changes must be reported within ten (10) days of the date the change occurs. The change is effective the month after it is reported, allowing for timely notice. (4-11-06)*~~

~~***02. Student Residing in a Simplified Reporting Household****. Changes in household composition are not required to be reported for simplified reporting households. If a simplified*~~

~~*reporting household does report a change in household composition, 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.* *(4-11-06)*~~

576. CERTIFICATION PERIODS.
A certification period must be assigned for each household. Households must be assigned a certification period based on household circumstances at the time of application approval, ~~*or*~~ recertification, or twelve-month contact in accordance with 7 CFR 273.10(f) and 273.12~~*, and the Farm Bill under Title IV, Subtitle A - Food Stamp Programs, Section 4109, regarding the state option to reduce reporting requirements*~~. Households are assigned a six (6) month certification period unless they meet the criteria for extended certification, in which case they are assigned a twenty-four (24) month certification period. At the end of each certification period, entitlement to Food Stamps ends. Further eligibility starts only upon recertification based upon a newly completed application, an interview, and verification. The certification period cannot be lengthened nor can benefits be continued beyond the end of a certification period without a new determination of eligibility. ~~*(3-30-07)*~~( )

577. ~~*LENGTHENING*~~ CHANGING THE CERTIFICATION PERIOD.
~~*The certification period cannot be lengthened.*~~ If a household has an extended certification period, and at the twelve-month contact it is determined that they remain eligible but they no longer meet the criteria for extended certification, the current certification will be ended and a six-month certification period will be assigned for ongoing benefits. ~~*(4-6-05)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

601. REPORTING REQUIREMENTS AND RESPONSIBILITIES.
~~*The household must report and verify changes in circumstances based on the requirements for the reporting group to which the household is assigned.*~~ Changes may be reported by phone, ~~*by*~~ mail, or e-mail, or directly to the Department. Households must report as follows: ~~*(4-6-05)*~~( )

~~***01. Change Reporting (CR) Households**. Change reporting households must report the following:* *(4-11-06)*~~

~~***a.** Unearned income changes of more than fifty dollars ($50);* *(4-6-05)*~~

~~***b.** Earned income changes of more than one hundred dollars ($100);* *(4-6-05)*~~

~~***c.** Address changes;* *(4-11-06)*~~

~~***d.** Changes in household composition; and* *(4-6-05)*~~

~~***e.** When resources exceed the resource limit unless the household is categorically eligible under Sections 178 or 181 of these rules.* *(6-1-09)T*~~

~~***02. Simplified Reporting (SR) Households**. Simplified reporting households must report the following:* *(4-6-05)***~~

~~*a*~~**01. Income Exceeds One Hundred Thirty Percent (130%) of FPG**. When the household's total gross income exceeds one hundred thirty percent (130%) of the Federal Poverty Guideline (FPG) for the household size~~;~~. ~~*(4-6-05)*~~( )

~~***b.** Any change of address; and* *(4-11-06)***~~

~~*c*~~**02. Decrease in ABAWD Hours to Less Than Eighty (80) Hours Per Month**. When there is ~~A~~a decrease in the household's ABAWD hours to less than eighty (80) hours per month. ~~*(4-6-05)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

611. TIME FRAMES FOR REPORTING CHANGES IN HOUSEHOLD CIRCUMSTANCES.

Households must report changes in circumstances as required ~~*by the household's reporting group*~~ in Section 601 of these rules. Households ~~*must*~~ reporting required changes to the Department must do so by the tenth day of the month following the month in which the change occurred. ~~*(4-2-08)*~~( )

~~***01. Change After the Certification Interview**. If changes in circumstances occur after the certification interview but before the Notice of Decision is sent, the household must report changes to the Department by the tenth day of the month following the month in which they receive the Notice of Decision.* *(4-2-08)***~~

~~***02. Simplified Reporting Households**. When the actual gross income received in a month by a simplified reporting household is greater than one hundred thirty percent (130%) of the poverty limit for the household size, the household must report this change by the tenth day of the month following the month in which the income exceeded the limit.* *(4-2-08)***~~

0~~3~~1. Must Not Impose Added Reporting Requirements. The Department must not require additional household reporting not listed in these rules. (6-1-94)

0~~4~~2. Report Form. The Department must give households a Change Report Form at certification, at the twelve (12) month contact, at recertification, when the household reports a change, and when the household requests the form. ~~*(4-6-05)*~~( )

0~~5~~3. Reporting Methods. Changes can be reported by telephone, personal contact, ~~*or*~~ mail, or e-mail. Changes can be reported by a household member or authorized representative. ~~*(6-1-94)*~~( )

0~~6~~4. Failure to Report. If Food Stamps are overissued because a household fails to report required changes, a Claim Determination must be prepared. A person can be disqualified

for failure to report a change if he commits an Intentional Program Violation. (7-1-99)

612. (RESERVED).

613. CHANGES ON WHICH THE DEPARTMENT MUST ACT.

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.*** *There is a change of address; or* *(4-11-06)*~~

~~i~~h. The household reports that ~~*A*~~all members of the household moved out of the state of Idaho. ~~*(4-6-05)*~~( )

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. (4-11-06)

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.
~~*Regardless of the reporting group to which it belongs, a*~~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 or the twelve (12) 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. ~~*(4-11-06)*~~( )

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. ~~*The increase must be handled as follows regardless of the reporting requirement.*~~
( )

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. ~~*(4-11-06)*~~( )

0~~1~~3. 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)

0~~2~~4. Proof Not Provided Within Ten Days. If the household fails to provide proof within ten (10) days of reporting the change, but ~~*shows*~~ provides proof later, benefits are increased the month after the proof of the change is provided. ~~*(4-11-06)*~~( )

618. DECREASES IN FOOD STAMP BENEFITS.
If a change that is required to be ~~*reported*~~ acted upon results in a decrease in Food Stamp benefits,

~~*and proof is required,*~~ the Department must ~~*verify and*~~ take action ~~*within ten (10) days of the date the change was reported. If the household fails to provide proof within ten (10) days, the Food Stamp case must be closed with*~~ and must give timely notice, if required. The notice must explain the reason for the action. ~~*If the household then provides proof before the first day of the month the case would close, benefits must be continued, adjusted, or ended as appropriate. The Department must give adequate notice to adjust or end benefits.*~~ ~~*(4-11-06)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

852. FOOD STAMP HOUSEHOLD RESPONSIBILITIES.

The Food Stamp household must provide correct and complete information so the Department can make accurate eligibility and benefit decisions. The responsibilities of the Food Stamp household are listed below: (6-1-94)

01. Provide Information. The Food Stamp household must provide information to determine Food stamp eligibility. This includes, but is not limited to, all information about household income, work and housing cost. ~~*This includes information about people moving in or out of the household and any other changes in circumstances.*~~ ~~*(6-1-94)*~~( )

02. Change Reporting. The Food Stamp household must report changes ~~*of income, expenses, resources or household composition*~~ as required under Section 601 of these rules to the Department. ~~*(6-1-94)*~~( )

03. Change of Address. The Food Stamp household ~~*must*~~ is encouraged to report any move or change of address. ~~*(6-1-94)*~~( )

04. Quality Control. The Food Stamp household must cooperate with Quality Control if the case is selected for review. (6-1-94)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.04 - RULES GOVERNING THE FOOD STAMP PROGRAM IN IDAHO

DOCKET NO. 16-0304-0904

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 56-203, Idaho Code, and 7 CFR 273.10(c)(2) re: determining income.

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 method used in this rule to determine a full month of income for food stamp households was changed to align it with the method used by the Department's new eligibility system (IBES). The method is described under 7 CFR 273.10(c)(2).

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 7, 2009, Idaho Administrative Bulletin, Vol. 09-10, pages 349 through 351.

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 impact to the state general fund as a result of this rulemaking. Food stamp benefits are 100% federally-funded. The necessary programming changes to the new eligibility system (IBES) have already been made and were funded as part of the EPICS Replacement Project.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Darlene Rydalch at (208) 528-5811.

DATED this 6th day of November, 2009.

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

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is October 1, 2009.

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, and 7 CFR 273.10(c)(2) re: determining income.

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 Wednesday, October 21, 2009.

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 rule is being changed to align it with the method used to calculate income used by the Department's new eligibility system (IBES). The method is described under 7 CFR 273.10(c)(2). Specifically, the rule change clarifies the criteria used to determine a full month of income for food stamp households.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(a and c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate since it both protects public health, safety, or welfare, and it confers a benefit to some food stamp 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: 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 impact to the state general fund as a result of this rulemaking. Food stamp benefits are 100% federally-funded. The necessary programming changes to the new eligibility system (IBES) have already been made and were funded as part of the EPICS Replacement Project.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because the rule changes are being made to align with the Code of

Federal Regulations (CFR) and the Department's new eligibility system (IBES).

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Darlene Rydalch at (208) 528-5811.

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 Wednesday, October 28, 2009.

DATED this 28th day of August, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

508. PROJECTING MONTHLY INCOME.
Income is projected for each month. Past income may be used to project future income. Changes expected during the certification period must be considered. Criteria for projecting monthly income is listed below: (6-1-94)

01. Income Already Received. Count income already received by the household during the month. If the actual amount of income from any pay period is known, use the actual pay period amounts to determine the total month's income. Convert the actual income to a monthly amount if a full month's income has been received or is expected to be received. If no changes are expected, use the known actual pay period amounts for the past thirty (30) days to project future income. (6-1-94)

02. Anticipated Income. Count income the household and the Department believe the household will get during the remainder of the certification period. If the exact income amount is uncertain or unknown, that portion must not be counted. If the date of receipt of income cannot be anticipated for the month of the eligibility determination, that portion must not be counted. If the income has not changed and no changes are anticipated, use the income received in the past thirty (30) days as one indicator of anticipated income. If changes in income have occurred or are anticipated, past income cannot be used as an indicator of anticipated income. If income changes and income received in the past thirty (30) days does not reflect anticipated income, the Department can use the household income received over a longer period to anticipate income. If income changes seasonally, the Department can use the household income from the last season, comparable to the certification period, to anticipate income. (6-1-94)

03. Full Month's Income ~~*Not Expected*~~. ~~*(10-1-94)*~~( )

a. ~~*Ongoing income is income from an ongoing source. Ongoing income has been received in the past and is expected to be received in the future. If a full month's income is not expected from an ongoing source, count the amount of income expected for the month:*~~ If income will be received for all regular paydates in the month, it is considered a full month of income and it is converted. ~~*(10-1-94)*~~( )

~~*i. If the actual amount of income is known, use the actual income. (10-1-94)*~~

~~*ii If the actual amount of income is unknown, project the expected income. (10-1-94)*~~

~~*iii. Convert the income to a monthly amount. (10-1-94)*~~

~~***b.** If income is from a new source and a full month's income is not expected, count the actual amount of income expected for the month. Do not convert the new source of income to a monthly amount. (10-1-94)*~~

~~***c.** If income is from a terminated source and no additional income is expected in a future month from this source, count the actual income received during the month. Do not convert the terminated source of income. (10-1-94)*~~

~~***d**~~**b.** ~~*If a full month's income is not expected from a new source of income, count the amount of income expected for the month:*~~ If income will not be received for all regular paydates in the month, it is not considered a full month of income and it is not converted. ~~*(4-11-06)*~~( )

~~*i. If the actual amount of income is known, use the actual known income. (10-1-94)*~~

~~*ii. If the actual amount of income is unknown, project the income. (10-1-94)*~~

~~*iii. Do not convert the income to a monthly amount if a full month's income from a new source is not expected. (4-11-06)*~~

04. Income Paid on Salary. Income received on salary, rather than an hourly wage, is counted at the expected monthly salary rate. (6-1-94)

05. Income Paid at Hourly Rate. Compute anticipated income paid on an hourly basis by multiplying the hourly pay by the expected number of hours the client will work in the pay period. Convert the pay period amount to a monthly amount. (6-1-94)

06. Fluctuating Income. When income fluctuates each pay period and the rate of pay remains the same, average the income from the past thirty (30) days to determine the average pay period amount. Convert the average pay period amount to a monthly amount. (6-1-94)

07. Converting Income to a Monthly Amount. If a full month's income is expected, but is received on other than a monthly basis, convert the income to a monthly amount using one of the formulas below: (6-1-94)

a. Multiply weekly amounts by four point three (4.3). (6-1-94)

b. Multiplying bi-weekly amounts by two point one five (2.15). (6-1-94)

c. Multiplying semi-monthly amounts by two (2). (6-1-94)

d. Use the exact monthly income if it is expected for each month of the certification period. (6-1-94)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

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

DOCKET NO. 16-0305-0903

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: These rules have been adopted by the agency and are now pending review by the 2010 Idaho State Legislature for final approval. The pending rules become final and effective at the conclusion of the legislative session, unless the rules are approved, rejected, amended, or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rules are approved, amended, or modified by concurrent resolution, the rules 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: 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 pending rules, aligning Department rules with federal regulations and reducing costs, are being adopted as proposed. The complete text of the proposed rules was published in the August 5, 2009, Idaho Administrative Bulletin, Vol. 09-8, pages 72 through 81.

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 anticipated fiscal impact for capping the State Supplemental Payment is a net cost savings over a 12-month period of $1,093,920 in state general funds. The anticipated fiscal impact for aligning AABD citizenship rules with SSA regulations is a net cost savings over a 12-month period of $24,080 in state general funds. There is no anticipated fiscal impact to state general funds for the new changes aligning these rules with federal regulations.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Peggy Cook at (208) 334-5969.

DATED this 28th day of September, 2009.

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

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective dates of these temporary rules are March 1, 2009, March 11, 2009, April 1, 2009, and July 1, 2009.

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 Law 111-8, the American Recovery and Reinvestment Act of 2009, CHIP Reauthorization Act of 2009, and 20 CFR 416.1233.

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 19, 2009.

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:

In order to reduce costs, the Department worked with the Social Security Administration (SSA) concerning the State Supplemental Payment (SSP) program which is a state-funded program that provides financial aid to the aged, blind, and disabled population in Idaho. The Department amended this chapter under temporary rule Docket No. 16-0305-0901 published in the February 4, 2009, Idaho Administrative Bulletin, Vol. 09-2, pages 12-19. The temporary rule allowed the state to remain in compliance with SSA federal regulations and reduce costs. The original temporary rules are being rescinded in this Bulletin, and republished as temporary and proposed rules under this Docket No. 16-0305-0903 with the same effective dates.

This new docket includes all changes made in the original temporary rules, as well as the following changes made to align these rules with federal regulations:

1. **Extension of Afghani immigrant benefits under P.L. 111-8;**
2. **Resources excluded under the American Recovery and Reinvestment Act of 2009;**
3. **Citizenship documentation requirements and newborns deemed eligible under the CHIP Reauthorization Act of 2009; and**
4. **Lump sum payments for retroactive Social Security benefits under 20 CFR 416.1233.**

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate **because of his order to reduce cost and to align these rules with federal regulations.**

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.

The anticipated fiscal impact for capping the State Supplemental Payment is a net cost savings over a 12-month period of $1,093,920 in state general funds. The anticipated fiscal impact for aligning AABD citizenship rules with SSA regulations is a net cost savings over a 12-month period of $24,080 in state general funds. There is no anticipated fiscal impact to state general funds for the new changes aligning these rules with federal regulations.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because these cost saving measures are being required to meet legislative intent.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Peggy Cook at (208) 334-5969.

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 26, 2009.

DATED this 2nd day of July, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

102. ~~*103.*~~ (RESERVED).

104. SOCIAL SECURITY NUMBER (SSN) REQUIREMENT.
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. The SSN must be verified by the Social Security Administration (SSA) electronically. An applicant with an unverified SSN is not eligible for AABD cash or Medicaid benefits. The Department must notify the applicant in writing if eligibility is denied or lost for failure to meet the SSN requirement. (3-20-04)

01. 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 can not deny, delay, or stop benefits. The Department will help an applicant with required documentation when the applicant applies for an

SSN. (3-20-04)

02. 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)

03. 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)

10~~5~~4. U.S. CITIZENSHIP AND IDENTITY DOCUMENTATION REQUIREMENTS. To be eligible for AABD cash and Medicaid, an individual must provide documentation of U.S. citizenship and identity unless he has otherwise met the requirements under Subsection 10~~5~~4.09 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. ~~*(4-2-08)*~~( )

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; (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 document issued by a federally-recognized Indian tribe evidencing membership, enrollment in, or affiliation with such tribe. ( )

02. Documents Accepted as Secondary Level Proof of U.S. Citizenship but Not Identity. The following documents are accepted as proof of U.S. citizenship if the proof in Subsection 10~~5~~4.01 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 10~~5~~4.05 through 10~~5~~4.07 of this rule to establish both citizenship and identity. ~~*(4-2-08)*~~( )

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; (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 verification 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)

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 10~~5~~4.05 through 10~~5~~4.07 of this rule to establish both citizenship and identity. ~~*(4-2-08)*~~( )

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)

c. 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 10~~5~~4.01 through 10~~5~~4.03 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 10~~5~~4.05 through 10~~5~~4.07 of this rule to establish both citizenship and identity. ~~*(4-2-08)*~~( )

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. Seneca Indian tribal census record; (3-30-07)*~~

i~~*i*~~. Bureau of Indian Affairs tribal census records of the Navajo Indians; (3-30-07)

ii~~*i*~~. U.S. State vital Statistics official notification of birth registration; (3-30-07)

i~~v~~ii. 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~~*i*~~. Medical (clinic, doctor, or hospital) record; (3-30-07)

vi~~i~~. Institutional admission papers from a nursing facility, skilled care facility or other institution; (4-2-08)

vii~~i~~. Bureau of Indian Affairs (BIA) roll of Alaska Natives; or (4-2-08)

c. 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)

05. Documents Accepted for Proof of Identity but Not Citizenship. The following documents are accepted as proof of identity. They are not proof of citizenship and must be used in combination with at least one (1) document listed in Subsection 10~~5~~4.02 through 10~~5~~4.04 of this rule to establish both citizenship and identity. ~~*(4-2-08)*~~( )

a. A state-issued driver's license bearing the individual's picture or other identifying information such as name, age, gender, race, height, weight, or eye color; (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 10~~5~~4.05.a. of this rule; ~~*(3-30-07)*~~( )

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.*** *Certificate of Degree of Indian blood;* *(4-2-08)*~~

~~***h.*** *Native American Indian or Alaska Native Tribal document with a photograph or other personal identifying information relating to the individual;* *(4-2-08)*~~

***i*g.** A cross-match with a federal or state governmental, public assistance, law enforcement, or corrections agency's data system; or (4-2-08)

***j*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 10*5*4.05.a. through 10*5*4.05.i. of this rule. *(4-2-08)*( )

06. Additional Documents Accepted for Proof of Identity. If the participant provides citizenship documentation as described in Subsections 10*5*4.02 or 10*5*4.03 of this rule, three (3) or more corroborating documents may be used to prove identity. *(4-2-08)*( )

07. Identity Rules for Children. The following documentation of identity for children under sixteen (16) may be used: (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)

c. 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 10*5*4.02 of this rule are not available. A declaration may be used if it meets the following conditions: *(3-30-07)*( )

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 10*5*4.05.a. through 10*5*4.05.c. of this rule are not available. *(4-2-08)*( )

e. A declaration cannot be used for identity if a declaration for citizenship documentation was provided for the child. (3-30-07)

08. Eligibility for Applicants and Medicaid Participants Who Do Not Provide Citizenship and Identity Documentation. (3-30-07)

a. Eligibility will be denied to any applicant who does not provide proof of citizenship and identity documentation; (3-30-07)

b. Any Medicaid participant, who does not provide proof of citizenship and identity documentation at a scheduled renewal and who is making a good faith effort to obtain documentation, will not be terminated from Medicaid for lack of documentation unless the participant: (3-30-07)

i. Does not meet other eligibility criteria required in this chapter of rules; or (3-30-07)

ii. Refuses to obtain the documentation. (3-30-07)

09. 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 10~~5~~4.01 through 10~~5~~4.08 of this rule is provided: ~~(4-2-08)~~( )

a. Supplemental Security Income (SSI) recipients; (4-2-08)

b. Individuals determined by the SSA to be entitled to or are receiving Medicare; (4-2-08)

c. Social Security Disability Income (SSDI) recipients; and (4-2-08)

d. Adoptive or foster care children receiving assistance under Title IV-B or Title IV-E of the Social Security Act. (4-2-08)

e. Individuals deemed eligible for Medicaid as a newborn under Section 800 of these rules. ( )

10. Assistance in Obtaining Documentation. The Department will assist individuals who are mentally or physically incapacitated and who lack a representative to assist them in obtaining such documentation. (3-30-07)

11. Provide Documentation of Citizenship and Identity One Time. When an individual has provided citizenship and identity documents, changes in eligibility will not require an individual to provide such documentation again unless later verification of the documents provided raises a question of the individual's citizenship or identity. (3-30-07)

10~~6~~5. 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 10~~6~~5.01 through 10~~6~~5.17 of ~~these~~ this rule~~s~~. An individual must also provide proof of identity as provided in Section 10~~5~~4 of these rules. ~~(5-8-09)~~( )

01. U.S. Citizen. A U.S. Citizen. (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)

03. 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)

04. 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)

05. 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)

06. 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)

07. 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; or (3-20-04)

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. (3-30-07)

08. 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)

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

10. 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)

11. 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)

12. 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)

13. 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)

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

15. Afghan Special Immigrants. An Afghan special immigrant, as defined in Public Law 110-161, who has special immigration status after December 26, 2007, are eligible for ~~*six*~~ eight (~~6~~8) months from the date they enter into the U.S. as a special immigrant or the date they convert to the special immigrant status. ~~*(5-8-09)*~~( )

16. Iraqi Special Immigrants. An Iraqi special immigrant, as defined in Public Law 110-181, who has special immigration status after January 28, 2008, is eligible for eight (8) months from the date they enter the U.S. as a special immigrant or the date they convert to the special immigrant status. (5-8-09)

17. Individuals Not Meeting the Citizenship or Qualified Non-Citizen Requirements. Individuals who do not meet the citizenship or qualified non-citizen requirements in Subsections 10~~6~~5.01 through 10~~6~~5.16 of this rule, may be eligible for emergency medical services if they meet all other conditions of eligibility. ~~*(5-8-09)*~~( )

106. QUALIFIED NON-CITIZEN ELIGIBILITY REQUIREMENTS FOR AABD CASH.

01. Eligibility Requirements for AABD Cash Beginning March 1, 2009. Beginning with applications dated March 1, 2009, to be eligible for AABD cash assistance, a qualified non-citizen must meet the requirements in Section 105 of these rules and must meet the eligibility requirements for Supplemental Security Income (SSI) payments. ( )

02. Receiving AABD Cash Prior to March 1, 2009. A qualified non-citizen who was eligible for and received an AABD cash payment for February 2009, but does not meet the SSI eligibility requirements, will continue to receive an un-capped cash benefit as long as all other eligibility requirements are met until one (1) of the following occurs: ( )

a. A break in the qualified non-citizen's AABD cash payment occurs because he failed to complete a redetermination for benefits; or ( )

b. The qualified non-citizen has not become a naturalized citizen and two (2) years have passed from March 1, 2009, and he does not meet the eligibility requirements for SSI payments. ( )

(BREAK IN CONTINUITY OF SECTIONS)

210. RESOURCES EXCLUDED BY FEDERAL LAW.
A resource excluded by federal law is not counted in determining the resource amount available to the participant. ( )

21~~0~~1. -- 214. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

242. ~~*TRUST OR RESTRICTED*~~ INDIAN ~~*LANDS*~~ PROPERTY EXCLUDED.
~~*Restricted allotted land, owned by a participant who is of Indian descent from a Federally recognized Indian tribe, is an excluded resource if the participant cannot sell, transfer or otherwise dispose of it without permission from other participants, his tribe or an agency of the Federal Government.*~~ For the purposes of determining eligibility for an individual who is an Indian, the following property is excluded: ~~*(7-1-99)*~~( )

01. Property. Real property and improvements located on a reservation, including any federally recognized Indian Tribe's reservation, pueblo, or colony, and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs. ( )

02. Natural Resources. Ownership interest in rents, leases, royalties, or usage rights

related to natural resources resulting from the exercise of federally protected rights. ( )

03. Other Ownership Interests or Usage Rights. Ownership interests in or usage rights to property not covered by Subsections 242.01 or 242.02 of this rule that have a unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or traditional lifestyle according to applicable tribal law or custom. ( )

(BREAK IN CONTINUITY OF SECTIONS)

255. RETROACTIVE SSI AND AABD BENEFITS.
Retroactive SSI and AABD benefits are issued after the calendar month for which they are paid. Retroactive AABD, SSI and RSDI benefits are excluded from resources for ~~six~~ nine (~~6~~9) calendar months after the month they are received. Interest earned by excluded funds is counted as income. ~~(7-1-99)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

500. FINANCIAL NEED AND AABD CASH AMOUNT.

01. Meet Eligibility for Financial Need. To be eligible for AABD cash and Medicaid, the participant must have financial need. The participant has financial need if his allowances, as described in Sections 501 through 513 of these rules, are more than his income. The amount of financial need is the amount that the allowances exceed income. ( )

02. Maximum Monthly AABD Cash Payment. If the participant is eligible, his AABD cash payment is the difference between his financial need and his countable income. If the difference is not an even dollar amount, AABD cash is paid at the next higher dollar. The maximum monthly AABD cash payment, for a participant described in Subsections 501.01 and 501.02 of these rules, is fifty-three ($53) dollars. AABD cash is paid electronically as set forth in IDAPA 16.03.20, "Rules Governing Electronic Payments (EP) of Public Assistance, Food Stamps, and Child Support." ~~(3-30-07)~~( )

(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. ~~*The child must live with his mother. She must be eligible for Medicaid, or would be, if pregnant.*~~ 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. ~~(7-1-99)~~( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.06 - REFUGEE MEDICAL ASSISTANCE

DOCKET NO. 16-0306-0901

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 and 56-203, Idaho Code, 45 CFR Parts 400 and 401, Section 412E, Title IV, Public Law 96-212 also known as the "Refugee Act of 1980," 94 Stat. 114 (8 USC 1521) and Action Transmittal ORR-AT-80-6, and Public Law 111-8, Sections 601 and 602, "Afghan Allies Protection Act of 2009."

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:

Afghani immigrant benefits were extended from six months to eight months to bring them into alignment with recent changes in federal law (P.L. 111-8, Sections 601 and 602).

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the July 1, 2009, Idaho Administrative Bulletin, Vol. 09-7, pages 48 through 50.

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 impact to the state general fund as a result of this rulemaking. This program is 100% federally funded, and due to the low number of participants, the additional two months of eligibility is expected to have minimal impact on federal funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Kathy McGill at (208) 334-4934.

DATED this 21st day of September, 2009.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
P.O. Box 83720
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(208) 334-5564 phone
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THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is March 11, 2009.

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 and 56-203, Idaho Code, 45 CFR Parts 400 and 401, Section 412E, Title IV, Public Law 96-212 also known as the "Refugee Act of 1980," 94 Stat. 114 (8 USC 1521) and Action Transmittal ORR-AT-80-6, and Public Law 111-8, Sections 601 and 602, "Afghan Allies Protection Act of 2009."

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 Wednesday, July 15, 2009.

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:

Afghani special immigrant benefits need to be extended from six months to eight months to bring them into alignment with recent changes in federal law (P.L. 111-8, Sections 601 and 602).

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 both to comply with deadlines in amendments to governing law or federal programs, and to confer a benefit.

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 impact to the state general fund as a result of this rulemaking. This program is 100% federally funded, and due to the low number of participants, the additional two months of eligibility is expected to have minimal impact on federal funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because the rule changes are being made to align with changes in

federal statute made under the "Afghan Allies Protection Act of 2009."

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Kathy McGill at (208) 334-4934.

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 Wednesday, July 22, 2009.

DATED this 29th day of May, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

100. IDENTIFICATION OF REFUGEES.

01. Refugee Immigration Status. A person has refugee status for purposes of assistance under the Refugee Medical Assistance Program if he is one (1) of the following: (4-2-08)

a. A person from Cambodia, Laos, or Vietnam who has a Form I-94 indicating that the person has been paroled under Section 212(d)(5) of the Immigration and Nationality Act (INA). The I-94 must clearly indicate that the person has been paroled as a refugee or asylee. (4-2-08)

b. A person from Cuba who is present in the United States, and who has an I-94 indicating that the person has been paroled under Section 212(d)(5) of the INA. The I-94 must clearly indicate that the person has been paroled as a refugee or asylee. (4-2-08)

c. A person from any country who has Form I-94 indicating that the person has been: (4-2-08)

i. Paroled under Section 212(d)(5) of the INA as a refugee or asylee; or (4-2-08)

ii. Admitted as a conditional entrant under Section 203(a)(7) of the INA; or (4-2-08)

iii. Admitted as a refugee under Section 207 of INA; or (4-2-08)

iv. Granted asylum under Section 208 of INA; or (4-2-08)

d. A person who entered the United States and has Form I-151 or I-551 showing that his status has been subsequently adjusted from one (1) of the statuses in Subsection 100.02.c. of this rule to that of permanent resident alien, provided he can document his previous status. (4-2-08)

e. A child born in the United States to eligible refugee parent(s) with whom he lives. (4-2-08)

f. An Amerasian together with close family members who entered the United States beginning March 20, 1988, in immigrant status through the Orderly Departure Program. Close family members who are eligible refugees under this provision are limited to: (4-2-08)

i. The Amerasian's spouse and child(ren); (4-2-08)

ii. The mother of an unmarried Amerasian and such mother's spouse and child(ren); and (4-2-08)

iii. A person who has acted as the parent of an unmarried Amerasian and that person's spouse and child(ren). (4-2-08)

02. Afghan Special Immigrants. An Afghan special immigrant, as defined in Public Law 110-161, who has special immigration status after December 26, 2007, is eligible for ~~*six*~~ eight (~~6~~8) months from the date they enter into the U.S. as a special immigrant or the date they convert to the special immigrant status. ~~*(5-8-09)*~~( )

03. Iraqi Special Immigrants. An Iraqi special immigrant, as defined in Public Law 110-181, who has special immigration status after January 28, 2008, is eligible for eight (8) months from the date they enter the U.S. as a special immigrant or the date they convert to the special immigrant status. (5-8-09)

04. Other Factors in Determining Eligibility for the Refugee Medical Assistance Program. (4-2-08)

a. An applicant who has applied for, but has not been granted asylum, is not eligible. (4-2-08)

b. A person who entered the United States as a resident alien is not eligible. (4-2-08)

c. A Form I-94 which shows a person has been paroled into the United States under Section 212(d)(5) of the INA must clearly indicate that the person has been paroled as a "Refugee" or "Asylee" if such form was issued: (4-2-08)

i. To a person from Cambodia, Laos, or Vietnam before October 1, 1997, in accordance with P.L. 106-429, Section 101(a), as amended by P.L. 108-447; or (4-2-08)

ii. To a person from Cuba; or (4-2-08)

iii. To a person from any other country at any time. (4-2-08)

d. A person whose status is Cuban/Haitian Entrant must have his eligibility for benefits under the Refugee Medical Assistance Program determined under Sections 125 and 200 of these rules. (4-2-08)

e. An Amerasian or close family member admitted as an immigrant but eligible for Refugee Medical Assistance as though he were a refugee must have either of the following documents verifying his status: (4-2-08)

i. A temporary identification document, Form I-94 stamped "Processed for I-551. Temporary evidence of lawful admission for permanent residence. Valid until (expiration date). Employment authorized." The back of Form I-94 contains the stamped word "Admitted" and is coded AM1, AM2, or AM3; or (4-2-08)

ii. A permanent identification document, Form I-551 coded AM6, AM7, or AM8. (4-2-08)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.08 - RULES GOVERNING THE TEMPORARY ASSISTANCE FOR FAMILIES IN IDAHO (TAFI) PROGRAM

DOCKET NO. 16-0308-0901

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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, 45 CFR Parts 260 through 265, and Public Law 111-8, Sections 601 and 602, "Afghan Allies Protection Act of 2009."

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:

Afghani immigrant benefits were extended from six months to eight months to bring them into alignment with recent changes in federal law (P.L. 111-8, Sections 601 and 602).

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the July 1, 2009, Idaho Administrative Bulletin, Vol. 09-7, pages 51 through 53.

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 impact to the state general fund as a result of this rulemaking. This program is 100% federally funded, and due to the low number of participants, the additional two months of eligibility is expected to have minimal impact on federal funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Chris Baylis at (208) 334-5742.

DATED this 17th day of September, 2009.

Tamara Prisock
DHW - Administrative Procedures Section
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THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is March 11, 2009.

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, 45 CFR Parts 260 through 265, and Public Law 111-8, Sections 601 and 602, "Afghan Allies Protection Act of 2009."

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 Wednesday, July 15, 2009.

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:

Afghani special immigrant benefits need to be extended from six months to eight months to bring them into alignment with recent changes in federal law (P.L. 111-8, Sections 601 and 602).

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 **both to comply with deadlines in amendments to governing law or federal programs, and to confer a benefit.**

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 impact to the state general fund as a result of this rulemaking. This program is 100% federally funded, and due to the low number of participants, the additional two months of eligibility is expected to have minimal impact on federal funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because the rule changes are being made to align with changes in federal statute made under the "Afghan Allies Protection Act of 2009."

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Chris Baylis at (208) 334-5742.

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 Wednesday, July 22, 2009.

DATED this 29th day of May, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

131. CITIZENSHIP AND QUALIFIED NON-CITIZEN CRITERIA.
To be eligible, an individual must be a member of one (1) of the groups listed in Subsections 131.01 through 131.10 of this rule. (5-8-09)

01. U.S. Citizen. A U.S. Citizen; or (3-20-04)

02. U.S. National, National of American Samoa or Swains Island. A U. S. National, National of American Samoa or Swains Island; or (3-20-04)

03. Full-Time Active Duty U.S. Armed Forces Member. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) currently on full-time active duty with the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard, or a spouse or unmarried dependent child of the U.S. Armed Forces member; or (3-20-04)

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

05. Non-Citizen Entering the U.S. Before August 22, 1996. A non-citizen who entered the U.S. before August 22, 1996, and is currently a qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c); or (3-20-04)

06. Non-Citizen Entering on or After August 22, 1996. A non-citizen who entered on or after August 22, 1996, and (3-20-04)

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; or (3-20-04)

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; or (3-20-04)

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; or (3-20-04)

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; or (3-20-04)

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; or (3-20-04)

07. Qualified Non-Citizen Entering on or After August 22, 1996. A qualified non-citizen under 8 U.S.C. 1641(b) or (c), entering the U.S. on or after August 22, 1996, and who has had a qualified non-citizen status for at least five (5) years; or (3-20-04)

08. 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. (3-20-04)

09. Afghan Special Immigrants. An Afghan special immigrant, as defined in Public Law 110-161, who has special immigration status after December 26, 2007, is eligible for ~~*six*~~ eight (~~6~~8) months from the date they enter into the U.S. as a special immigrant or the date they convert to the special immigrant status. ~~*(5-8-09)*~~( )

10. Iraqi Special Immigrants. An Iraqi special immigrant, as defined in Public Law 110-181, who has special immigration status after January 28, 2008, is eligible for eight (8) months from the date they enter the U.S. as a special immigrant or the date they convert to the special immigrant status. (5-8-09)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-0804

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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(g), 56-203(i), 56-250 through 56-257, Idaho Code; and the "U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007," Section 70029(b), P.L. 110-28 and P.L. 110-90.

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 pending rule is being adopted as proposed. The complete text of the proposed rule was published in the November 5, 2008, Idaho Administrative Bulletin, Vol. 08-11, pages 56 and 57.

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. N/A

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Jeanne Siroky at (208) 364-1897.

DATED this 29th day of July, 2009.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
P.O. Box 83720, Boise, ID 83720-0036
(208) 334-5564 phone; (208) 334-6558 fax
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THE FOLLOWING NOTICE PUBLISHED WTH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is October 1, 2008.

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), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code; and the "U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007," Section 70029(b), P.L. 110-28 and P.L. 110-90.

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 19, 2008.

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:

As of October 1, 2008, all handwritten and computer generated printed prescriptions for fee-for-service Medicaid patients must be fully tamper resistant in compliance with federal implementation of an amendment to 42 USC 1396b(i).

Rules are being amended to require at least one industry recognized feature from each of the three categories of tamper resistance (characteristics that prevent unauthorized copying, erasure or modification of information, or the use of counterfeit prescription forms) for all handwritten and computer generated printed prescription for fee-for-service Medicaid patients. Prescriptions for Medicaid patients that are telephoned, faxed, or ePrescribed are exempt from these tamper resistance requirements.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5220, Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons: This rulemaking is necessary to meet deadlines in federal regulation.

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.

This rulemaking will have no anticipated fiscal impact to the state general fund.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 67-5220, negotiated rulemaking was not conducted because this rule is being written to comply with federal regulations.

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 November 26, 2008.

DATED this 2nd day of October, 2008.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

661. PRESCRIPTION DRUGS - PARTICIPANT ELIGIBILITY.

01. Obtaining a Prescription Drug. To obtain a prescription drug, a Medicaid participant or authorized agent must present the participant's Medicaid identification card to a participating pharmacy together with a prescription from a licensed prescriber. (3-30-07)

02. Tamper-Resistant Prescription Requirements. Any written, non-electronic prescription for a Medicaid participant must be written on a tamper-resistant prescription form. The paper on which the prescription is written must have: ( )

a. One (1) or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form; ( )

b. One (1) or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; ( )

c. One (1) or more industry-recognized features designed to prevent the use of counterfeit prescription forms. ( )

03. Tamper-Resistant Prescription Requirements Not Applicable. The tamper-resistant prescription requirements do not apply when the prescription is communicated by the prescriber to the pharmacy electronically, verbally, by fax, or when drugs are provided in an inpatient hospital or a nursing facility where the patient and family do not have direct access to the paper prescription. ( )

02~~.~~4. Drug Coverage for Dual Eligibles. For Medicaid participants who are also eligible for Medicare known as ~~(~~"dual eligibles"~~)~~, the Department will pay for Medicaid-covered drugs that are not covered by Medicare Part D. Dual eligibles will be subject to the same limits and processes used for any other Medicaid participants. ~~(3-30-07)~~( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-0901

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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(g), 56-203(i), 56-250 through 56-257, Idaho Code; also Executive Order No. 2008-05 and House Bill 322 (2009).

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 were amended in response to the Governor's Executive Order No. 2008-05 that directed state agencies to hold back 4% of their state general fund budgets for State Fiscal Year 2009. This reduction was carried over for the Department's Division of Medicaid for State Fiscal Year 2010 under House Bill 322 (2009). Cost savings under these rule changes will be realized through reduction in reimbursement percentages to Medicaid providers of hospital services.

Medicaid reimbursement for hospitals is based on a percentage of customary charges. This rule change reduced the current maximum and minimum reimbursement percentages from 96.5% maximum and 81.5% minimum to new percentages of 91.7% maximum and 77.4% minimum. These percentages reflect a 5% decrease in the hospital reimbursement percentages, a reduction from the 10% decrease originally proposed.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the July 1, 2009, Idaho Administrative Bulletin, Vol. 09-7, pages 54 through 57.

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 projected fiscal impact is a total savings of $11,045,900; this includes state funds and federal matching funds. The projected savings to the state general fund is approximately $2,299,700.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions

concerning this pending rule, contact Sheila Pugatch at (208) 364-1817.

DATED this 25th day of November, 2009.

Tamara Prisock
DHW - Administrative Procedures Section
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THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2009.

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), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code; also Executive Order No. 2008-05 and House Bill 322 (2009).

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 Wednesday, July 15, 2009.

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 amended in response to the Governor's Executive Order No. 2008-05 that directed state agencies to hold back 4% of their state general fund budgets for State Fiscal Year 2009. This reduction is being carried over for the Department's Division of Medicaid for State Fiscal Year 2010 under House Bill 322 (2009). Cost savings under these rule changes will be realized through reduction in reimbursement percentages to Medicaid providers of hospital services.

Medicaid reimbursement for hospitals is based on a percentage of customary charges. This rule change will reduce the current maximum and minimum reimbursement

percentages from 96.5% maximum and 81.5% minimum to new percentages of 91.7% maximum and 77.4% minimum. These percentages reflect a 5% decrease in the hospital reimbursement percentages, a reduction from the 10% decrease originally proposed.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate **since it is being done to comply with Executive Order No. 2008-05, which created a deadline for compliance.**

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:

The projected savings to the state general fund is approximately $4,326,650. These savings are already reflected in the State Fiscal Year 2010 appropriation.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because these rule changes are being made to comply with Executive Order No. 2008-05 that requires a 4% holdback of the Department's budget for State Fiscal Year 2009 and continued for State Fiscal Year 2010 under House Bill 322 (2009).

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

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 Wednesday, July 22, 2009.

DATED this 2nd day of June, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

400. INPATIENT HOSPITAL SERVICES - DEFINITIONS.

01. Administratively Necessary Day (AND). An Administratively Necessary Day (AND) is intended to allow a hospital time for an orderly transfer or discharge of participant inpatients who are no longer in need of a continued acute level of care. ANDs may be authorized for inpatients who are awaiting placement for nursing facility level of care, or in-home services which are not available, or when catastrophic events prevent the scheduled discharge of an inpatient. (3-30-07)

02. Allowable Costs. The current year's Medicaid apportionment of a hospital's

allowable costs determined at final or interim settlement consist of those costs permitted by the principles of reimbursement contained in the Provider Reimbursement Manual (PRM) and do not include costs already having payment limited by Medicaid rate file or any other Medicaid charge limitation. (3-30-07)

03. Apportioned Costs. Apportioned costs consist of the share of a hospital's total allowable costs attributed to Medicaid program participants and other patients so that the share borne by the program is based upon actual services received by program participants, as set forth in the applicable Title XVIII principles of cost reimbursement as specified in the PRM and in compliance with Medicaid reimbursement rules. (3-30-07)

04. Capital Costs. For the purposes of hospital reimbursement, capital costs are those allowable costs considered in the settlement that represent the cost to each hospital for its reasonable property related and financing expense, and property taxes. (3-30-07)

05. Case-Mix Index. The Case-Mix Index for a hospital is the average weight of values assigned to a range of diagnostic related groups, including but not limited to, those used in the Medicare system or adjoining states and applied to Medicaid discharges included in a hospital's fiscal year end settlement. The index will measure the relative resources required to treat Medicaid inpatients. The Case-Mix Index of the current year will be divided by the index of the principal year to assess the percent change between the years. (3-30-07)

06. Charity Care. Charity care is care provided to individuals who have no source of payment, third- party or personal resources. (3-30-07)

07. Children's Hospital. A Medicare-certified hospital as set forth in 42 CFR Section 412.23(d). (3-30-07)

08. Current Year. Any hospital cost reporting period for which reasonable cost is being determined will be termed the current year. (3-30-07)

09. Customary Hospital Charges. Customary hospital charges reflect the regular rates for inpatient or outpatient services charged to patient(s) liable for payment for their services on a charge basis. Implicit in the use of charges as the basis for comparability (or for apportionment under certain apportionment methods) is the objective that services are related to the cost of services billed to the Department. No more than ninety-~~*six*~~one and ~~*a half*~~ seven-tenths percent (~~96.5~~ 91.7%) of covered charges will be reimbursed for the separate operating costs for either total inpatient services or total outpatient services at the time of final cost settlement for any fiscal year with the exception set forth in Subsection 405.03.b. of these rules. ~~*(3-30-07)*~~( )

10. Disproportionate Share Hospital (DSH) Allotment Amount. The DSH allotment amount determined by CMS that is eligible for federal matching funds in any federal fiscal period for disproportionate share payments. (3-30-07)

11. Disproportionate Share Hospital (DSH) Survey. The DSH survey is an annual data request from the Department to the hospitals to obtain the information necessary to compute DSH in accordance with Subsection 405.09.a. of these rules. (3-30-07)

12. Disproportionate Share Threshold. The disproportionate share threshold is: (3-30-07)

a. The arithmetic mean plus one (1) standard deviation of the Medicaid Utilization Rates of all Idaho Hospitals; or (3-30-07)

b. A Low Income Revenue Rate exceeding twenty-five percent (25%). (3-30-07)

13. Excluded Units. Excluded units are distinct units in hospitals which are certified by Medicare according to 42 CFR Sections 412.25, 412.27 and 412.29 for exclusion from the Medicare prospective payment system. (3-30-07)

14. Hospital Inflation Index. An index calculated through Department studies and used to adjust inpatient operating cost limits and interim rates for the current year. (3-30-07)

15. Low Income Revenue Rate. The Low Income Revenue Rate is the sum of the following fractions, expressed as a percentage, calculated as follows: (3-30-07)

a. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues and cash subsidies of the hospital for inpatient services in the same cost reporting period; plus (3-30-07)

b. The total amount of the hospital's charges for inpatient hospital services attributable to charity care in the same cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care must not include contractual allowances and discounts and reduction in charges given to Medicare, Medicaid, other third-party payors, or cash for patient services received directly from state and local governments county assistance programs. (3-30-07)

16. Medicaid Inpatient Day. For purposes of DSH payments, an inpatient day is defined as a Medicaid inpatient day in a hospital for which there is also no Medicare inpatient day counted. (3-30-07)

17. Medicaid Utilization Rate (MUR). The MUR for each hospital will be computed using the Department's record of paid inpatient days for the fiscal year divided by the total inpatient days for the same fiscal year as reported in the DSH survey. In this paragraph, the term “inpatient days” includes Medicaid swing-bed days, administratively necessary days, newborn days, days in specialized wards, days provided at an inappropriate level of care, and Medicaid inpatient days from other states. In this paragraph, “Medicaid inpatient days” includes paid days not counted in prior DSH threshold computations. (3-30-07)

18. Obstetricians. For purposes of an adjustment for hospitals serving a disproportionate share of low income patients, and in the case of a hospital located in a rural area, as defined by the federal Executive Office of Management and Budget, the term “obstetrician” includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. (3-30-07)

19. On-Site. A service location over which the hospital exercises financial and administrative control. "Financial and administrative control" means a location whose relation to budgeting, cost reporting, staffing, policy- making, record keeping, business licensure, goodwill and decision-making are so interrelated to those of the hospital that the hospital has ultimate financial and administrative control over the service location. The service location must be in close proximity to the hospital where it is based, and both facilities serve the same patient population (e.g. from the same area, or catchment, within Medicare's defined Metropolitan Statistical Area (MSA) for urban hospitals or thirty-five (35) miles from a rural hospital). (3-30-07)

20. Operating Costs. For the purposes of hospital reimbursement, operating costs are the allowable costs included in the cost centers established in the finalized Medicare cost report to accumulate costs applicable to providing routine and ancillary services to patients for the purposes of cost assignment and allocation in the step- down process. (3-30-07)

21. Other Allowable Costs. Other allowable costs are those reasonable costs recognized under the Medicaid reasonable cost principles for services not subject to Medicaid limitations of coverage or reimbursement limits. Costs which are not reimbursed as operating costs, but recognized by Medicare principles as allowable costs will be included in the total reasonable costs. Other allowable costs include, but are not necessarily limited to, physician's component which was combined-billed, capital costs, ambulance costs, excess costs, carry-forwards and medical education costs. (3-30-07)

22. Principal Year. The principal year is the period from which the Medicaid Inpatient Operating Cost Limit is derived. (3-30-07)

a. For inpatient services rendered on or after November 1, 2002, the principal year is the provider's fiscal year ending in calendar year 1998 in which a finalized Medicare cost report or its equivalent is prepared for Medicaid cost settlement. (3-30-07)

b. For inpatient services rendered on or after January 1, 2007, the principal year is the provider's fiscal year ending in calendar year 2003 and every subsequent fiscal year-end in which a finalized Medicare cost report, or its equivalent, is prepared for Medicaid cost settlement. (3-30-07)

23. Public Hospital. For purposes of Subsection 405.03.b. of these rules, a Public Hospital is a hospital operated by a federal, state, county, city, or other local government agency or instrumentality. (3-30-07)

24. Reasonable Costs. Except as otherwise provided in Section 405.03 of these rules, reasonable costs include all necessary and ordinary costs incurred in rendering the services related to patient care which a prudent and cost-conscious hospital would pay for a given item or service which do not exceed the Medicaid cost limit. (3-30-07)

25. Reimbursement Floor Percentage. The floor calculation for hospitals with more than forty (40) beds is ~~*eighty-one*~~ seventy-seven and ~~*a half*~~ four-tenths percent (~~81.5~~ 77.4%) of Medicaid costs, and the floor calculation for hospitals with forty (40) or fewer beds is ninety-

~~*six*~~one and ~~*a half*~~ seven-tenths percent (~~96.5~~ 91.7%). ~~*(4-2-08)*~~( )

26. TEFRA. TEFRA is the Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248. (3-30-07)

27. Uninsured Patient Costs. For the purposes of determining the additional costs beyond uncompensated Medicaid costs that may be reimbursed as a DSH payment without exceeding the state Allotment Amount, only inpatient costs of uninsured patients will be considered. An inpatient with insurance but no covered benefit for the particular medically necessary service, procedure or treatment provided is an uninsured patient. (3-30-07)

28. Upper Payment Limit. The Upper Payment Limit for hospital services is defined in the Code of Federal Regulations. (3-30-07)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-0902

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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(g), 56-203(i), 56-250 through 56-257, Idaho Code; and House Bill No. 123, 2009 Legislature.

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 pending rule is being adopted as proposed. The complete text of the proposed rule was published in the July 1, 2009 Idaho Administrative Bulletin, Vol. 09-7, pages 58 through 67.

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 projected fiscal impact is a total savings of $5,900,000; this includes state funds only. These savings are already reflected in the State Fiscal Year 2010 appropriation.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Sheila Pugatch at (208) 364-1817.

DATED this 30th day of September, 2009.

Tamara Prisock
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THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2009.

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), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code; and House Bill No. 123, 2009 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 July 15, 2009.

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 amended in response to statutory changes made during the 2009 Legislative session under House Bill No. 123. Cost savings under these rule changes will be realized by using private hospital provider taxes to match federal funds for disproportionate share (DSH) payments to private hospitals.

Medicaid DSH payments to hospitals are based on the results of an annual survey. This rule change will eliminate out-of-state providers from receiving DSH payments.

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:

This rulemaking is necessary to comply with House Bill No. 123, passed during the 2009 Legislative session.

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:

The projected fiscal impact is a total savings of $5,900,000; this includes state funds only. These savings are already reflected in the State Fiscal Year 2010 appropriation.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 67-5220(2), negotiated rulemaking was not conducted because this rule is being written to comply with House Bill No. 123, passed during the 2009 Legislative session.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Sheila Pugatch at (208) 364-1817.

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 22, 2009.

DATED this 4th day of June, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

405. INPATIENT HOSPITAL SERVICES - PROVIDER REIMBURSEMENT.
Under the Medicaid provisions of the Social Security Act, in reimbursing hospitals, the Department will pay the lesser of customary hospital charges or the reasonable cost of inpatient services in accordance with the procedures detailed under this Section of rule. The upper limits observed by the Department in reimbursing each individual hospital must not exceed the payment that would be determined as a reasonable cost under the policies, definitions and procedures observed under Medicare (Title XVIII) principles of cost reimbursement. (3-30-07)

01. Exemption of New Hospitals. A hospital that has operated as the type of facility for which it is certified (or the equivalent thereof) under present and previous ownership for less than three (3) full years will be paid in accordance with the Title XVIII principles of reasonable cost reimbursement, including those provisions applicable to new providers for the carryover and recovery of unreimbursed costs, in accordance with 42 CFR Section 413.64. (3-30-07)

02. Medicaid Inpatient Operating Cost Limits. The following describe the determination of inpatient operating cost limits. (3-30-07)

a. Medicaid Cost Limits for Dates of Service Prior to a Current Year. The reimbursable reasonable costs for services rendered prior to the beginning of the principal year, but included as prior period claims in a subsequent period's cost report, will be subject to the same operating cost limits as the claims under settlement. (3-30-07)

b. Application of the Medicaid Cost Limit. In the determination of a hospital's reasonable costs for inpatient services rendered after the effective date of a principal year, a Hospital Inflation Index, computed for each hospital's fiscal year end, will be applied to the operating costs, excluding capital costs and other allowable costs as defined for the principal year and adjusted on a per diem basis for each subsequent year under the Hospital Inflation Index. (3-30-07)

i. Each inpatient routine service cost center, as reported in the finalized principal year end Medicare cost report, will be segregated in the Medicaid cost limit calculation and assigned a share of total Medicaid inpatient ancillary costs. The prorated ancillary costs will be determined by the ratio of each Medicaid routine cost center's reported costs to total Medicaid inpatient routine service costs in the principal year. (3-30-07)

ii. Each routine cost center's total Medicaid routine service costs plus the assigned share of Medicaid inpatient ancillary costs of the principal year will be divided by the related Medicaid patient days to identify the total costs per diem in the principal year. (3-30-07)

(1) The related inpatient routine service cost center's per diem capital and graduate medical education costs plus the prorated share of inpatient ancillary capital costs will be subtracted from the per diem amount identified in Subsection 405.02.b.ii. of this rule to identify each inpatient routine service cost center per diem cost limit in the principal year. (3-30-07)

(2) If a provider did not have any Medicaid inpatient utilization or render any Medicaid inpatient services in an individual inpatient routine service cost center in the fiscal year serving as the principal year, the principal year for only those routine cost centers without utilization in the provider's principal year will be appropriately calculated using the information available in the next subsequent year in which Medicaid utilization occurred. (3-30-07)

iii. Each routine cost center's cost per diem for the principal year will be multiplied by the Hospital Inflation Index for each subsequent fiscal year. (3-30-07)

iv. The sum of the per diem cost limits for the Medicaid inpatient routine service cost centers of a hospital during the principal year, as adjusted by the Hospital Inflation Index, will be the Medicaid cost limit for operating costs in the current year. (3-30-07)

(1) At the date of final settlement, reimbursement of the Medicaid current year inpatient routine cost centers plus the assigned ancillary costs will be limited to the total per diem operating costs as adjusted for each subsequent fiscal year after the principal year through the current year by the Hospital Inflation Cost Index. (3-30-07)

(2) Providers will be notified of the estimated inflation index periodically or Hospital Inflation Index (CMS Market Basket Index) prior to final settlement only upon written request. (3-30-07)

03. Adjustments to the Medicaid Cost Limit. A hospital's request for review by the Department concerning an adjustment to or exemption from the cost limits imposed under the provisions set forth in Section 405 of this chapter of rules, must be granted under the following circumstances: (3-30-07)

a. Adjustments. Because of Extraordinary Circumstances. Where a provider's costs exceed the Medicaid limit due to extraordinary circumstances beyond the control of the provider, the provider can request an adjustment to the cost limit to the extent the provider proves such higher costs result from the extraordinary circumstances including, but not limited to, increased costs attributable to strikes, fires, earthquake, flood, or similar, unusual occurrences with substantial cost effects. (3-30-07)

b. Reimbursement to Public Hospitals. A Public Hospital that provides services free or at a nominal charge, which is less than, or equal to fifty percent (50%) of its total allowable costs, will be reimbursed at the same rate that would be used if the hospital's charges were equal to, or greater than, its costs. (3-30-07)

c. Adjustment to Cost Limits. A hospital is entitled to a reasonable increase in its Medicaid Cost limits if the hospital shows that its per diem costs of providing services have increased due to increases in case- mix, the adoption of new or changed services, the discontinuation of services or decrease in average length of stay for Medicaid inpatients since the principal year. Any hospital making such showing is entitled to an increase commensurate with the increase in per diem costs. (3-30-07)

i. The Medicaid operating cost limit may be adjusted by multiplying cost limit by the ratio of the current year's Case-Mix Index divided by the principal year's Case-Mix Index. (3-30-07)

ii. The contested case procedure set for forth in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings," is available to larger hospitals seeking such adjustments to their Medicaid Cost Limits. (3-30-07)

d. Medicaid Operating and Capital and Medical Education Costs. All hospitals will be guaranteed at least eighty percent (80%) of their total allowable Medicaid Operating and Capital and medical education costs upon final settlement excluding DSH payments. (3-30-07)

i. With the exception of Subsection 405.03.d.ii. of this rule, at the time of final settlement, the allowable Medicaid costs related to each hospital's fiscal year end will be according to the Reimbursement Floor Percentage. (3-30-07)

ii. In the event that CMS informs the Department that total hospital payments under the Inpatient Operating Cost Limits exceed the inpatient Upper Payment Limit, the Department may reduce the guaranteed percentage defined as the Reimbursement Floor Percentage to hospitals. (3-30-07)

e. Adjustment to the Proration of Ancillary Costs in the principal year. Where the provider asserts that the proration of ancillary costs does not adequately reflect the total Medicaid cost per diem calculated for the inpatient routine service cost centers in the principal year, the provider may submit a detailed analysis of ancillary services provided to each participant for each type of patient day during each participant's stay during the principal year. The provider will be granted this adjustment only once upon appeal for the first cost reporting year that the limits are in effect. (3-30-07)

04. Payment Procedures. The following procedures are applicable to in-patient hospitals: (3-30-07)

a. The participant's admission and length of stay is subject to preadmission, concurrent and retrospective review by a Quality Improvement Organization (QIO) designated by the Department. QIO review will be governed by provisions of the QIO Idaho Medicaid Provider

Manual as amended. If such review identifies that an admission or continued stay is not medically necessary, then no Medicaid payment will be made. Failure to obtain a timely QIO review as required by Section 405 of this chapter of rules, and as outlined in the QIO Idaho Medicaid Provider Manual as amended, will result in the QIO conducting a late review. After a QIO review has determined that the hospital stay was medically necessary, Medicaid will assess a late review penalty to the hospital as outlined in Subsection 405.05 of this rule. (3-30-07)

i. All admissions are subject to QIO review to determine if continued stay in inpatient status is medically necessary. A QIO continued stay review is required when the participant's length of stay exceeds the number of days certified by the QIO. If no initial length of stay certification was issued by the QIO, a QIO continued stay review is required when the admission exceeds a number of days as specified by the Department. (3-30-07)

ii. Reimbursement for services originally identified as not medically necessary by the QIO 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)

iii. Absent the Medicaid participant's informed decision to incur services deemed unnecessary by the QIO, or not authorized by the QIO due to the negligence of the provider, no payment for denied services may be obtained from the participant. (3-30-07)

b. In reimbursing licensed hospitals, the Department will pay the lesser of customary hospital charges or the reasonable cost of semi-private rates for in-patient hospital care as set forth in this rule, unless an exception applies as stated in Section 402 of these rules. The upper limits for payment must not exceed the payment which would be determined as reasonable cost using the Title XVIII standards and principles. (3-30-07)

05. Hospital Penalty Schedule. (3-30-07)

a. A request for a preadmission and/or continued stay QIO review that is one (1) day late will result in a penalty of two hundred and sixty dollars ($260), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

b. A request for a preadmission and/or continued stay QIO review that is two (2) days late will result in a penalty of five hundred and twenty dollars ($520), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

c. A request for a preadmission and/or continued stay QIO review that is three (3) days late will result in a penalty of seven hundred and eighty dollars ($780), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

d. A request for a preadmission and/or continued stay QIO review that is four (4) days late will result in a penalty of one thousand and forty dollars ($1,040), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

e. A request for a preadmission and/or continued stay QIO review that is five (5) days late or greater will result in a penalty of one thousand three hundred dollars ($1,300), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

06. AND Reimbursement Rate. Reimbursement for an AND will be made at the weighted average Medicaid payment rate for all Idaho nursing facilities for routine services, as defined per 42 CFR 447.280(a)(1), furnished during the previous calendar year. ICF/MR rates are excluded from this calculation. (3-30-07)

a. The AND reimbursement rate will be calculated by the Department by March 15 of each calendar year and made effective retroactively for dates of service on or after January 1 of the respective calendar year. (3-30-07)

b. Hospitals with an attached nursing facility will be reimbursed the lesser of their Medicaid per diem routine rate or the established average rate for an AND; and (3-30-07)

c. The Department will pay the lesser of the established AND rate or a facility's customary hospital charge to private pay patients for an AND. (3-30-07)

07. Reimbursement for Services. Routine services as addressed in Subsection 405.08 of this rule include all medical care, supplies, and services which are included in the calculation of nursing facility property and nonproperty costs as described in these rules. Reimbursement of ancillary services will be determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs will be in accord with Section 665 of these rules. (3-30-07)

08. Hospital Swing-Bed Reimbursement. The Department will pay for nursing facility care in certain rural hospitals. Following approval by the Department, such hospitals may provide service to participants in licensed hospital ("swing") beds who require nursing facility level of care. (3-30-07)

a. Facility Requirements. The Department will approve hospitals for nursing facility care provided to eligible participants under the following conditions: (3-30-07)

i. The Department's Licensure and Certification Section finds the hospital in conformance with the requirements of 42 CFR 482.66 "Special Requirements" for hospital providers of long-term care services ("swingbeds"); and (3-30-07)

ii. The hospital is approved by the Medicare program for the provision of "swing-bed" services; and (3-30-07)

iii. The facility does not have a twenty-four (24) hour nursing waiver granted under 42 CFR 488.54(c); and (3-30-07)

iv. The hospital must not have had a swing-bed approval terminated within the two (2) years previous to application for swing-bed participation; and (3-30-07)

v. The hospital must be licensed for less than one hundred (100) beds as defined by 42 CFR 482.66(a)(1) for swing-bed purposes; and (3-30-07)

vi. Nursing facility services in swing-beds must be rendered in beds used

interchangeably to furnish hospital or nursing facility-type services. (3-30-07)

b. Participant Requirements. The Department will reimburse hospitals for participants under the following conditions: (3-30-07)

i. The participant is determined to be entitled to such services in accordance with IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled"; and (3-30-07)

ii. The participant is authorized for payment in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 222.02. (3-30-07)

c. Reimbursement for "Swing-Bed" Patient Days. The Department will reimburse swing-bed hospitals on a per diem basis utilizing a rate established as follows: (3-30-07)

i. Payment rates for routine nursing facility services will be at the weighted average Medicaid rate per patient day paid to hospital-based nursing facility/ICF facilities for routine services furnished during the previous calendar year. ICF/MR facilities' rates are excluded from the calculations. (3-30-07)

ii. The rate will be calculated by the Department by March 15 of each calendar year. The rate will be based on the previous calendar year and effective retroactively for dates of service on or after January 1 of the respective year. (3-30-07)

iii. The weighted average rate for nursing facility swing-bed days will be calculated by dividing total payments for routine services, including patient contribution amounts but excluding miscellaneous financial transactions relating to prior years, by total patient days for each respective level of care occurring in the previous calendar year. (3-30-07)

iv. Routine services include all medical care, supplies, and services which are included in the calculation of nursing facility property and nonproperty costs as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 225.01. (3-30-07)

v. The Department will pay the lesser of the established rate, the facility's charge, or the facility's charge to private pay patients for "swing-bed" services. (3-30-07)

vi. Reimbursement of ancillary services not included in the nursing facility rates furnished for extended care services will be billed and determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs will be in accord with Section 665 of these rules. (3-30-07)

vii. The number of swing-bed days that may be reimbursed to a provider in a twelve (12) month period will be limited to the greater of one thousand ninety five (1,095) days which may be prorated over a shorter fiscal period or, fifteen percent (15%) of the product of the average number of available licensed beds in the hospital in the period and the number of days in the fiscal period. (3-30-07)

d. Computation of "Swing-Bed" Patient Contribution. The computation of the

patient's contribution of swing-bed payment will be in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 224. (3-30-07)

09. Adjustment for Disproportionate Share Hospitals (DSH). All Idaho hospitals serving a disproportionate share of low income patients must qualify either as a Mandatory DSH or as Deemed DSH to receive a DSH payment. ~~(3-30-07)~~( )

a. DSH Survey Requirements. The Department will send each hospital a DSH survey on or before January 31 of each calendar year. The DSH survey must be returned to the Department on or before May 31 of the same calendar year. A hospital will not receive a DSH payment if the survey is not returned by the deadline, unless good cause is determined by the Department. No later than July 15 of each calendar year, the Department must notify each hospital of their calculated DSH payment and notify each hospital of its preliminary calculated distribution amount. A hospital may file an amended survey to complete, correct, or revise the original DSH survey by submitting the amended survey and supporting documentation to the Department no later than thirty (30) days after the notice of the preliminary DSH calculation is mailed to the hospital. The state's annual DSH allotment payment will be made by September 30 of the same calendar year based on the final DSH surveys and Department data. (3-30-07)

b. Mandatory Eligibility. Mandatory Eligibility for DSH status will be provided for hospitals which: (3-30-07)

i. Meet or exceed the disproportionate share threshold as defined in Subsection 400.13 of these rules. (3-30-07)

ii. Have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services~~, and have provided such services to individuals entitled to such services under the Idaho Medical Assistance Program for the reporting period~~.
~~(3-30-07)~~( )

(1) Subsection 405.09.b.ii. of this rule does not apply to a hospital in which the inpatients are predominantly individuals under eighteen (18) years of age; or (3-30-07)

(2) Does not offer nonemergency inpatient obstetric services as of December 21, 1987. (3-30-07)

iii. The MUR will not be less than one percent (1%). (3-30-07)

iv. If an Idaho hospital exceeds both disproportionate share thresholds, as described in Subsection 400.13 of these rules, and the criteria of Subsections 405.09.b.ii. and 405.09.b.iii. of this rule are met, the payment adjustment will be the greater of the amounts calculated using the methods identified in Subsections 405.09.b.vi. through 405.09.b.x. of this rule. ~~(3-30-07)~~( )

~~v. In order to qualify for a DSH payment, a hospital located outside the state of Idaho must:~~ ~~(3-30-07)~~

~~(1) Qualify under the Mandatory DSH requirements set forth in Subsection 405.09 of this chapter of rules;~~ ~~(3-30-07)~~

~~*(2) Qualify for DSH payments from the state in which the hospital is located; and (3-30-07)*~~

~~*(3) Have fifty thousand dollars ($50,000) or more in covered charges for services provided to Idaho participants during the year covered by the applicable DSH survey. (3-30-07)*~~

v~~i~~. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one (1) standard deviation and less than one and one-half (1 1/2) standard deviations above the mean of all Idaho hospitals will receive a DSH payment equal to two percent (2%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

vi~~i~~. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one and one-half (1 1/2) standard deviations and less than two (2) standard deviations of the mean of all Idaho hospitals will receive a DSH payment equal to four percent (4%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

vii~~i~~. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates exceeding two (2) standard deviations of the mean of all Idaho hospitals will receive a DSH payment equal to six percent (6%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

~~*ix*~~viii. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to or exceeding twenty-five percent (25%) will receive a DSH payment equal to four percent (4%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

ix. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to, or exceeding, thirty percent (30%) will receive a DSH payment equal to six percent (6%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

~~***c.*** *Out-of-State Hospitals Eligible for Mandatory DSH Payments. Out-of-state hospitals eligible for Mandatory DSH payments will receive DSH payments equal to one half (1/2) of the percentages provided for Idaho hospitals in Subsections 405.09.b.iv. through 405.09.b.x. of this rule. (3-30-07)*~~

~~***d.***~~**c.** Deemed Disproportionate Share Hospital (DSH). All hospitals in Idaho which have inpatient utilization rates of at least one percent (1%) only in Idaho inpatient days, and meet the requirements unrelated to patient day utilization specified in Subsection 405.09.b. of this rule, will be designated a Deemed Disproportionate Share Hospital. ~~*Out of state hospitals will not be designated as Deemed DSH.*~~ The disproportionate share payment to a Deemed DSH hospital will be the greater of: ~~*(3-30-07)*~~(____)

i. Five dollars ($5) per Idaho Medicaid inpatient day included in the hospital's MUR computation; or (3-30-07)

ii. An amount per Medicaid inpatient day used in the hospital's MUR computation that equals the DSH allotment amount, less the Mandatory DSH payment amount, divided by the number of Medicaid inpatient days used in the MUR computation for all Idaho DSH hospitals. (3-30-07)

~~e~~d. Insufficient DSH Allotment Amounts. When the DSH allotment amount is insufficient to make the aggregate amount of DSH payments to each DSH hospital, payments to each hospital will be reduced by the percentage by which the DSH allotment amount was exceeded. (3-30-07)

~~f~~e. DSH Payments Will Not Exceed Costs. A DSH payment will not exceed the costs incurred during the year of furnishing services to individuals who are either eligible for medical assistance under the State Plan or were uninsured for health care services provided during the year. (3-30-07)

i. Payments made to a hospital for services provided to indigent patients by a state or a unit of local government within a state will not be considered a source of third party payment. (3-30-07)

ii. Claims of uninsured costs which increase the maximum amount which a hospital may receive as a DSH payment must be documented. (3-30-07)

~~g~~f. DSH Will be Calculated on an Annual Basis. A change in a provider's allowable costs as a result of a reopening or appeal will not result in the recomputation of the provider's annual DSH payment. (3-30-07)

10. Out-of-State Hospitals. (3-30-07)

a. Cost Settlements for Certain Out-of-State Hospitals. Hospitals not located in the state of Idaho will have a cost settlement computed with the state of Idaho if the following conditions are met: (3-30-07)

i. Total inpatient and outpatient covered charges are more than fifty thousand dollars ($50,000) in the fiscal year; or (3-30-07)

ii. When less than fifty thousand dollars ($50,000) of covered charges are billed to the state by the provider, and a probable significant underpayment or overpayment is identifiable, and the amount makes it administratively economical and efficient for cost settlement to be requested by either the provider or the state, a cost settlement will be made between the hospital and the Department. (3-30-07)

b. Payment for Hospitals Without Cost Settlement. Those out-of-state hospitals not cost settling with the state will have annually adjusted rates of payment no greater than seventy-five percent (75%) for inpatient covered charges and no greater than eighty percent (80%) of outpatient covered charges or, the Department's established fee schedule for certain outpatient services. These rates represent average inpatient and outpatient reimbursement rates paid to Idaho hospitals. (3-30-07)

11. Institutions for Mental Disease (IMD). Except for individuals under twenty-two (22) years of age which are contracted with the Department under the authority of the Division of Family and Community Services and certified by the Health Care Financing Administration, no services related to inpatient care will be covered when admitted to a freestanding psychiatric hospital. (3-30-07)

12. Audit Function. Under a common audit agreement, the Medicare Intermediary may perform any audit required for both Title XVIII and Medicaid purposes. The Department may elect to perform an audit even though the Medicare Intermediary does not choose to audit the facility. (3-30-07)

13. Adequacy of Cost Information. Cost information as developed by the provider must be current, accurate, and in sufficient detail and in such form as needed to support payments made for services rendered to participants. This includes all ledgers, books, reports, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of reasonable costs, leaving an audit trail capable of being audited. Financial and statistical records will be maintained in a consistent manner from one (1) settlement period to another. (3-30-07)

14. Availability of Records of Hospital Providers. A participating hospital provider of services must make available to the Department in the state in which the facility is licensed, the provider's fiscal and other necessary records for the purpose of determining its ongoing record keeping capability and to ascertain information pertinent to the determination of the proper amount of program payments due the provider. (3-30-07)

15. Interim Cost Settlements. The Department may initiate or a hospital may request an interim cost settlement based on the Medicare cost report as submitted to the Medicare Intermediary. (3-30-07)

a. Cost Report Data. Interim settlement cost report data will be adjusted to reflect Medicaid payments and statistical summary reports sent to providers before the filing deadline. (3-30-07)

b. Hard Copy of Cost Report. Hospitals which request to undergo interim cost settlement with Idaho Medicaid must submit a hard copy of the Medicare cost report to the Department upon filing with the Intermediary. (3-30-07)

c. Limit or Recovery of Payment. The Department may limit a recovery or payment of an interim settlement amount up to twenty-five percent (25%) of the total settlement amount when the cost report information is in dispute. (3-30-07)

16. Notice of Program Reimbursement. Following receipt of the finalized Medicare cost report and the timely receipt of any other information requested by the Department to fairly cost settle with the provider, a certified letter with the return receipt requested will be sent to the provider which sets forth the amounts of underpayment or overpayment made to the provider. The notice of the results of the final retroactive adjustment will be sent even though the provider

intends to request a hearing on the determination, or has appealed the Medicare Intermediary's determination of cost settlement. Where the determination shows that the provider is indebted to the Medicaid program because total interim and other payments exceed cost limits, the state will take the necessary action to recover overpayment, including the suspension of interim payments sixty (60) days after the provider's receipt of the notice. Such action of recovery or suspension will continue even after a request for an informal conference or hearing is filed with the state. If the hearing results in a revised determination, appropriate adjustments will be made to the settlement amount. (3-30-07)

a. Timing of Notice. The Department will make every effort to issue a notice of program reimbursement within twelve (12) months of receipt of the cost report from the Medicare Intermediary. (3-30-07)

b. Reopening of Completed Settlements. A Medicaid completed cost settlement may be reopened by the provider or the state within a three (3) year period from the date of the letter of notice of program reimbursement. The issues must have been raised, appealed and resolved through the reopening of the cost report by the Medicare Intermediary. Issues previously addressed and resolved by the Department's appeal process are not cause for reopening of the finalized cost settlement. (3-30-07)

17. Nonappealable Items. The formula for the determination of the Hospital Inflation Index, the principles of reimbursement which define allowable cost, non-Medicaid program issues, interim rates which are in compliance with state and federal rules, and the preliminary adjustments prior to final cost settlement determinations as supported by properly completed cost reports and audits must not be accepted as appealable items. (3-30-07)

18. Interim Reimbursement Rates. The interim reimbursement rates are reasonable and adequate to meet the necessary costs which must be incurred by economically and efficiently operated providers which provide services in conformity with applicable state and federal laws, rules, and quality and safety standards. (3-30-07)

a. Annual Adjustments. Interim rates will be adjusted at least annually based on the best information available to the Department. The interim rate will reflect the Medicaid Inpatient Operating Cost Limits used to set inpatient rates and the Reimbursement Floor Percentage. (3-30-07)

b. Retrospective Adjustments. Interim rates will not be adjusted retrospectively upon request for rate review by the provider. (3-30-07)

c. Basis for Adjustments. The Department may make an adjustment based on the Medicare cost report as submitted and accepted by the Intermediary after the provider's reporting year to bring interim payments made during the period into agreement with the tentative reimbursable amount due the provider at final settlement. If the settlement amount is equal to or greater than ten percent (10%) of the payments received or paid and equal to or greater than one hundred thousand dollars ($100,000), the interim rate will be adjusted to account for half (½) of the difference. (3-30-07)

d. Unadjusted Rate. The Medicaid interim reimbursement rate on file is synonymous

with the term unadjusted rate used by other payors. (3-30-07)

19. Audits. All financial reports are subject to audit by Departmental representatives in accordance with Section 305 of these rules. (3-30-07)

20. Interim Reimbursement Rates. The interim reimbursement rates are reasonable and adequate to meet the necessary costs which must be incurred by economically and efficiently operated providers which provide services in conformity with applicable state and federal laws, rules, and quality and safety standards. (3-30-07)

a. Annual Adjustments. Interim rates will be adjusted at least annually based on the best information available to the Department. The interim rate will reflect the Medicaid Inpatient Operating Cost Limits used to set inpatient rates and the Reimbursement Floor Percentage. (3-30-07)

b. Retrospective Adjustments. Interim rates will not be adjusted retrospectively upon request for rate review by the provider. (3-30-07)

c. Basis for Adjustments. The Department may make an adjustment based on the Medicare cost report as submitted and accepted by the Intermediary after the provider's reporting year to bring interim payments made during the period into agreement with the tentative reimbursable amount due the provider at final settlement. If the settlement amount is equal to or greater than ten percent (10%) of the payments received or paid and equal to or greater than one hundred thousand dollars ($100,000), the interim rate will be adjusted to account for half (½) of the difference. (3-30-07)

d. Unadjusted Rate. The Medicaid interim reimbursement rate on file is synonymous with the term unadjusted rate used by other payors. (3-30-07)

21. Audits. All financial reports are subject to audit by Departmental representatives in accordance with Section 305 of these rules. (3-30-07)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-0903

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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(g), 56-203(i), 56-250 through 56-257, 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 adopted as proposed with one revision to the guidelines for paraprofessionals. Based on comment to the rule and to ensure that best practices are followed for the supervision of paraprofessionals, a reference to the current American Speech-Language-Hearing Association (ASHA) guidelines for Medicaid Speech-Language Pathology Services is being added to the rule. This requirement has also been incorporated by reference.

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 Book 1 of the October 7, 2009, Idaho Administrative Bulletin, Vol. 09-10, pages 353 through 361.

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 the state general fund due to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Lauren Ertz at (208) 287-1169.

DATED this 18th day of November, 2009.

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

THE FOLLOWING NOTICE 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 The action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2009.

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:

Due to a recent court ruling stating that the Idaho Medicaid program cannot limit the "place of service" where medically necessary services can be delivered, revisions are being made to the rules dealing with provider reimbursement. Also, psychosocial rehabilitation rules will be revised to match new rewritten mental health rules. Finally, rules pertaining to paraprofessionals will be revised to align with licensure rules and DDA 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.

There is no fiscal impact to the state general fund due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because this rulemaking is being done due to a recent court ruling that invalidated Medicaid rules for the for the billing of services delivered in schools.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Lauren Ertz at (208) 287-1169.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2009.

DATED this 14th day of August, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

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://www.access.gpo.gov/nara/cfr/cfr-table-search.html. (3-30-07)

02. American Academy of Pediatrics (AAP) Periodicity Schedule. This document is available on the internet at: http://aappolicy.aappublications.org/cgi/reprint/pediatrics;105/3/645.pdf. 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. ( )*

0~~3~~*4*. 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)

0~~4~~*5*. 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. (3-30-07)

0~~5~~*6*. 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)

0~~6~~*7*. 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 the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702. (3-30-07)

0~~7~~*8*. 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.state.id.us/SpecialEd/manual/sped.asp. 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)

0~~8~~*9*. 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: www.noridianmedicare.com. (3-30-07)

***~~09~~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)

1~~0~~*1*. 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 internet site at http://www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filter ByDID=- 99&sortByDID=1&sortOrder=ascending&itemID=C MS021929 and http://www.cms. hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=0&sortBy DID=1&sort Order=ascending&itemID=CMS021935. (3-30-07)

1~~1~~*2*. 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)

1~~2~~*3*. 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)

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 ~~*or required by federal and state educational statutes or regulations*~~.

~~*(3-30-07)*~~( )

03. School-Based Services. School-based services are health-related and rehabilitative services provided by Idaho public school districts, charter schools, and the Idaho Infant Toddler program under the Individuals with Disabilities Education Act (IDEA). (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

852. SCHOOL-BASED SERVICE - COVERAGE AND LIMITATIONS.
The Department will pay school districts, charter schools, and the Idaho Infant Toddler Program, 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. (3-30-07)

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. Recommended or Referred by a Physician or Other Practitioner of the Healing Arts. Be recommended or referred by a physician or other practitioner of the healing arts licensed and approved by the state of Idaho to make such recommendations or referrals; (3-30-07)

b. Conducted by Qualified Professionals. Be conducted by qualified professionals for the respective discipline as defined in Section 854 of these rules; (3-30-07)

c. Directed Toward Diagnosis. Be directed toward a diagnosis; and (3-30-07)

d. Recommend Interventions. Include recommended interventions to address each need. (3-30-07)

03. Reimbursable Services. School districts, charter schools, and the Idaho Infant Toddler program 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 licensed and approved by the state of Idaho to make such recommendations or referrals for the Medicaid services for which the school district, charter school, or Idaho Infant Toddler Program is seeking reimbursement. (3-30-07)

a. Collateral Contact. Consultation or treatment direction about the student to a significant other in the student's life may be face-to-face or by telephone contact. Collateral contact for general staff training, regularly scheduled parent-teacher conferences, or general parent education, or for ~~*treatment*~~ the Individualized Education Program (IEP) development and review team meetings, even when the parent is present, is not reimbursed. The term collateral contact is defined in Subsection 010.16 of these rules. ~~*(3-30-07)*~~( )

b. Developmental Therapy and Evaluation. Developmental therapy may be billed, including evaluation and instruction in daily living skills the student has not gained at the normal developmental stages in his life, or is not likely to develop without training or therapy beyond age-appropriate learning situations. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the student's disability. (3-30-07)

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 or for the Idaho Infant Toddler Program 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 or Idaho Infant Toddler Program by the student. (3-30-07)

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 such as basic personal care and grooming; assistance with bladder or bowel requirements; assistance with eating (including feeding), or other tasks delegated by a licensed professional nurse (RN). (3-30-07)

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. ~~*such as t*~~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 ~~*individual and group*~~ PSR services. ~~*(3-30-07)*~~( )

k. Intensive Behavioral Intervention (IBI). Intensive behavioral interventions are individualized, comprehensive, proven interventions used on a short term, one-to-one basis that produce measurable outcomes which diminish behaviors that interfere with the development and use of language and appropriate social interaction skills or broaden an otherwise severely restricted range of interest. Professionals may provide consultation to parents and to other staff who provide therapy for the child in other disciplines to assure successful integration and transition from IBI to other therapies and environments. (3-30-07)

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

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

n. Transportation Services. School districts, charter schools, and the Idaho Infant Toddler programs can receive reimbursement for mileage for transporting a student to and from home, school, or location of services when: (3-30-07)

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 854 of these rules for documentation requirements. (3-30-07)

o. Interpretive Services. Interpretive services needed by a student who 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: (3-30-07)

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)

(BREAK IN CONTINUITY OF SECTIONS)

854. SCHOOL-BASED SERVICE - PROVIDER QUALIFICATIONS AND DUTIES. In addition to the evaluations and maintenance of the plans, the following documentation must be maintained by the provider and retained for a period of six (6) years: (3-30-07)

01. Service Detail Reports. A service detail report which includes: (3-30-07)

a. Name of student; (3-30-07)

b. Name and title of the person providing the service; (3-30-07)

c. Date, time, and duration of service; (3-30-07)

d. Place of service, if provided in a location other than school; and (3-30-07)

e. Student's response to the service. (3-30-07)

02. 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. (3-30-07)

03. Documentation of Qualifications of Providers. (3-30-07)

04. Copies of Required Referrals and Recommendations. Copies of required referrals and recommendations. (3-30-07)

05. Parental Notification. School districts, charter schools, and the Idaho Infant Toddler programs must document that parents were notified of the health-related services and equipment for which they will bill Medicaid. Notification must comply with the requirements in Subsection 854.06 of this rule. (3-30-07)

06. Requirements for Cooperation with and Notification of Parents and Agencies. Each school district, charter school, or Idaho Infant Toddler Program 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. (3-30-07)

a. Notification of Parents. For all students who are receiving Medicaid reimbursed

services, school districts, charter schools, and the Idaho Infant Toddler program 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 or 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 (3-30-07)

b. Notification to Primary Care Physician. School districts, charter schools, and the Idaho Infant Toddler program 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: (3-30-07)

i. Results of evaluations within sixty (60) days of completion; (3-30-07)

ii. A copy of the cover sheet and services page within thirty (30) days of the plan meeting; and (3-30-07)

iii. A copy of progress notes, if requested by the physician, within sixty (60) days of completion. (3-30-07)

c. Other Community and State Agencies. Upon receiving a request for a copy of the evaluations or the current plan, the school district, charter school, or Idaho Infant Toddler Program 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. (3-30-07)

d. Parental Consent to Release Information. School districts, charter schools, and the Idaho Infant Toddler program: (3-30-07)

i. Must obtain consent from the parent to release information regarding education-related services, in accordance with Federal Education Rights and Privacy Act (FERPA) regulations; (3-30-07)

ii. Must document the parent's denial of consent if the parent refuses to consent to the release of information regarding education-related services, including release of the name of the student's primary care physician. (3-30-07)

07. Provider Staff Qualifications. Medicaid will only reimburse for services provided by qualified staff. See Subsection 854.08 of this rule for the limitations and requirements for paraprofessional service providers. The following are the minimum qualifications for professional providers of covered services: (3-30-07)

a. Collateral Contact. Contact and direction must be provided by the professional who provides the treatment to the student. (3-30-07)

b. Developmental Therapy and Evaluation. Must be provided by or under the direction of a developmental specialist, as set forth in IDAPA 16.04.11, "Developmental Disabilities Agencies." Certified special education teachers are not required to take the

Department-approved course indicated in IDAPA 16.04.11 and be certified as a Developmental Specialist, Child. Only those school personnel who are working under a Letter of Authorization or as a Specialty Consultant must meet the certification requirements in IDAPA 16.04.11. (3-30-07)

c. Medical Equipment and Supplies. See Subsection 852.03 of these rules. (3-30-07)

d. Nursing Services. Must be provided by a licensed professional nurse (RN) or licensed practical nurse (LPN) licensed to practice in Idaho. (3-30-07)

e. Occupational Therapy and Evaluation. Must be provided by or under the supervision of an individual qualified and registered to practice in Idaho. (3-30-07)

f. Personal Care Services. Must be provided by or under the direction of, a licensed professional nurse (RN) or licensed practical nurse (LPN), licensed by the State of Idaho. When services are provided by a CNA, the CNA must be supervised by an RN. Medically-oriented services having to do with the student's physical or functional requirements, such as basic personal care and grooming, assistance with bladder or bowel requirements, and assistance with eating (including feeding), must be identified on the plan of care and may be delegated to an aide in accordance with IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (3-30-07)

g. Physical Therapy and Evaluation. Must be provided by an individual qualified and licensed as a physical therapist to practice in Idaho. (3-30-07)

h. Psychological Evaluation. Must be provided by a: (3-30-07)

i. Licensed psychiatrist; (3-30-07)

ii. Licensed physician; (3-30-07)

iii. Licensed psychologist; (3-30-07)

iv. Psychologist extender registered with the Bureau of Occupational Licenses; or (3-30-07)

v. Certified school psychologist. (3-30-07)

i. Psychotherapy. Provision of psychotherapy services must have, at a minimum, one (1) or more of the following credentials: (3-30-07)

i. Psychiatrist, M.D.; (3-30-07)

ii. Physician, M.D.; (3-30-07)

iii. Licensed psychologist; (3-30-07)

iv. Licensed clinical social worker; (3-30-07)

v. Licensed clinical professional counselor; (3-30-07)

vi. Licensed marriage and family therapist; (3-30-07)

vii. Certified psychiatric nurse (R.N.), as described in Subsection 707.~~0~~13 of these rules; ~~(3-30-07)~~( )

viii. Licensed professional counselor whose provision of psychotherapy is supervised ~~by persons qualified under Subsections 854.07.i.i. through 854.07.i.vii. of this rule~~ in compliance with IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; ~~(3-30-07)~~( )

ix. 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"; ~~or~~ ~~(3-30-07)~~( )

x. ~~Psychologist extender registered with the Bureau of Occupational Licenses.~~ 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 ~~(3-30-07)~~( )

xi. 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." ( )

j. Psychosocial Rehabilitation. Must be provided by a: (3-30-07)

i. Licensed physician, ~~or~~ licensed practitioner of the healing arts, or licensed psychiatrist; ~~(3-30-07)~~( )

ii. Licensed master's level psychiatric nurse; (3-30-07)

iii. Licensed psychologist; (3-30-07)

iv. Licensed clinical professional counselor or professional counselor; (3-30-07)

v. Licensed marriage and family therapist or associate marriage and family therapist; ~~(3-30-07)~~( )

vi. Licensed masters social worker, licensed clinical social worker, or licensed social worker; (3-30-07)

vii. Psychologist extender registered with the Bureau of Occupational Licenses; (3-30-07)

~~viii. Clinician;~~ ~~(3-30-07)~~

~~ix. Licensed pastoral counselor;~~ ~~(3-30-07)~~

~~x~~viii. Licensed professional nurse (RN); (3-30-07)

~~x~~ix. Psychosocial rehabilitation specialist as defined in ~~*Section 456 in these rules*~~ IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 131; ~~*(3-30-07)*~~( )

x~~i~~i. Licensed occupational therapist; (3-30-07)

xi~~i~~i. Certified school psychologist; or (3-30-07)

xi~~v~~i. Certified school social worker. (3-30-07)

k. Intensive Behavioral Intervention. Must be provided by or under the direction of a qualified professional who meets the requirements set forth in IDAPA 16.04.11 "Developmental Disabilities Agencies." (3-30-07)

l. 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. (3-30-07)

m. Social History and Evaluation. Must be provided by a 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. (3-30-07)

n. 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. (3-30-07)

08. Paraprofessionals. ~~*Paraprofessionals, such as aides or therapy technicians, may be used by the school/Infant Toddler program*~~ The schools and Infant Toddler Program may use paraprofessionals to provide developmental therapy; occupational therapy; physical therapy; and speech therapy if they are under the supervision of the appropriate professional. The services provided by paraprofessionals must be ~~*within the scope of practice of an aide or therapy technician*~~ delegated and supervised by a professional therapist as defined by the ~~*scope of practice of the therapy professional*~~ appropriate licensure and certification rules. The portions of the treatment plan which can be delegated to the paraprofessional must be identified in the IEP or IFSP. ~~*(3-30-07)*~~( )

a. ~~*Competency of Paraprofessional. The professional must have assessed the competence of the paraprofessional or aide to perform assigned tasks.*~~ Occupational Therapy. Refer to IDAPA 24.06.01, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants," for supervision and service requirements. ~~*(3-30-07)*~~( )

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

~~*b*~~**c.** ~~*Monthly Orientation. The paraprofessional, on a monthly basis, must be given*~~

~~*orientation and training on the program and procedures to be followed.*~~ 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 supervision and service requirements for speech-language pathology. *The guidelines have been incorporated by reference in Section 004 of these rules.* ~~*(3-30-07)*~~*( )*

~~***c***~~**d.** ~~*Reevaluation. The professional must reevaluate the student and adjust the treatment plan as their individual practice dictates.*~~ Developmental Therapy. Refer to IDAPA 16.04.11, "Developmental Disabilities Agencies," for supervision and service requirements. ~~*(3-30-07)*~~*( )*

~~***d.*** *Changes in Condition. Any changes in the student's condition not consistent with planned progress or treatment goals necessitates a documented reevaluation by the professional before further treatment is carried out.* *(3-30-07)*~~

~~***e.*** *Review of Independent Paraprofessional. If the paraprofessional works independently there must be a review conducted by the appropriate professional at least once per month. This review will include the dated initials of the professional conducting the review.* *(3-30-07)*~~

~~***f.*** *Utilizing Paraprofessional to Assist in Provision of Physical Therapy. In addition to the above, if a paraprofessional is utilized to assist in the provision of actual physical therapy they may do so only when the following conditions are met:* *(3-30-07)*~~

~~*i. Student reevaluation must be performed and documented by the supervising PT every five (5) visits or once a week if treatment is performed more than once per day.* *(3-30-07)*~~

~~*ii. The number of PTAs utilized in any practice or site, must not exceed twice in number the full time equivalent licensed PTs.* *(3-30-07)*~~

855. SCHOOL-BASED SERVICE - PROVIDER REIMBURSEMENT.
Payment for health-related services provided by school districts, charter schools, and the Idaho Infant Toddler program must be in accordance with rates established by the Department. (3-30-07)

01. Payment in Full. Providers of services must accept as payment in full the school district, charter school, or Idaho Infant Toddler Program payment for such services and must not bill Medicaid or Medicaid participants for any portion of any charges. (3-30-07)

02. Third Party. For requirements regarding third party billing, see Section 215 of these rules. (3-30-07)

~~***03. Contracted Providers****. When an employee of a school district, charter school, or Idaho Infant Toddler program does not deliver the services identified on the plan, the school district, charter school, or Idaho Infant Toddler Program must contract with a service provider to deliver the services and bill Medicaid for the contracted services. The contracted service provider must not bill Medicaid or the Medicaid participant.* *(3-30-07)*~~

043. 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)

054. 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)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-0904

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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(g), 56-203(i), 56-250 through 56-257, 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 pending rule, that removes the cap for earned points to offset premiums and updates preventive health assistance services, is being adopted as proposed. The complete text of the proposed rule was published in Book 1 of the October 7, 2009, Idaho Administrative Bulletin, Vol.09-10, Book 1, pages 362 through 365.

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 anticipated fiscal impact for this rulemaking to state general funds is minimal.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Robin Pewtress at (208) 364-1892.

DATED this 6th day of November, 2009.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5564 phone
(208) 334-6558 fax
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THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency and the Board of Health and Welfare has initiated proposed rulemaking procedures. This action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), and 56-250 through 56-257, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2009.

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 Preventive Health Assistance (PHA) benefit currently has a cap on how many points a child can earn when the child participates in both the Behavioral PHA and Wellness PHA at the same time. This cap is less than the cap for a child who does not participate in both types of PHA concurrently. The Department is removing the more restrictive cap to allow a participant to earn the maximum number of points for both PHA types. Other changes are being made to align pharmacy provider qualifications, remove references to sporting and fitness programs, remove references to vouchers, require prior authorization for PHA services and products, and to restrict use of Wellness PHA points earned to offsetting premiums.

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

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

The anticipated fiscal impact for this rulemaking to the state general funds is minimal.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because this is a benefit that is being amended, and is removing a limitation.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Robin Pewtress at (208) 364-1892.

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

2009.

DATED this 25th day of August, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

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. ~~*Points earned by a participant can be exchanged for a voucher to purchase products or services as specified in Subsections 622.02 through 622.06 of this rule.*~~ Each point equals one (1) dollar. ~~*(3-30-07)*~~( )

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)

~~*iii. The total maximum number of points that can be earned by a participant who has both a Behavioral and a Wellness PHA is two hundred (200) 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)

c. Points expire and are removed from a participant's PHA benefit at the end of the participant's benefit year. (3-30-07)

d. 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)

~~***03. Sporting or Fitness Program***. *(3-30-07)*~~

~~***a.*** *Each program must emphasize safety and improved physical health.* *(3-30-07)*~~

~~***b.*** *Each program must be approved by any and all applicable regulatory bodies.* *(3-30-07)*~~

~~***04. Sports Safety Equipment****. Each piece of sports safety equipment must afford protection or otherwise support safe participation in a sport with an expected outcome of improved physical health, and meet any and all established, applicable independent standards related to the product.* *(3-30-07)*~~

0~~5~~3. 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)

0~~6~~4. 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)

0~~7~~5. Premiums. (3-30-07)

a. Wellness PHA benefit points must be used to ~~*pay*~~ offset a participant's ~~*delinquent*~~ premiums~~*, if any, before a voucher can be issued for products or services*~~. ~~*(3-30-07)*~~( )

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)

0~~8~~6. 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)

c. Each participant who chooses a goal of weight management must participate in a physician approved or monitored weight management program. (3-30-07)

d. 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)

e. 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.*** *An initial thirty (30) points are earned when the benefit is established.* ***(3-30-07)***~~

~~***c***~~**b.** ~~*An additional thirty*~~ Ten (~~*3*~~10) points can be earned each ~~*quarter*~~ month by a participant who receives all recommended wellness visits and immunizations for his age during the benefit year. ~~***(3-30-07)***~~( )

~~***03. Vouchers****. The participant must contact the Department to request a voucher to purchase selected products or services. The participant must deliver the voucher to the vendor prior to receiving products or services.* ***(3-30-07)***~~

0~~4~~3. Approved Products and Services. The reimbursable products and services of each vendor must be prior approved by the Department. (3-30-07)

624. PREVENTIVE HEALTH ASSISTANCE (PHA): PROVIDER QUALIFICATIONS AND DUTIES.

~~***01. Voucher Acceptance****. Each vendor must be willing to accept PHA vouchers and bill the Department for reimbursement.* ***(3-30-07)***~~

~~***02. Voucher Expiration****. The vendor must accept a voucher prior to the expiration date printed on the voucher.* ***(3-30-07)***~~

0~~3~~1. Provider Agreement. A ~~*voucher signed by a*~~ behavioral PHA vendor ~~*and presented to the Department for reimbursement constitutes*~~ must have a fully-executed provider agreement on file with the Department prior to providing services or products. ~~***(3-30-07)***~~( )

02. Prior Authorization. A behavioral PHA vendor must request prior authorization from the Department for each product or service provided as a PHA benefit. ( )

0~~4~~3. Medications and Pharmaceutical Supplies Vendor. Each vendor must be a licensed pharmacy and must meet the criteria in Section 664 of these rules for prescription drug

provider qualifications and duties. ~~*(3-30-07)*~~( )

~~***05. Sporting or Fitness Program Vendor**. Each vendor must be able to provide a sporting or fitness program as described in Section 622 of these rules. (3-30-07)*~~

~~***06. Sports Safety Equipment Vendor**. (3-30-07)*~~

~~***a.** Each vendor must be established as a business serving the general public that provides sports safety equipment. (3-30-07)*~~

~~***b.** Each vendor must meets all state, county, and local business licensing requirements. (3-30-07)*~~

~~***c.** Each vendor must be able to provide sports safety equipment as described in Section 622 of these rules. (3-30-07)*~~

0~~7~~4. **Weight Management Program Vendor**. (3-30-07)

a. Each vendor must be established as a business that serves the general public. (3-30-07)

b. Each vendor must meet all state, county, and local business licensing requirements. (3-30-07)

c. Each vendor must be able to provide a weight management program as described in Section 622 of these rules. (3-30-07)

625. PREVENTIVE HEALTH ASSISTANCE (PHA): PROVIDER REIMBURSEMENT.
With the prior agreement of the participant, the vendor may bill the participant for the difference between the Department's reimbursement and the vendor's usual and customary charge for Behavioral PHA products or services provided. ( )

~~***01. Voucher Must Be Signed**. The Department, the participant, and the vendor must sign each PHA voucher for which a vendor requests reimbursement. (3-30-07)*~~

~~***02. Voucher Amount**. The vendor must agree to accept the amount stated on each PHA voucher as full or partial payment of approved products and services. (3-30-07)*~~

~~***03. Voucher Redemption**. Each voucher must be redeemed by the vendor within ninety (90) days of providing the product or service to the participant. (3-30-07)*~~

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-0903

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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(g), 56-203(i), 56-250 through 56-257, Idaho Code; and House Bill No. 123, 2009 Legislature.

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 pending rule is being adopted as proposed. The complete text of the proposed rule was published in the July 1, 2009, Idaho Administrative Bulletin, Vol. 09-7, pages 68 through 71.

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 projected fiscal impact is a total savings of $3,479,363; this includes state funds and federal matching funds. The projected savings to the state general fund is approximately $724,751. These savings are already reflected in the State Fiscal Year 2010 appropriation.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Robert Kellerman at (208) 364-1994.

DATED this 30th day of September, 2009.

Tamara Prisock
DHW - Administrative Procedures Section
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THE FOLLOWING NOTICE PUBLISHED WITH THE THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2009.

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), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code; and HB 123 (2009).

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 15, 2009.

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 amendments are in response to the passage of HB 123 during the 2009 Legislative session. Cost savings under these rule changes will be realized through reductions in incentive payments to nursing facilities and reductions in percentage increases to the inflation index used to calculate the nursing facility daily reimbursement rate.

Nursing facilities are reimbursed with a daily rate that is adjusted for inflation and increased/decreased costs on an annual basis. This rule change will realize cost savings through establishing a capped incentive payment rate of $9.50 per patient day, reduce the daily reimbursement rate inflation index adjustment from 1% to 0% per year, reduce the inflation index adjustment to costs reported in a nursing facilities annual cost report for purposes of rate setting from 1% to 0%, and reduce the inflation index adjustment to annual cost limits from 2% to 1%.

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: This rulemaking is necessary to comply with HB 123 (2009).

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:

The projected fiscal impact is a total savings of $3,479,363; this includes state funds and federal matching funds. The projected savings to the state general fund is approximately $724,751. These savings are already reflected in the State Fiscal Year 2010 appropriation.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 67-5220(2), negotiated rulemaking was not conducted because this rule is being written to comply with changes in Idaho statute.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Robert Kellerman at (208) 364-1994.

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 22, 2009.

DATED this 4th day of June, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

257. NURSING FACILITY - DEVELOPMENT OF THE RATE.
Nursing facility rates are prospective, with new rates effective July 1st of each year, and are recalculated annually with quarterly adjustments for case mix. The rate for a nursing facility is the sum of the cost components described in Subsection 257.04 through 257.09 of this rule. In no case will the rate be set higher than the charge for like services to private pay patients in effect for the period for which payment is made as computed by the lower of costs or customary charges.
(5-8-09)

01. Applicable Case Mix Index (CMI). The Medicaid CMI used in establishing each facility's rate is calculated based on the most recent assessment for each Medicaid resident in the nursing facility on the first day of the month of the preceding quarter (for example, assessments as of April 1are used to establish the CMI needed to establish rates for the quarter beginning July 1st). Facility-wide CMI is calculated based on the most recent assessment for all residents in the nursing facility. The CMI is recalculated quarterly and each nursing facility's rate is adjusted accordingly. A facility-wide CMI is also established each year by averaging four (4) calendar quarter CMIs for the cost reporting period from historical data to represent each fiscal quarter in the cost reporting period (for example, an October 1 CMI would represent the fiscal quarter ended September 30th). (3-19-07)

02. Applicable Cost Data. The cost data used in establishing the cost components of the rate calculation are from the audited or unaudited cost report which ended during the previous calendar year (for example, cost reports ending during the period from January 1, 1998 - December 31, 1998 are used in setting rates effective July 1, 1999). The draft audit of a cost report submitted by a facility will be issued by the Department no later than five (5) months after the date all information required for completion of the audit is filed with the Department.
(3-19-07)

03. Interim Rates. Nursing facilities with unaudited cost reports are given an interim rate established by the Department until a rate is calculated based on an audited cost report. When audited data are available, a retroactive adjustment to the payment rate is made through the calculation of the finalized rate. (3-19-07)

04. Direct Care Cost Component. The direct care cost component of a nursing facility's rate is determined as follows: (3-19-07)

a. The direct care per diem cost limit applicable to the rate period for a nursing facility type (free- standing and urban hospital-based nursing facility or rural hospital-based nursing facility) is identified. The identified direct care cost limit is divided by the statewide average CMI for the cost reporting period, and then multiplied by the nursing facility's facility-wide CMI for the cost reporting period to derive the adjusted direct care per diem cost limit. (3-19-07)

b. The adjusted direct care per diem cost limit is compared to the nursing facility's inflated direct care per diem costs. The lower of the two (2) amounts is then case mix adjusted. (3-19-07)

i. If the adjusted direct care per diem cost limit is lower, the adjusted limit is divided by the nursing facility's facility-wide CMI for the cost reporting period, and then multiplied by the nursing facility's most recent quarterly Medicaid CMI for the rate period to arrive at the direct care cost component. (3-19-07)

ii. If the inflated direct care per diem costs are lower, these costs, minus raw food and Medicaid related ancillary costs, are divided by the nursing facility's facility-wide CMI for the cost reporting period, then multiplied by the nursing facility's most recent quarterly Medicaid CMI for the rate period. Raw food and Medicaid related ancillary costs are then added back to arrive at the direct care cost component. (3-19-07)

05. Indirect Care Cost Component. The indirect care cost component of a facility's rate is the lesser of the facility's inflated indirect care per diem costs, or the indirect per diem cost limit for that type of provider -- free-standing and urban hospital-based nursing facilities, or rural hospital-based nursing facilities. (3-19-07)

06. Efficiency Incentive. The efficiency incentive is available to those providers, both free-standing and hospital-based, which have inflated per diem indirect care costs less than the indirect per diem cost limit for that type of provider. The efficiency incentive is calculated by multiplying the difference between the per diem indirect cost limit and the facility's inflated per diem indirect care costs by ~~*seventy*~~ fifty percent (~~7~~50%) not to exceed nine dollars and fifty cents ($9.50) per patient day. There is no incentive available to those facilities with per diem costs in excess of the indirect care cost limit, or to any facility based on the direct care cost component. ~~*(3-19-07)*~~( )

07. Costs Exempt From Limitation. Costs exempt from cost limits are property taxes, property insurance, utilities and costs related to new legal mandates as defined in Section 264 of these rules. (3-19-07)

08. Property Reimbursement. The property reimbursement component is calculated in accordance with Section 275 and Subsection 240.19 of these rules. (3-19-07)

09. Revenue Offset. Revenues from products or services provided to nonpatients will be offset from the corresponding rate component(s) as described in Section 257 of these rules. (3-19-07)

258. NURSING FACILITY - COST LIMITS BASED ON COST REPORT.
Each July 1st cost limitations will be established for nursing facilities based on the most recent audited cost report with an end date of June 30th of the previous year or before. Calculated limitations will be effective for a one (1) year period, from July 1 through June 30th of each year, which is the rate year. (5-8-09)

01. Percentage Above Bed-Weighted Median. Prior to establishing the first "shadow rates" at July 1, 1999, the estimated Medicaid payments under the previous retrospective system for the year period from July 1, 1999, through June 30, 2000, will be calculated. This amount will then be used to model the estimated payments under the case mix system set forth in Sections 255 through 257 of these rules. The percentages above the bed-weighted median, for direct and indirect costs, will be established at a level that approximates the same amount of Medicaid expenditures as would have been produced by the retrospective system. The percentages will also be established to approximate the same distribution of total Medicaid dollars between the hospital-based and freestanding nursing facilities as existed under the retrospective system. Once the percentage is established, it will be used to calculate the limit by multiplying the bed-weighted median per diem direct cost times the calculated percentage for that class of provider. There will be a direct and indirect percentage that is applied to freestanding and urban hospital-based nursing facilities, and a higher direct and indirect percentage that is applied to rural hospital-based nursing facilities. Once established, these percentages will remain in effect for future rate setting periods. (3-19-07)

02. Direct Cost Limits. The direct cost limitation will be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be normalized and arrayed from high to low, with freestanding and hospital-based nursing facilities included in the same array, and the bed-weighted median will be computed. (3-19-07)

03. Indirect Cost Limits. The indirect cost limitation will be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be arrayed, with freestanding and hospital- based nursing facilities included in the same array, and the bed-weighted median will be computed. (3-19-07)

04. Limitation on Increase or Decrease of Cost Limits. Increases in the direct and indirect cost limits will be determined by the limitations calculated in the most recent base year, indexed forward each year from the midpoint of the base year to the midpoint of the rate year by the inflation factor plus ~~*two*~~ one percent (~~2~~1%) per annum. The calculated direct and indirect cost limits will not be allowed to decrease below the limitations effective in the base year. The

maximum rate of growth on the cost limits, and the minimum cost limitation, will be examined by the oversight committee periodically to determine which factors to use in the calculation of the limitations effective in the new base year and forward. ~~*(5-8-09)*~~( )

05. Costs Exempt From Limitations. Costs exempt from limitations include property taxes, property insurance, and utilities. These costs will be reimbursed on a per diem basis and will not be included in the calculation of the direct or indirect care component. However, property taxes and property insurance will be subject to minimum occupancy levels as defined in Section 278 of these rules. (3-19-07)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-0904

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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(g), 56-203(i), 56-250 through 56-257, Idaho Code, as amended by House Bill No. 123, 2009 Legislature.

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 pending rule is being adopted as proposed. The complete text of the proposed rule was published in the July 1, 2009, Idaho Administrative Bulletin, Vol. 09-7, pages 72 and 73.

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 projected fiscal impact is a total savings of $314,200; this includes state funds and federal matching funds. The projected savings to the state general fund is approximately $65,448. These savings are already reflected in the State Fiscal Year 2010 appropriation.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Lourie Neal at (208) 287-1162.

DATED this 30th day of September, 2009.

Tamara Prisock
DHW - Administrative Procedures Section
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THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2009.

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), 56-203(g), 56-203(i), 56-250 through 56-257; and 56-113, Idaho Code, as amended by HB 123 (2009).

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 15, 2009.

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 amended in response to statutory changes to Section 56-113, Idaho Code. Cost savings under these rule changes will be realized through a rate freeze for Intermediate Care Facilities for the Mentally Retarded (ICFs/MR).

ICFs/MR are reimbursed with a daily rate that is adjusted for inflation and increased/ decreased costs on an annual basis. This rule change will freeze the daily reimbursement rate so that ICFs/MR will be paid the same daily rate in state fiscal year 2010 as in state fiscal year 2009.

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: This rulemaking is necessary to comply with HB 123 (2009).

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:

The projected fiscal impact is a total savings of $314,200; this includes state funds and federal matching funds. The projected savings to the state general fund is approximately $65,448. These savings are already reflected in the State Fiscal Year 2010 appropriation.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 67-5220, negotiated rulemaking was not conducted because this rule is being written to comply with changes to Idaho statute.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Lourie Neal at (208) 287-1162.

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 22, 2009.

DATED this 4th day of June, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

622. ICF/MR - PRINCIPLE PROSPECTIVE RATES.
Providers of ICF/MR facilities will be paid a per diem rate which, with certain exceptions, is not subject to an audit settlement. The per diem rate for a fiscal period will be based on audited historical costs adjusted for inflation. The provider will report these cost items in accordance with other provisions of this chapter or the applicable provisions of PRM consistent with this chapter. Sections 622 through 628 of these rules provide procedures and specifications necessary to implement the provisions and accomplish the objectives of the payment system for ICF/MR providers. Total payment will include the following components: Property reimbursement, capped costs, an efficiency increment, exempt costs, excluded costs. Except as otherwise provided in this section, ICF/MR providers will be reimbursed in state fiscal year 2010 (July 1, 2009 through June 30, 2010) at the same rate of reimbursement that was paid in state fiscal year 2009 (July 1, 2008 through June 30, 2009). ~~*(3-19-07)*~~( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-0905

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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(g), 56-203(i), 56-250 through 56-257, 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 were amended in response to the federal audit conducted by Centers for Medicare and Medicaid Services (CMS) for the period of July 1, 2006, through June 30, 2007, on the Personal Care Services (PCS) program. In order to comply with the recommendations from CMS, the Department changed the payment methodology for children receiving PCS in a PCS home and establishing rules specific to PCS for children.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in Book 1 of the October 7, 2009, Idaho Administrative Bulletin, Vol. 09-10, pages 366 through 373.

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 projected fiscal impact is a total savings of $445,700; this includes state funds and federal matching funds. The projected savings to the state general fund is approximately $84,922.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Susan Choules at (208) 364-1891.

DATED this 25th day of November, 2009.

Tamara Prisock
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THE FOLLOWING NOTICE 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(g), 56-203(i), 56-250 through 56-257, 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 Wednesday, October 21, 2009.

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 are being amended in response to the federal audit conducted by Centers for Medicare and Medicaid Services (CMS) for the period of July 1, 2006, through June 30, 2007, on the Personal Care Services (PCS) program. In order to comply with the recommendations from CMS, the Department is changing the payment methodology for children receiving PCS in a PCS home and establishing rules specific to PCS for children.

The following is the summary of the proposed changes:

1. **Update the current rules for Personal Care Services (PCS) to reflect changes in the payment methodology for PCS homes;**
2. **Separate, align, clarify, and augment the rules that govern adult PCS and children's PCS; and**
3. **Clarify PCS medication 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 projected fiscal impact is a total savings of $445,700; this includes state funds and federal matching funds. The projected savings to the state general fund is approximately $84,922.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted. Negotiated rulemaking was not conducted because these rule changes are being made in response to a federal audit.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN

COMMENTS: For assistance on technical questions concerning the proposed rule, contact Susan Choules at (208) 364-1891.

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 Wednesday, October 28, 2009.

DATED this 2nd day of September, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

301. ~~*(RESERVED)*~~ PERSONAL CARE SERVICES - DEFINITIONS.

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

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

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

04. PCS Family Alternate Care Home. The private home of an individual licensed by the Department to provide personal care services to one (1) or two (2) children, who are unable to reside in their own home and require assistance with medically-oriented tasks related to the child's physical or functional needs. ( )

302. PERSONAL CARE SERVICES - ELIGIBILITY.

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

02. Other Eligibility Requirements. Regional Medicaid Services (RMS) will prior authorize payment for the amount and duration of all services when all of the following conditions are met: (3-19-07)

a. The RMS finds that the participant is capable of being maintained safely and effectively in his own home or personal residence using PCS. (3-19-07)

b. The participant is an adult for whom a Uniform Assessment Instrument (UAI) has been completed~~.~~, ~~*A UAI is not to be completed for a child participant*~~ or a child for whom a children's PCS assessment has been completed; ~~*(3-19-07)*~~( )

c. The RMS reviews the documentation for medical necessity; and (4-2-08)

d. The participant has a plan of care. (4-2-08)

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

04. Annual Eligibility Redetermination. The participant's eligibility for PCS must be redetermined at least annually unde**r** Subsections 302.01. through 302.03 of these rules. (3-19-07)

a. The annual financial eligibility redetermination must be conducted under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," or 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." RMS must make the medical eligibility redetermination. The redetermination can be completed more often than once each year at the request of the participant, the Self-Reliance Specialist, the Personal Assistance Agency, the personal assistant, the supervising RN, the QMRP, or the physician. (4-2-08)

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

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

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

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

303. PERSONAL CARE SERVICES ~~*(PCS)*~~ - COVERAGE AND LIMITATIONS.

01. Medical Care and Services. PCS services include medically-oriented tasks related to a participant's physical or functional requirements, as opposed to housekeeping or skilled nursing care, provided in the participant's home or personal residence. The provider must deliver at least one (1) of the following services: (3-19-07)

a. Basic personal care and grooming to include bathing, care of the hair, assistance with clothing, and basic skin care; (3-19-07)

b. Assistance with bladder or bowel requirements that may include helping the participant to and from the bathroom or assisting the participant with bedpan routines; (3-19-07)

c. ~~*Assisting the participant with physician-ordered medications that are ordinarily self-administered, such as opening the packaging or reminding the participant to take medications*~~ Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need; ~~*(3-19-07)*~~( )

d. ~~*Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need*~~ The continuation of active treatment training programs in the home setting to increase or maintain participant independence for the participant with developmental disabilities; ~~*(3-19-07)*~~( )

e. ~~*The continuation of active treatment training programs in the home setting to increase or maintain participant independence for the developmentally disabled participant*~~ Assisting the participant 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; ~~*(3-19-07)*~~( )

f. Non-nasogastric gastrostomy tube feedings if authorized by RMS prior to implementation and if the following requirements are met: (3-19-07)

i. The task is not complex and can be safely performed in the given participant care situation; (3-19-07)

ii. A Licensed Professional Nurse (RN) has assessed the participant's nursing care needs and has developed a written standardized procedure for gastrostomy tube feedings, individualized for the participant's characteristics and needs; (3-19-07)

iii. Individuals to whom the procedure can be delegated are identified by name. The RN must provide proper instruction in the performance of the procedure, supervise a return demonstration of safe performance of the procedure, state in writing the strengths and weaknesses of the individual performing the procedure, and evaluate the performance of the procedure at least monthly; (3-19-07)

iv. Any change in the participant's status or problem related to the procedure must be reported immediately to the RN; (3-19-07)

v. The individualized procedure, the supervised performance of the procedure, and follow-up evaluation of the performance of the procedure must be documented in writing by the supervising RN and must be readily available for review, preferably with the participant's record; and (3-19-07)

vi. Routine medication may be given by the personal assistant through the non-nasogastric tube if authorized by the supervising RN. (3-19-07)

02. Non-Medical Care and Services. PCS services may also include non-medical tasks. In addition to performing at least one (1) of the services listed in Subsections 303.01.a. through 303.01.f. of this rule, the provider may also perform the following services, if no natural supports are available: ~~*(3-19-07)*~~( )

a. Incidental housekeeping services essential to the participant's comfort and health, including changing bed linens, rearranging furniture to enable the participant to move around more easily, laundry, and room cleaning incidental to the participant's treatment. Cleaning and laundry for any other occupant of the participant's residence are excluded. (3-19-07)

b. Accompanying the participant to clinics, physicians' office visits or other trips that are reasonable for the purpose of medical diagnosis or treatment. (3-19-07)

c. Shopping for groceries or other household items specifically required for the health and maintenance of the participant. (3-19-07)

03. Place of Service Delivery. PCS may be provided only in the participant's own home or personal residence. The participant's personal residence may be a Certified Family Home or a Residential Care or Assisted Living Facility, or a PCS Family Alternate Care Home. The following living situations are specifically excluded as a personal residence: ~~(3-19-07)~~( )

a. Certified nursing facilities or hospitals. (3-19-07)

b. Licensed Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). (3-19-07)

c. A home that receives payment for specialized foster care, professional foster care or group foster care, as described in IDAPA 16.06.01, "Child and Family Services." (3-19-07)

04. Type of Service Limitations. The provider is excluded from delivering the following services: (3-19-07)

a. Irrigation or suctioning of any body cavities that require sterile procedures or the application of dressings involving prescription medication and aseptic techniques; (3-19-07)

b. Insertion or sterile irrigation of catheters; (3-19-07)

c. Injecting fluids into the veins, muscles or skin; and (3-19-07)

d. Administering medication. (3-19-07)

05. Participant Service Limitations. (3-19-07)

a. Adults who receive PCS under the State Medicaid Plan option are limited to a maximum of sixteen (16) hours per week per participant. (3-19-07)

b. Children who meet the necessity criteria for EPSDT services under IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Section 882, may receive up to twenty-four (24) hours per day of PCS per child through the month of their twenty-first birthday. (3-19-07)

06. Provider Coverage Limitations. (3-19-07)

a. The provider must not bill for more time than was actually spent in service delivery. (3-19-07)

b. No provider home, regardless of the number of providers in the home, may serve more than two (2) children who are authorized for eight (8) or more hours of PCS per day.

(3-19-07)

304. PERSONAL CARE SERVICES - PROCEDURAL REQUIREMENTS.

01. Service Delivery Based on Plan of Care or NSA. All PCS services are provided based on a written plan of care or a negotiated service agreement (NSA). The requirements for the NSA for participants in Residential Care or Assisted Living Facilities are described in IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." The requirements for the NSA for participants in Certified Family Homes are described in IDAPA 16.03.19, "Rules Governing Certified Family Homes." The Personal Assistance Agency and the participant who lives in his own home are responsible to prepare the plan of care. (3-19-07)

a. The plan of care for participants who live in their own homes or in a PCS Family Alternate Care Home is based on: ~~(3-19-07)~~( )

i. The physician's or authorized provider's information if applicable; (4-2-08)

ii. The results of the UAI for adults, the ~~Personal Assistance Agency's assessment for~~ children's PCS assessment and, if applicable, the QMRP's assessment and observations of the participant; and ~~(3-19-07)~~( )

iii. Information obtained from the participant. (3-19-07)

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

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

02. Service Supervision. The delivery of PCS may be overseen by a licensed professional nurse (RN) or Qualified Mental Retardation Provider (QMRP). The RMS must identify the need for supervision. (3-19-07)

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

i. Assistance in the development of the written plan of care; (3-19-07)

ii. Review of the treatment given by the personal assistant through a review of the participant's PCS record as maintained by the provider; (3-19-07)

iii. Reevaluation of the plan of care as necessary; and (3-19-07)

iv. Immediate notification of the guardian, emergency contact, or family members of any significant changes in the participant's physical condition or response to the services delivered. (3-19-07)

b. All participants who are developmentally disabled, other than those with only a

physical disability as determined by the RMS, may receive oversight by a QMRP as defined in 42 CFR 483.430. Oversight must include: (3-19-07)

i. Assistance in the development of the plan of care for those aspects of active treatment which are provided in the participant's personal residence by the personal assistant; (3-19-07)

ii. Review of the care or training programs given by the personal assistant through a review of the participant's PCS record as maintained by the provider and through on-site interviews with the participant; (3-19-07)

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

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

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

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

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

c. Any other medical information that supports the medical need. ( )

0~~3~~4. PCS Record Requirements for a Participant in His Own Home. The PCS records must be maintained on all participants who receive PCS in their own homes or in a PCS Family Alternate Care Home. ~~(3-19-07)~~( )

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

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

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

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

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

b. Participant's Signature. The participant must sign the record of service delivery verifying that the services were delivered. The RMS may waive this requirement if it determines the participant is not able to verify the service delivery. (3-19-07)

c. A copy of the information required in Subsection 304.03 of these rules must be maintained in the participant's home unless the RMS authorizes the information to be kept elsewhere. Failure to maintain this information may result in recovery of funds paid for undocumented services. (3-19-07)

d. Telephone Tracking System. Agencies may employ a software system that allows personal assistants to register their start and stop times and a list of services by placing a telephone call to the agency system from the participant's home. This system will not take the place of documentation requirements of Subsection 304.03 of these rules. (3-19-07)

e. Participant in a Residential or Assisted Living Facility. The PCS record requirements for participants in Residential Care or Assisted Living Facilities are described in IDAPA 16.03.22. "Residential Care or Assisted Living Facilities in Idaho." (3-19-07)

f. Participant in a Certified Family Home. The PCs record requirements for participants in Certified Family Homes are described in IDAPA 16.03.19, "Rules Governing Certified Family Homes." (3-19-07)

04~~.~~5. Provider Responsibility for Notification. The Personal Assistance Agency is responsible to notify the RMS and physician or authorized provider when any significant changes in the participant's condition are noted during service delivery. This notification must be documented in the Personal Assistance Agency record. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

307. PERSONAL CARE SERVICES - PROVIDER REIMBURSEMENT.

01. Reimbursement Rate. Personal assistance providers will be paid a uniform reimbursement rate for service as established by the Department on an annual basis according to Section 39-5606, Idaho Code. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (3-19-07)

02. Calculated Fee. The fee calculated for personal care provider reimbursement includes a basic rate for services and mileage. No separate charges for mileage will be paid by the Department for non-medical transportation, unless approved by the RMS under a Home and Community-Based Services (HCBS) waiver, or provider transportation to and from the participant's home. Fees will be calculated as provided in Subsections 307.03 through 307.07 of these rules. (3-19-07)

03. Weighted Average Hourly Rates. Annually Medicaid will conduct a poll of all Idaho nursing facilities and ICFs/MR, and establish the weighted average hourly rates (WAHR) for nursing facility industry employees in comparable positions (i.e. RN, QMRP, certified and non-certified nurse's aides) in Idaho to be used ~~*for*~~ in calculating the reimbursement rate to be

effective on July 1st of that year. ~~*(3-19-07)*~~( )

04. Payment ~~*Levels*~~ for ~~*PAA*~~ Personal Assistance Agency. ~~*Medicaid*~~ The Department will ~~*then*~~ establish ~~*payment levels for*~~ Personal Assistance ~~*Agencies*~~ Agency rates for personal assistance services ~~*as follows:*~~ ~~*(3-19-07)*~~

~~***a.*** *Weekly service needs of zero to sixteen (0-16) hours under the State Medicaid Plan, or a HCBS waiver*~~ based on the WAHR, plus the WAHR times a fifty-five percent (55%) supplemental component to cover travel, administration, training, and all payroll taxes and fringe benefits, as follows:

Personal Assistance Agencies	WAHR x 1.55	=	$ amount/hour

~~*(3-19-07)*~~( )

~~***b.*** *Extended visit, one (1) child (eight and one-quarter (8.25) hours up to twenty-four (24) hours):*~~

~~*Personal Assistance Agencies*~~	~~*(WAHR x actual hours of care up to 5 hours x 1.55) plus ($.65 x 1.55 hours on site on-call)*~~	~~=~~	~~*$ amount/hour*~~
~~*Licensed Child Foster Homes*~~	~~*(WAHR x actual hours of care up to 5 hours x 1.22) plus ($.65 x 1.22 x actual hours on site on-call)*~~	~~=~~	~~*$ amount/hour*~~

~~*(3-19-07)*~~

~~***c.*** *Extended visit, two (2) children (eight and one-quarter (8.25) hours up to twenty-four (24) hours):*~~

~~*Personal Assistance Agencies*~~	~~*(WAHR x actual hours of care up to 4 hours) x (1.55 plus $.65 x 1.55 x hours on site on-call)*~~	~~=~~	~~*$ amount/hour*~~
~~*Licensed Child Foster Homes*~~	~~*(WAHR x hours actual care up to 4 hours x 1.22) plus ($.65 x 1.22 x hours on site on-call)*~~	~~=~~	~~*$ amount/hour*~~

~~*(3-19-07)*~~

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

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

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

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

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

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

07. Supervisory RN and QMRP Reimbursement Level. The supervisory RN and QMRP will be reimbursed at a per visit amount established by the Department for supervisory visits. Participant evaluations and Care Plan Development will be reimbursed at a rate established by the Department, following authorization by the RMS. (3-19-07)

a. The number of supervisory visits by the RN or QMRP to be conducted per calendar quarter will be approved as part of the PCS care plan by the RMS. (3-19-07)

b. Additional evaluations or emergency visits in excess of those contained in the approved care plan will be authorized when needed by the RMS. (3-19-07)

08. Payment for PCS Family Alternate Care Home. The Department will establish PCS Family Alternate Care Home rates for personal assistance services based on the WAHR, plus the product of the WAHR times fifty-five percent (55%) less the current payroll tax and fringe benefit rate to cover travel, administration, and training, as follows:

PCS Family Alternate Care Home	Children's PCS Assessment Weekly Hours x (WAHR x (1.55 minus payroll taxes and fringe benefits cost percentage)	=	$ amount/week

( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-0906

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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(g), 56-203(i), 56-250 through 56-257, 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 pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 7. 2009, Idaho Administrative Bulletin, Vol. 09-10, pages 353 through 361.

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 the state general fund due to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Lauren Ertz at (208) 287-1169.

DATED this 18th day of November, 2009.

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

THE FOLLOWING NOTICE 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 The action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2009.

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:

Due to a recent court ruling stating that the Idaho Medicaid program cannot limit the "place of service" where medically necessary services can be delivered, the requirement that developmental disability and psychosocial rehabilitation providers must contract with the school to provide services is being removed from this rule. Also, since the Idaho State School and Hospital (ISSH) Waiver expired June 30, 2009, references to the ISSH Waiver are being removed from the rules. Finally, as of July 1, 2009, the Independent Assessor Provider no longer reviews individual support plans, therefore, revisions will be made to the rule dealing with the negotiations for the plan of service.

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 the state general fund due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because this rulemaking is being done due to a recent court ruling that invalidated Medicaid rules for the for the billing of services delivered in schools.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Lauren Ertz at (208) 287-1169.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2009.

DATED this 14th day of August, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

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 six (6) hours per participant annually. The following assessments are included in this limitation: (5-8-09)

a. Intake Assessment; (5-8-09)

b. Comprehensive Diagnostic Assessment. This assessment must be completed for each participant at least once annually; (5-8-09)

c. Functional Assessment. (5-8-09)

d. Psychological and Neuropsychological Assessments. 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)

e. 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. Individualized Treatment Plan. Two (2) hours per year per participant per provider agency are available for treatment plan development. (3-19-07)

03. 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)

04. 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)

05. 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. Up to five (5) additional weekly hours are available with prior authorization. (5-8-09)

06. Pharmacological Management. Pharmacological management services beyond twenty-four (24) encounters per calendar year must be prior authorized by the Department. (5-8-09)

07. Collateral Contact. Collateral contact services beyond six (6) hours 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)

~~***c.*** *Prior to delivering any services in a school-based setting, the PSR agency must have a contract with the school or the Infant Toddler program. The PSR agency must not bill Medicaid or the Medicaid participant for these contracted services. Only the school district, charter school, or the Idaho Infant Toddler program may bill Medicaid for these contracted services when provided in accordance with IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Sections 850 through 856.~~ ~~*(3-19-07)*~~

(BREAK IN CONTINUITY OF SECTIONS)

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 for Services Provided in a School**. PSR Services provided by a PSR agency in a school-based setting, must be billed by the school district, charter school, or the Idaho Infant Toddler program.* *(3-19-07)***~~

(BREAK IN CONTINUITY OF SECTIONS)

508. BEHAVIORAL HEALTH PRIOR AUTHORIZATIONS - DEFINITIONS.

For the purposes of these rules the following terms are used as defined below. (3-19-07)

01. Adult. A person who is eighteen (18) years of age or older~~ *or an ISSH Waiver participant*~~. ~~*(3-19-07)*~~( )

02. Assessment. A process that is described in Section 509 of these rules for program eligibility and in Section 512 of these rules for plan of service. (3-19-07)

03. Clinical Review. A process of professional review that validates the need for continued services. (3-19-07)

04. Community Crisis Support. Intervention for participants who are at risk of losing housing, employment or income, or who are at risk of incarceration, physical harm, family altercations or other emergencies. (3-19-07)

05. Concurrent Review. A clinical review to determine the need for continued prior authorization of services. (3-19-07)

06. Exception Review. A clinical review of a plan that falls outside the established standards. (3-19-07)

07. Interdisciplinary Team. For purposes of these rules, the interdisciplinary team is a team of professionals, determined by the Department, that reviews requests for reconsideration. (3-19-07)

08. Level of Support. An assessment score derived from the SIB-R that indicates types and amounts of services and supports necessary to allow the individual to live independently and safely in the community. (3-19-07)

09. Person-Centered Planning Process. A meeting facilitated by the plan developer, comprised of family and individuals significant to the participant who collaborate with the participant to develop the plan of service. (3-19-07)

10. Person-Centered Planning Team. The group who develops the plan of service. This group includes, at a minimum, the participant and the service coordinator or plan developer chosen by the participant. The person-centered planning team may include others identified by the participant or agreed upon by the participant and the Department as important to the process. (3-19-07)

11. Plan Developer. A paid or non-paid person identified by the participant who is responsible for developing one (1) plan of service and subsequent addenda that cover all services and supports, based on a person-centered planning process. (3-19-07)

12. Plan Monitor. A person who oversees the provision of services on a paid or non-paid basis. (3-19-07)

13. Plan Monitor Summary. A summary that provides information to evaluate plans and initiate action to resolve any concerns. The plan monitor must complete a plan monitor summary when the plan has been in effect for six (6) months and at the annual person-centered planning process. The summary is based on the provider status reviews referred to in Subsection 513.06 of these rules. The plan monitor will use the provider information to evaluate plans and initiate action to resolve any concerns. (3-19-07)

14. Plan of Service. An initial or annual plan that identifies all services and supports based on a person-centered planning process. Plans are authorized annually every three hundred sixty-five (365) days. (3-19-07)

15. Prior Authorization (PA). A process for determining a participant's eligibility for services and medical necessity prior to the delivery or payment of services as provided by these rules. (3-19-07)

16. Provider Status Review. The written documentation that identifies the participant's progress toward goals defined in the plan of service. (3-19-07)

17. Right Care. Accepted treatment for defined diagnosis, functional needs and abilities to achieve the desired outcome. The right care is consistent with best practice and continuous quality improvement. (3-19-07)

18. Right Place. Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. (3-19-07)

19. Right Price. The most integrated and least expensive services that are sufficiently intensive to address the participant's needs. The amount is based on the individual's needs for services and supports as identified in the assessment. (3-19-07)

20. Right Outcomes. Services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant. (3-19-07)

21. Service Coordination. Service coordination is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual. (3-19-07)

22. Service Coordinator. An individual who provides service coordination to a Medicaid-eligible participant, is employed by a service coordination agency, and meets the training, experience, and other requirements under Sections 729 through 732 of these rules. (3-19-07)

23. Services. Services paid for by the Department that enable the individual to reside safely and effectively in the community. (3-19-07)

24. SIB-R. The Scales of Independent Behavior - Revised (SIB-R) is a standardized assessment tool evaluating functional skill levels and evaluating maladaptive behavior. The SIB-R is used by the Department to determine developmental disability eligibility, waiver eligibility, skill level to identify the participant's needs for the plan of service, and for determining the participant budget. (3-19-07)

25. Supports. Formal or informal services and activities, not paid for by the Department, that enable the individual to reside safely and effectively in the setting of his choice. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

511. INDIVIDUALS WITH A DEVELOPMENTAL DISABILITY - COVERAGE AND LIMITATIONS.

The scope of these rules defines prior authorization for the following Medicaid behavioral health services for adults: (3-19-07)

01. DD~~/ISSH~~ Waiver Services. DD~~/ISSH~~ Waiver services as described in Sections 700 through 719 of these rules; and ~~(3-19-07)~~( )

02. Developmental Disability Agency Services. Developmental Disability Agency services as described in Sections 650 through 660 of these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies"; and (3-19-07)

03. Service Coordination. Service Coordination for persons with developmental disabilities as described in Sections 720 through 779 of these rules. (3-19-07)

512. BEHAVIOR HEALTH PRIOR AUTHORIZATION - PROCEDURAL REQUIREMENTS.

01. Assessment for Plan of Service. The assessment for a plan of service is required for all participants prior to the development of the plan of service. This assessment must include the following in Subsections 512.02 through 512.06 of these rules. (3-19-07)

02. Physician's History and Physical. The history and physical must include a physician's referral for nursing services under the DD ~~*and ISSH*~~ waivers and for developmental disabilities agencies' services, if they are anticipated to be part of the plan of service. A physician's history and physical is required within the year prior to the initiation of service and thereafter on a frequency determined by the physician. For participants in Healthy Connections:
~~*(3-19-07)*~~( )

a. The Healthy Connections physician may delegate to the Department the authority to approve developmental disability services. (3-19-07)

b. The Healthy Connections physician must conduct the history and physical, and may refer the participant for other evaluations. (3-19-07)

03. Medical, Social, and Developmental History. (3-19-07)

04. SIB-R. The results of the SIB-R are used to determine the level of support for the participant. A current SIB-R assessment must be evaluated prior to the initiation of service and must be reviewed annually to assure it continues to reflect the functional status of the participant. (3-19-07)

05. Medical Condition. The participant’s medical conditions, risk of deterioration, living conditions, and individual goals. (3-19-07)

06. Behavioral or Psychiatric Needs. Behavioral or psychiatric needs that require special consideration. (3-19-07)

513. BEHAVIOR HEALTH PRIOR AUTHORIZATION - PLAN OF SERVICE.
In collaboration with the participant, the Department must assure that the participant has one (1) plan of service. This plan of service is based on the individualized participant budget referred to in Section 514 of these rules and must identify all services and supports. Participants may develop their own plan or designate a paid or non-paid plan developer. In developing the plan of service, the plan developer and the participant must identify services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. Authorized services must be delivered by providers who are selected by the participant. (3-19-07)

01. Qualifications of a Paid Plan Developer. Neither a provider of direct service to the participant nor the assessor may be chosen to be the paid plan developer. Family members and

all others who wish to be paid for plan development must be employed as a service coordinator as defined in Sections 729 through 732 of these rules. (3-19-07)

02. Plan Development. The plan must be developed with the participant. With the participant's consent, the person-centered planning team may include family members, guardian, or individuals who are significant to the participant. In developing the plan of service, the plan developer and participant must identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. The plan of service must be submitted within forty-five (45) days prior to the expiration of the existing plan of service unless delayed because of participant unavailability due to extenuating circumstances. If the plan is not submitted within this time period, authorization for provider payments may be terminated. (3-19-07)

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

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

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

c. Physical therapy, occupational therapy, and speech-language pathology services provided outside of a Development Disabilities Agency (DDA). (4-2-08)

04. No Duplication of Services. The plan developer will ensure that there is no duplication of services if there are multiple plans of service. Duplicate services will not be authorized. (3-19-07)

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

a. Review of the plan of service in a face-to-face contact with the participant to identify the current status of programs and changes if needed; (3-19-07)

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

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

d. Review of provider status reviews and complete a plan monitor summary after the six (6) month review and for annual plan development. (3-19-07)

e. Immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as well as injuries of unknown origin to the agency administrator, the Regional Medicaid Services (RMS), the adult protection authority, and any other entity identified under

Section 39-5303, Idaho Code, or federal law. (3-19-07)

06. Provider Status Reviews. Service providers, with exceptions identified in Subsection 513.11 of these rules, must report the participant's progress toward goals to the plan monitor on the provider status review when the plan has been in effect for six (6) months and at the annual person-centered planning meeting. The semi-annual and annual reviews must include: (3-19-07)

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

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

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

07. Plan Monitor Summary. The plan monitor must complete a plan monitor summary when the plan has been in effect for six (6) months and at the annual person-centered planning process. The summary is based on the provider status review. (3-19-07)

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

09. Negotiation for the Plan of Service. If ~~*T*~~the services requested on the plan of service ~~*must be individualized with the participant if the requested services*~~ fall outside the individualized budget or do not reflect the assessed needs of the participant, the plan developer and the participant will have the opportunity to negotiate the plan of service with the Department's care manager. ~~*When the plan of service cannot be negotiated by the assessor, the plan developer, and the participant, it will be referred by the assessor to the Department's care manager for additional evaluation.*~~ Services will not be paid for unless they are authorized on the plan of service. ~~*(3-19-07)*~~( )

10. Informed Consent. Unless the participant has a guardian with appropriate authority, the participant must make decisions regarding the type and amount of services required. During plan development and amendment, planning team members must each indicate whether they believe the plan meets the needs of the participant, and represents the participant's choice. If not, the plan or amendment must be referred to the Bureau of Care Management's Medicaid Consumer Relations Specialist to negotiate a resolution with members of the planning team. (3-19-07)

11. Provider Implementation Plan. Each provider of Medicaid services, subject to prior authorization, must develop an implementation plan that identifies specific objectives that demonstrate how the provider will assist the participant to meet the participant's goals and needs identified in the plan of service. (3-19-07)

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

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

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

iii. Environmental modifications; (3-19-07)

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

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

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

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

b. Time for Completion. The implementation plan must be completed within fourteen (14) days after the initial provision of service, and revised whenever participant needs change. (3-19-07)

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

12. Addendum to the Plan of Service. A plan of service may be adjusted during the year with an addendum to the plan. These adjustments must be based on changes in a participant's need or demonstrated outcomes. Additional assessments or information may be clinically necessary. Adjustment of the plan of service is subject to prior authorization by the Department. (3-19-07)

13. Community Crisis Supports. Community crisis supports are interventions for participants who have been determined eligible for developmental disability services and who are at risk of losing housing, employment or income, or are at risk of incarceration, physical harm, family altercation, or other emergencies. Community crisis support may be authorized the following business day after the intervention if there is a documented need for immediate intervention, no other means of support are available, and the services are appropriate to rectify the crisis. Community crisis support is limited to a maximum of twenty (20) hours during any consecutive five (5) day period. (3-19-07)

a. Emergency Room. Crisis services may be provided in an emergency room during the ER evaluation process if the goal is to prevent hospitalization and return the participant to the community. (3-19-07)

b. Before Plan Development. Community crisis support may be provided before or after the completion of the assessment and plan of service. If community crisis support is provided before the completion of the assessment and plan of service, the plan of service must include an identification of the factors contributing to the crisis and a strategy for addressing those factors in the future. (3-19-07)

c. Crisis Resolution Plan. After community crisis support has been provided, the provider of the community crisis support service must complete a crisis resolution plan and submit it to the Department for approval within three (3) business days. (3-19-07)

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

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

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

ii. Obtain a copy of the current annual provider status review from each provider for use by the person-centered planning team. Each provider status review must meet the requirements in Subsection 513.14.d of these rules. (3-19-07)

iii. Convene the person-centered planning team to develop a new plan of service. (3-19-07)

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

c. Adjustments to the Annual Budget and Services. The annual budget and services may be adjusted based on demonstrated outcomes, progress toward goals and objectives, and benefit of services. (3-19-07)

d. Annual Status Reviews Requirement. If the provider's annual status reviews are not submitted with the annual plan, services will not be authorized at the time of the annual reauthorization. These services may be added to the plan of service only by means of an addendum to the plan in accordance with Subsection 513.12 of these rules. (3-19-07)

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

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

15. Reconsiderations, Complaints, and Administrative Appeals. (3-19-07)

a. Reconsideration. Participants with developmental disabilities who are adversely affected by a Department decision regarding program eligibility and authorization of services under these rules may request a reconsideration within twenty-eight (28) days from the date the

decision was mailed. The reconsideration must be performed by an interdisciplinary team as determined by the Department with at least one (1) individual who was not involved in the original decision. The reviewers must consider all information and must issue a written decision within fifteen (15) days of receipt of the request. (3-19-07)

b. Complaints. Participant complaints about the assessment process, eligibility determination, plan development, quality of service, and other relevant concerns may be referred to the Division of Medicaid, Bureau of Care Management. (3-19-07)

c. Administrative Appeals. Administrative appeals are governed by provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (3-19-07)

514. BEHAVIORAL HEALTH PRIOR AUTHORIZATION - PROVIDER REIMBURSEMENT.
Providers are reimbursed on a fee for service basis based on a participant budget. (3-19-07)

01. Methodology for Developing Participant Budget Prior to October 1, 2006. The participant budget is developed using the following methodology: (3-19-07)

a. Evaluate the past three (3) years of Medicaid expenditures from the participant's profile, excluding physician, pharmacy, and institutional services; (3-19-07)

b. Review all assessment information identified in Section 512 of these rules; (3-19-07)

c. Identify the level of support derived from the most current SIB-R. The level of support is a combination of the individual's functional abilities and maladaptive behavior as determined by the SIB-R. Six (6) broad levels of support have been identified on a scale from zero to one hundred (0 - 100) (see Table 514.01.c.). There are six (6) levels of support, each corresponding to a support score range.

TABLE 514.01.c. - LEVEL OF SUPPORT

Support Score Range	Level of Support
1-24	Pervasive
25-39	Extensive
40-54	Frequent
55-69	Limited
70-84	Intermittent
85-100	Infrequent

(3-19-07)

d. Correlate the level of support identified by the SIB-R to a budget range derived

from the expenditures of individuals at the same level of support across the adult DD population. This correlation will occur annually prior to the development to the plan of service; (3-19-07)

02. Negotiating an Appropriate Participant Budget Prior to October 1, 2006. The assessor, the participant, and the plan developer must use all the information from Subsections 514.01.a. through 514.01.d. of these rules to negotiate an appropriate budget that will support the participant's identified needs. (3-19-07)

03. Individualized Budget Beginning on October 1, 2006. Beginning October 1, 2006, for DD ~~*and ISSH*~~ waiver participants, and beginning January 1, 2007, for all other adult DD participants, the Department sets an individualized budget for each participant according to an individualized measurement of the participant's functional abilities, behavioral limitations, medical needs, and other individual factors related to the participant's disability. Using these specific participant factors, the budget-setting methodology will correlate a participant's characteristics with the participant's individualized budget amount, so participants with higher needs will be assigned a higher individualized budget amount. ~~*(3-19-07)*~~( )

a. During the implementation phase of using the new individualized budget-setting methodology, the budget calculation will include reviewing the participant's previous year's budget. When the calculated budget is less than five percent (5%) above or below the previous year's budget, the participant's set budget amount is the calculated budget amount. When the calculated budget is greater than five percent (5%) above or below the previous year's budget, the participant's set budget amount is the previous year's budget amount. The Department will collect information on discrepancies between the calculated budget and the previous year's budget as part of the ongoing assessment and improvement process of the budget-setting methodology. (3-19-07)

b. The Department notifies each participant of his set budget amount. The notification will include how the participant may request reconsideration of the set budget amount. (3-19-07)

c. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes in the participant's individualized needs and it is demonstrated that these additional needs cannot be supported by the current budget. (3-19-07)

04. Residential Habilitation - Supported Living Acuity-Based Levels of Support. Reimbursement for residential habilitation - supported living is based on the participant's assessed level of support need. All plans of service that include supported living must include community integration goals that provide for maintained or enhanced independence, quality of life, and self-determination. As a participant's independence increases and he is less dependent on supports, he must transition to less intense supports. (3-19-07)

a. High support is for those participants who require twenty-four (24) hour per day supports and supervision and have an SIB-R Support Level of Pervasive, Extensive, or Frequent. High support allows for a blend of one-to-one and group staffing. Participants authorized at the high support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the high support daily rate.

(3-19-07)

b. Intense support is for those exceptional participants who require intense, twenty-four (24) hour per day supports and supervision. This support level typically requires one-on-one staffing, but requests for a blend of one-on-one and group staffing will be reviewed on a case-by-case basis. Participants authorized at the intense support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the intense support daily rate. To qualify for this level of support, participants must be evaluated to meet one or more of the following criteria: (3-19-07)

i. Recent felony convictions or charges for offenses related to the serious injury or harm of another person. These participants must have been placed in a supported living setting directly from incarceration or directly after being diverted from incarceration. (3-19-07)

ii. History of predatory sexual offenses and are at high risk to re-offend based on a sexual offender risk assessment completed by an appropriate professional. (3-19-07)

iii. Documented, sustained history of serious aggressive behavior showing a pattern of causing harm to themselves or others. The serious aggressive behavior must be such that the threat or use of force on another person makes that person reasonably fear bodily harm. The participant must also have the capability to carry out such a threat. The frequency and intensity of this type of aggressive behavior must require continuous monitoring to prevent injury to themselves or others. (3-19-07)

iv. Chronic or acute medical conditions that are so complex or unstable that one-to-one staffing is required to provide frequent interventions and constant monitoring. Without this intervention and monitoring the participant would require placement in a nursing facility, hospital, or ICF/MR with twenty-four (24) hour on-site nursing. Verification of the complex medical condition and the need for this level of service requires medical documentation. (3-19-07)

c. Hourly support is for those individuals that do not meet criteria for either high or intense supports or those individuals who qualify for a daily rate but whose needs can be met with less than twenty-four (24) per day support. The combination of hourly supported living, developmental therapy, community supported employment, and adult day care will not be authorized to exceed the maximum set daily amount established by the Department except when all of the following conditions are met: (3-19-07)

i. The participant is eligible to receive the high support daily rate; (3-19-07)

ii. Community supported employment is included in the plan and is causing the combination to exceed the daily limit; (3-19-07)

iii. There is documentation that the Person-Centered Planning team has explored other options including using lower cost services and natural supports; and (3-19-07)

iv. The participant's health and safety needs will be met using hourly services despite having been assessed to qualify for twenty-four (24) hour care. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

653. DDA SERVICES - COVERAGE REQUIREMENTS AND LIMITATIONS.

01. Requirement for Plan of Service and Prior Authorization. (3-19-07)

a. All therapy services for children must be identified on the Individual Program Plan developed by the developmental disabilities agency (DDA) as described in IDAPA 16.04.11, "Developmental Disabilities Agencies." (3-19-07)

b. All therapy services for adults with developmental disabilities ~~*and ISSH waiver participants*~~ must be identified on the plan of service and prior authorized as described in Sections 507 through 520 of these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies." ~~*(3-19-07)*~~( )

02. Assessment and Diagnostic Services. Twelve (12) hours is the maximum Medicaid reimbursable time allowed for the combination of all assessment, evaluation or diagnostic services provided in any calendar year. Additional hours may be approved for a child through the month of his twenty-first birthday with approval from EPSDT staff in the Division of Medicaid. The following assessment and diagnostic services are reimbursable when provided in accordance with these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies": (3-19-07)

a. Comprehensive Developmental Assessment; (3-19-07)

b. Comprehensive Intensive Behavioral Intervention (IBI) Assessment. Before conducting the comprehensive IBI assessment, the DDA must receive prior authorization from the Department. The time required to complete this assessment is included in the thirty-six (36) month IBI limitation but does not count against the twelve (12) hour limitation described in this subsection; (3-19-07)

c. Occupational Therapy Assessment (3-19-07)

d. Physical Therapy Assessment; (3-19-07)

e. Speech and Language Assessment; (3-19-07)

f. Medical/Social History; and (3-19-07)

g. Psychological Assessment. Includes psychological testing and psychiatric diagnostic interview. (3-19-07)

03. Therapy Services. Developmental disabilities agency services must be recommended by a physician or other practitioner of the healing arts and provided in accordance with objectives as specified in IDAPA 16.04.11, "Developmental Disabilities Agencies." The following therapy services are reimbursable when provided in accordance with these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies." (3-19-07)

a. Developmental Therapy. Developmental therapy may be delivered in a developmental disabilities agency center-based program, the community, or the home of the participant. Participants living in a certified family home must not receive home-based developmental therapy in a certified family home. Developmental therapy includes individual developmental therapy and group developmental therapy. (3-19-07)

b. Psychotherapy Services. Psychotherapy services, alone or in combination with supportive counseling, are limited to a maximum of forty-five (45) hours in a calendar year, and include: (3-19-07)

i. Individual psychotherapy; (3-19-07)

ii. Group psychotherapy; and (3-19-07)

iii. Family-centered psychotherapy which must include the participant and one (1) other family member at any given time. (3-19-07)

c. Supportive Counseling. Supportive counseling must only be delivered on an individualized, one to-one basis. Supportive counseling, alone or in combination with psychotherapy services, is limited to a maximum of forty-five (45) hours in a calendar year. (3-19-07)

d. Speech-Language Pathology Services. Speech-language pathology services include individual or group therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. (4-2-08)

e. Physical Therapy Services. Physical therapy services include individual or group therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. (4-2-08)

f. Occupational Therapy Services. Occupational therapy services include individual occupational therapy and group occupational therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. (4-2-08)

g. Intensive Behavioral Intervention (IBI). IBI is limited to a lifetime limit of thirty six (36) months. (3-19-07)

i. The DDA must receive prior authorization from the Department prior to delivering IBI services. (3-19-07)

ii. IBI must only be delivered on an individualized, one-to-one basis. (3-19-07)

h. Intensive Behavioral Intervention (IBI) Consultation. IBI consultation is included in the thirty-six (36) month IBI limitation. The DDA must receive prior authorization from the Department prior to providing IBI Consultation. (3-19-07)

i. Collateral Contact. Collateral contact is consultation or treatment direction about

the participant to a significant other in the participant's life and may be conducted face-to-face or by telephone contact. Collateral contact for general staff training, regularly scheduled parent-teacher conferences, general parent education, or for treatment team meetings, even when the parent is present, is not reimbursable. (3-19-07)

j. Pharmacological Management. Pharmacological management is consultation for the purpose of prescribing, monitoring, or administering medications. These consultations must be provided by a physician or other practitioner of the healing arts in direct face-to-face contact with the participant and be provided in accordance with the plan of service with the type, amount, frequency and duration of the service specified. The telephoning of prescriptions to the pharmacy is not a billable service. (3-19-07)

04. Excluded Services. The following services are excluded for Medicaid payments: (3-19-07)

a. Vocational services; (3-19-07)

b. Educational services; and (3-19-07)

c. Recreational services. (3-19-07)

05. Limitations on DDA Services. Therapy services may not exceed the limitations as specified below. (3-19-07)

a. The combination of therapy services listed in Subsections 653.03.a. through 653.03.g. of these rules must not exceed twenty-two (22) hours per week. (1-1-09)T

b. Therapy services listed in Subsections 653.03.a. through 653.03.g. of these rules provided in combination with Community Supported Employment services under Subsection 703.04 of these rules must not exceed forty (40) hours per week. (3-19-07)

c. When a HCBS waiver participant under Sections 700 through 719 of these rules receives Adult Day Care as provided in Subsection 703.12 of these rules, the combination of Adult Day Care, Developmental Therapy and Occupational therapy must not exceed thirty (30) hours per week. (3-19-07)

d. Only one (1) type of therapy service will be reimbursed during a single time period by the Medicaid program. No therapy services will be reimbursed during periods when the participant is being transported to and from the agency. (3-19-07)

~~**e.** *Prior to delivering any services in a school-based setting, the DDA must have a contract with the school or the Infant Toddler program. The DDA must not bill Medicaid or the Medicaid participant for these contracted services. Only the school district, charter school, or the Idaho Infant Toddler program may bill Medicaid for these contracted services when provided in accordance with IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Sections 850 through 856.* *(3-19-07)*~~

(BREAK IN CONTINUITY OF SECTIONS)

700. INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES~~/ISSH~~ WAIVER SERVICES.
Under 42 CFR Section 440.180, it is the intention of the Department to provide waiver services to eligible participants to prevent unnecessary institutional placement, provide for the greatest degree of independence possible, enhance the quality of life, encourage individual choice, and achieve and maintain community integration. For a participant to be eligible the Department must find that the participant requires services due to a developmental disability that impairs his mental or physical function or independence, is capable of being maintained safely and effectively in a non-institutional setting, and would, in the absence of such services, need to reside in an ICF/MR. ~~(3-19-07)~~( )

701. (RESERVED).

702. DD~~/ISSH~~ WAIVER SERVICES - ELIGIBILITY.
Waiver eligibility will be determined by the Department as described in Section 509 of these rules. The participant must be financially eligible for Medical Assistance as described in IDAPA 16.03.05, "Rules Governing Eligibility for Aid for the Aged, Blind, and Disabled (AABD)," Section 787. The cited chapter implements and is in accordance with the Financial Eligibility Section of the Idaho State Plan. In addition, waiver participants must meet the following requirements: ~~(3-19-07)~~( )

01. Age of Participants. DD waiver participants must be eighteen (18) years of age or older. ~~ISSH waiver participants must be fifteen (15) years of age through the month of their eighteenth birthday.~~ ~~(3-19-07)~~( )

02. Eligibility Determinations. The Department must determine that: (3-19-07)

a. The participant would qualify for ICF/MR level of care as set forth in Section 584 of these rules, if the waiver services listed in Section 703 of these rules were not made available; and (3-19-07)

b. The participant could be safely and effectively maintained in the requested or chosen community residence with appropriate waiver services. This determination must: be made by a team of individuals with input from the person-centered planning team; and prior to any denial of services on this basis, be determined by the plan developer that services to correct the concerns of the team are not available. (3-19-07)

c. The average annual cost of waiver services and other medical services to the participant would not exceed the average annual cost to Medicaid of ICF/MR care and other medical costs. (7-1-06)

d. Following the approval by the Department for services under the waiver, the participant must receive and continue to receive a waiver service as described in these rules. A participant who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program. (3-19-07)

03. Home and Community Based Services Waiver Eligible Participants. A participant who is determined by the Department to be eligible for services under the Home and Community Based Services Waivers for ~~*ISSH and*~~ DD may elect to not utilize waiver services but may choose admission to an ICF/MR. ~~*(3-19-07)*~~(____)

04. Processing Applications. The participant's self-reliance staff will process the application in accordance with IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)," as if the application was for admission to an ICF/MR, except that the self-reliance staff will forward potentially eligible applications immediately to the Department for review. The Medicaid application process cited above conforms to all statutory and regulatory requirements relating to the Medicaid application process. (3-19-07)

05. Transmitted Decisions to Self-Reliance Staff. The decisions of the Department regarding the acceptance of the participants into the waiver program will be transmitted to the self-reliance staff. (3-19-07)

06. Case Redetermination. (3-19-07)

a. Financial redetermination will be conducted pursuant to IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." Medical redetermination will be made at least annually by the Department, or sooner at the request of the participant, the self-reliance staff, provider agency or physician. The sections cited implement and are in accordance with Idaho's approved State Plan with the exception of deeming of income provisions. (3-19-07)

b. The redetermination process will assess the following factors: (3-19-07)

i. The participant's continued need and eligibility for waiver services; and (3-19-07)

ii. Discharge from the waiver services program. (3-19-07)

07. Home and Community-Based Waiver Participant Limitations. The number of Medicaid participants to receive waiver services under the home and community based waiver for developmentally disabled participants will be limited to the projected number of users contained in the Department's approved waiver. Individuals who apply for waiver services after the waiver maximum has been reached will be placed on a waiting list and will have their applications processed after September 30th for the DD waiver ~~*and after June 30th for the ISSH waiver*~~ of each new waiver year. ~~*(3-19-07)*~~(____)

703. DD~~*/ISSH*~~ WAIVER SERVICES - COVERAGE AND LIMITATIONS.

01. Residential Habilitation. Residential habilitation services which consist of an integrated array of individually-tailored services and supports furnished to eligible participants which are designed to assist them to reside successfully in their own homes, with their families, or alternate family homes. The services and supports that may be furnished consist of the following: (3-19-07)

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

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

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

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

iv. Socialization including training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. (Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in non-therapeutic activities which are merely diversional or recreational in nature); (3-19-07)

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

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

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

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

02. Chore Services. Chore services which are heavy household maintenance and minor home repairs necessary to maintain the functional use of the home and to provide a clean,

sanitary and safe environment. Chore activities include washing windows; moving heavy furniture and shoveling snow to provide safe access inside and outside the home; chopping wood when wood is the participant's primary source of heat; and tacking down loose rugs and flooring. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (3-19-07)

03. Respite. Respite care services are those services provided on a short term basis because of the absence of persons normally providing non-paid care. Respite care services provided under this waiver will not include room and board payments. Respite care services are limited to participants who reside with non-paid caregivers. (3-19-07)

04. Supported Employment. Supported employment which is competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a severe disability; and who, because of the nature and severity of their disability, need intensive supported employment services or extended services in order to perform such work. (3-19-07)

a. Supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation will be maintained in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973 as amended, or IDEA. (3-19-07)

b. Federal Financial Participation (FFP) will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize employers' participation in a supported employment program; payments that are passed through to beneficiaries of supported employment programs; or payments for vocational training that is not directly related to a waiver participant's supported employment program. (3-19-07)

05. Transportation. Transportation services which are services offered in order to enable waiver participants to gain access to waiver and other community services and resources required by the plan of service. This service is offered in addition to medical transportation required under 42 CFR 440.431.53 and transportation services offered under the State Plan, defined at 42 CFR 440.170(a), and must not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge or public transit providers will be utilized. (3-19-07)

06. Environmental Accessibility Adaptations. Environmental accessibility adaptations which are those interior or exterior physical adaptations to the home, required by the waiver participant's plan of service, which are necessary to ensure the health, welfare, safety of the individual, or which enable the individual to function with greater independence in the home and without which, the waiver participant would require institutionalization. Such adaptations

may include the installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but must exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. All services must be provided in accordance with applicable State or local building codes. Permanent environmental modifications are limited to modifications to a home rented or owned by the participant or the participant's family when the home is the participant's principal residence. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (3-19-07)

07. Specialized Equipment and Supplies. Specialized medical equipment and supplies which include devices, controls, or appliances, specified in the plan of service which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. They also include items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds must be in addition to any medical equipment and supplies furnished under the State Plan and must exclude those items which are not of direct medical or remedial benefit to the participant. All items must meet applicable standards of manufacture, design and installation. (3-19-07)

08. Personal Emergency Response System. Personal Emergency Response Systems (PERS) which may be provided to monitor waiver participant safety or provide access to emergency crisis intervention for emotional, medical or environmental emergencies through the provision of communication connection systems. PERS are limited to participants who rent or own their home, who are alone for significant parts of the day, have no regular caretaker for extended periods of time and who would otherwise require extensive routine supervision. (3-19-07)

09. Home Delivered Meals. Home delivered meals which are designed to promote adequate wavier participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to participants who rent or own their own home, who are alone for significant parts of the day and have no regular caretaker for extended periods of time. (3-19-07)

10. Skilled Nursing. Nursing services are those intermittent nursing services or private duty nursing services which provide individual and continuous care listed in the plan of service which are within the scope of the Nurse Practice Act and are provided by a licensed professional (RN) nurse or licensed practical nurse (LPN) under the supervision of an RN, licensed to practice in Idaho. (3-19-07)

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

12. Adult Day Care. Adult Day Care is a supervised, structured day program, outside the home of the participant that offer one (1) or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. These activities need to be identified on the plan of service. Adult Day Care can not exceed thirty (30) hours per week either alone or in combination with developmental therapy, occupational therapy, or IBI. (3-19-07)

a. Services provided in a facility must meet the building and health standards identified in IDAPA 16.04.11, "Developmental Disabilities Agencies." (3-19-07)

b. Services provided in a home must meet the standards of home certification identified in IDAPA 16.03.19, "Rules Governing Certified Family Home," and health standards identified in IDAPA 16.04.11, "Developmental Disabilities Agencies." (3-19-07)

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

14. Place of Service Delivery. Waiver services may be provided in the participant's personal residence, a certified family home, day habilitation/supported employment program, or community. The following living situations are specifically excluded as a place of service for waiver services: (3-19-07)

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

b. Licensed Intermediate Care Facility for persons with Mental Retardation (ICF/MR); and (3-19-07)

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

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

704. DD~~/ISSH~~ WAIVER SERVICES - PROCEDURAL REQUIREMENTS.

01. Authorization of Services on a Written Plan. All waiver services must be identified on the plan of service and authorized by the process described in Sections 507 through 520 of these rules. The plan of service must be reviewed by a plan monitor or targeted service coordinator at a frequency determined by the person-centered planning team, but at least every ninety (90) days. (3-19-07)

02. Provider Records. Three (3) types of record information will be maintained on all participants receiving waiver services: (3-19-07)

a. Direct Service Provider Information which includes written documentation of each

visit made or service provided to the participant, and will record at a minimum the following information: (3-19-07)

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

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

iii. A statement of the participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and (3-19-07)

iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the participant is determined by the Service Coordinator to be unable to do so, the delivery will be verified by the participant as evidenced by their signature on the service record. (3-19-07)

v. A copy of the above information will be maintained in the participant's home unless authorized to be kept elsewhere by the Department. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. (3-19-07)

b. The plan of service developed by the plan developer and the person-centered planning team must specify which services are required by the participant. The plan of service must contain all elements required by Subsection 704.01 of these rules and a copy of the most current plan of service must be maintained in the participant's home and must be available to all service providers and the Department. (3-19-07)

c. In addition to the plan of service, all providers, with the exception of chore, non-medical transportation, and enrolled Medicaid vendors, must submit a provider status review six (6) months after the start date of the plan of service and annually to the plan monitor as described in Sections 507 through 520 of these rules. (3-19-07)

03. Provider Responsibility for Notification. It is the responsibility of the service provider to notify the service coordinator or plan developer when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. (3-19-07)

04. Records Maintenance. In order to provide continuity of services, when a participant changes service providers, plan developers, or service coordinators, all of the foregoing participant records will be delivered to and held by the Department until a replacement service provider, plan developer, or service coordinator is selected by the participant. When a participant leaves the waiver services program, the records will be retained by the Department as part of the participant's closed case record. Provider agencies will be responsible to retain their participant's records for five (5) years following the date of service. (3-19-07)

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

01. Residential Habilitation. Residential habilitation services must be provided by an

agency that is certified by the Department as a Residential Habilitation Agency under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies," and is capable of supervising the direct services provided. Individuals who provide residential habilitation services in their own home must be certified by the Department as a certified family home and must be affiliated with a Residential Habilitation Agency. The Residential Habilitation Agency provides oversight, training, and quality assurance to the certified family home provider. Individuals who provide residential habilitation services in the home of the participant (supported living), must be employed by a Residential Habilitation Agency. Providers of residential habilitation services must meet the following requirements: (3-19-07)

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

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

ii. Be a high school graduate or have a GED or demonstrate the ability to provide services according to an plan of service; (3-19-07)

iii. Have current CPR and First Aid certifications; (3-19-07)

iv. Be free from communicable diseases; (3-19-07)

v. Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. Staff previously trained on assistance with medications by a licensed nurse but who have not completed this course must meet this requirement by July 1, 2007. (3-19-07)

vi. Residential habilitation service providers who provide direct care or services must satisfactorily complete a criminal background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

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

b. All skill training for direct service staff must be provided by a Qualified Mental Retardation Professional (QMRP) who has demonstrated experience in writing skill training programs. (3-19-07)

c. Prior to delivering services to a participant, direct service staff must complete an orientation program. The orientation program must include the following subjects: (3-19-07)

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

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

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

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

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

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

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

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

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

d. Additional training requirements must be completed within six (6) months of employment or affiliation with the residential habilitation agency and include at a minimum: (3-19-07)

i. Instructional techniques: Methodologies for training in a systematic and effective manner; (3-19-07)

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

iii. Feeding; (3-19-07)

iv. Communication; (3-19-07)

v. Mobility; (3-19-07)

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

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

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

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

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

f. When residential habilitation services are provided in the provider's home, the provider's home must meet the requirements in IDAPA 16.03.19, “Rules Governing Certified Family Homes.” Non-compliance with the certification process is cause for termination of the provider's provider agreement. (3-19-07)

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

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

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

c. Chore service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

03. Respite. Providers of respite care services must meet the following minimum qualifications: (3-19-07)

a. Meet the qualifications prescribed for the type of services to be rendered or must be an individual selected by the waiver participant, the family or his guardian; (3-19-07)

b. Have received care giving instructions in the needs of the person who will be provided the service; (3-19-07)

c. Demonstrate the ability to provide services according to an plan of service; (3-19-07)

d. Have good communication and interpersonal skills and the ability to deal effectively, assertively and cooperatively with a variety of people; (3-19-07)

e. Be willing to accept training and supervision by a provider agency or the primary caregiver of services; and (3-19-07)

f. Be free of communicable diseases. (3-19-07)

g. Respite care service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

04. Supported Employment. Supported Employment services must be provided by an agency capable of supervising the direct service and be accredited by the Commission on Accreditation of Rehabilitation Facilities; or other comparable standards; or meet State requirements to be a State approved provider. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

05. Transportation. Providers of transportation services must: (3-19-07)

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

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

06. Environmental Accessibility Adaptations. Environmental accessibility adaptations services must: (3-19-07)

a. Be done under a permit, if required; and (3-19-07)

b. Demonstrate that all modifications, improvements, or repairs are made in accordance with local and state housing and building codes. (3-19-07)

07. Specialized Equipment and Supplies. Specialized Equipment and Supplies purchased under this service must: (3-19-07)

a. Meet Underwriter's Laboratory, FDA, or Federal Communication Commission standards where applicable; and (3-19-07)

b. Be obtained or provided by authorized dealers of the specific product where applicable. This may include medical supply businesses or organizations that specialize in the design of the equipment. (3-19-07)

08. Personal Emergency Response System. Personal Emergency Response Systems (PERS) must demonstrate that the devices installed in waiver participants' homes meet Federal Communications Standards or Underwriter's Laboratory standards or equivalent standards. (3-19-07)

09. Home Delivered Meals. Services of Home Delivered Meals under this section may only be provided by an agency capable of supervising the direct service and must: (3-19-07)

a. Provide assurances that each meal meets one third (1/3) of the Recommended Dietary Allowance as defined by the Food and Nutrition Board of National Research Council or meet physician ordered individualized therapeutic diet requirement; (3-19-07)

b. Must provide assurances that the meals are delivered on time and demonstrate the ability to deliver meals at a minimum of three (3) days per week; (3-19-07)

c. Maintain documentation reflecting the meals delivered are nutritionally balanced and made from the highest U.S.D.A. Grade for each specific food served; (3-19-07)

d. Provide documentation of current driver's license for each driver; and (3-19-07)

e. Must be inspected and licensed as a food establishment by the District Health Department. (3-19-07)

10. Skilled Nursing. Nursing service providers must provide documentation of current Idaho licensure as a licensed professional nurse (RN) or licensed practical nurse (LPN) in good standing. (3-19-07)

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

a. Work for a provider agency capable of supervising the direct service or work under the direct supervision of a licensed psychologist or Ph.D. in Special Education, with training and

experience in treating severe behavior problems and training and experience in applied behavior analysis; and (3-19-07)

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

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

d. Be a Qualified Mental Retardation Professional (QMRP). (3-19-07)

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

f. Behavior consultation or crisis management providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

12. Adult Day Care. Providers of adult day care services must be employed by or be affiliated with the residential habilitation agency that provides program coordination for the participant if the service is provided in a certified family home other than the participant's primary residence, be capable of supervising direct services, provide services as identified on the plan of service, provide care and supervision identified on the participant's residential habilitation plan, and must meet the following minimum qualifications: (3-19-07)

a. Demonstrate the ability to communicate and deal effectively, assertively, and cooperatively with a variety of people; (3-19-07)

b. Be a high school graduate, or have a GED or demonstrate the ability to provide services according to the plan of service; (3-19-07)

c. Be free from communicable disease; (3-19-07)

d. Adult day care providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks"; (4-2-08)

e. Demonstrate knowledge of infection control methods; and (3-19-07)

f. Agree to practice confidentiality in handling situations that involve waiver participants. (3-19-07)

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

706. DD~~/ASSH~~ WAIVER SERVICES - PROVIDER REIMBURSEMENT.

01. Fee for Service. Waiver service providers will be paid on a fee for service basis based on the type of service provided as established by the Department. (3-19-07)

02. Claim Forms. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (3-19-07)

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

(BREAK IN CONTINUITY OF SECTIONS)

723. SERVICE COORDINATION -- ELIGIBILITY -- INDIVIDUALS WITH A DEVELOPMENTAL DISABILITY.
An individual is eligible to receive service coordination if he meets the following requirements in Subsection 723.01 through 723.03 of this rule. (5-8-09)

01. Age. An adult eighteen (18) years of age or older~~, *or adolescent fifteen to eighteen (15-18) years of age who is authorized to receive services through the Idaho State School and Hospital (ISSH) waiver*~~. ~~*(5-8-09)*~~(____)

02. Diagnosis. Is diagnosed with a developmental disability, defined in Section 66-402, Idaho Code and Section 500 through 506 of these rules, that: (5-8-09)

a. Is attributable to an impairment, such as mental retardation, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one (1) of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments; (5-8-09)

b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (3-19-07)

c. Reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and individually planned and coordinated. (5-8-09)

03. Need Assistance. Requires and chooses assistance to access services and supports necessary to maintain his independence in the community. (5-8-09)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.13 - CONSUMER-DIRECTED SERVICES

DOCKET NO. 16-0313-0901

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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, and 56-250 through 257, 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:

Based on comments received during the public comment period, the Department is not pursuing the previously published proposed changes related to Home and Community-Based Services Waiver for the Aged and Disabled (HCBS A&D) services that appeared under this docket in the October 7, 2009, Administrative Bulletin. The Department will continue to work with stakeholders to develop self-direction options under the HCBS A&D waiver. The changes that appear in this pending rule are the sum of the changes under this docket going before the 2010 Legislature.

The Department is only proceeding with the changes to these rules that replace the requirement for a contract with a fiscal employer agent (FEA) with the requirement to use a provider agreement. As a result, the rules now contain the requirements for FEAs that were previously found only in the contract. These changes confer the benefit of expanding participant choice of FEA providers.

Amendments to Sections 009, 050, 101, 131-140, 160-169, 180, and 200 that were published in the proposed rule in the October Bulletin are not being made and have been removed from this pending rule. These sections are being reprinted following this notice as they are currently codified in the Administrative Code. Amendments made to Section 210 in the proposed rule have been removed also, however, new amendments have been made to the pending rule.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. The temporary rule is being rescinded and repromulgated under Docket No. 16-0313-1001. The notice of adoption of the temporary rule is published in the Bulletin immediately following this pending rule docket.

All sections that published as proposed in the October Bulletin are being republished in this Bulletin to the show the changes made to the pending rule. The complete text of the proposed rule was published in the October 7, 2009, Idaho Administrative Bulletin, Vol. 09-10, pages 416 through 447.

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 as a result of this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Paige Grooms at (208) 947-3364.

DATED this 16th day of November, 2009.

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

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2010.

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, and 56-250 through 257, 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 Wednesday, October 21, 2009.

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 Department is changing these rules to allow for the development of a uniform, state-wide financial management model for all Medicaid programs. This will allow all fiscal services provided to Medicaid participants, that are self-directing, to operate under the administrative rules. Current rules are written only for Home and Community-Based Services waiver services for individuals with developmental disabilities (HCBS DD).

The following is a summary of the proposed changes under this docket:

1. **Align, clarify, and augment the rules that govern self-direction programs to include self-direction services under the Home and Community-Based Services waiver for the Aged and Disabled (HCBS A&D).**

2. **Replace the requirement for a contract with the fiscal employer agent with the requirement to use a provider agreement.**

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

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 as a result of this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted. The negotiated rulemaking was informal. No "Notice of Intent to Promulgate Rules" was published.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Susan Scheuerer at (208) 287-1156.

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 Wednesday, October 28, 2009.

DATED this 2nd day of September, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

001. TITLE AND SCOPE.

01. Title. The~~se~~ title of these rules ~~*will be cited as*~~ is IDAPA 16.03.13, "Consumer-Directed Services." ~~*(3-30-07)*~~( )

02. Scope. Self-Directed Community Supports (SDCS) is a flexible program option for participants eligible for the Home and Community Based Services - Developmental Disabilities (HCBS-DD) waiver. The SDCS option allows the eligible participant to: choose the type and frequency of supports he wants, negotiate the rate of payment, and hire the person or agency he prefers to provide those supports. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Criminal History Check. The fiscal employer agent must verify that each support broker and community support worker, whose criminal history check has not been waived by the participant, has complied with IDAPA 16.05.06, "Criminal History and Background Checks." When a participant chooses to waive the criminal history check requirement for a community support worker, the waiver must be completed in accordance with Section 150 of these rules. (3-30-07)

02. Availability to Work or Provide Service. Participants, at their discretion, may review the completed application and allow the community support worker to provide services on a provisional basis if no disqualifying offenses listed in IDAPA 16.05.06, "Criminal History and Background Checks," are disclosed. (3-30-07)

03. Additional Criminal Convictions. Once criminal history clearances have been received, any additional criminal convictions must be immediately reported by the worker to the participant and by the participant to the Department. (3-30-07)

04. Notice of Pending Investigations or Charges. Once criminal history clearances have been received, any charges or investigations for abuse, neglect or exploitation of any vulnerable adult or child, criminal charges, or substantiated adult protection or child protection complaints, must be immediately reported by the worker to the participant and by the participant to the Department. (3-30-07)

05. Providers Subject to Criminal History Check Requirements. A community support worker, who has not had the requirement waived by the participant, and a support broker as defined in Section 010 of these rules. (3-30-07)

010. DEFINITIONS.

01. Circle of Supports. People who encourage and care about the participant and

provide unpaid supports. (3-30-07)

02. Community Support Worker. An individual, agency, or vendor selected and paid by the participant to provide community support worker services. (3-30-07)

03. Community Support Worker Services. Community support worker services are those identified supports listed in Section 110 of these rules. (3-30-07)

04. Financial Management Services (FMS). Services provided by a fiscal employer agent that include: ~~(3-30-07)~~( )

a. Financial guidance and support to the participant by tracking individual expenditures and monitoring overall budgets; (3-30-07)

b. Performing payroll services; and (3-30-07)

c. Handling billing and employment related documentation responsibilities. (3-30-07)

05. Fiscal Employer Agent (FEA). An agency that provides financial management services to participants who have chosen the SDCS option. The fiscal employer agent (FEA) is *selected* by the participant. *The* duties *of the FEA* are defined under Section 3504 of the Internal Revenue Code (26 USC 3504). ~~(3-30-07)~~( )

06. Goods. Tangible products or merchandise that are authorized on the support and spending plan. (3-30-07)

07. Guiding Principles for the SDCS Option. Self-Directed Community Supports is based upon the concept of self-determination and has the following guiding principles: (3-30-07)

a. Freedom for the participant to make choices and plan his own life; (3-30-07)

b. Authority for the participant to control resources allocated to him to acquire needed supports; (3-30-07)

c. Opportunity for the participant to choose his own supports; (3-30-07)

d. Responsibility for the participant to make choices and take responsibility for the result of those choices; and (3-30-07)

e. Shared responsibility between the participant and his community to help the participant become an involved and contributing member of that community. (3-30-07)

08. **Readiness Review**. A review conducted by the Department to ensure that each fiscal employer agent is prepared to enter into and comply with the requirements of the provider agreement and this chapter of rules. ( )

09. **Support and Spending Plan**. A support and spending plan is a document that

functions as a participant's plan of care when the participant is eligible for and has chosen a self-directed service option. This document identifies the goods or services, or both, selected by a participant and the cost of each of the identified goods and services. The participant uses this document to manage his individualized budget. ( )

08__*10*__**.** **Supports**. Services provided for a participant, or a person who provides a support service. A support service may be a paid service provided by a community support worker, or an unpaid service provided by a natural support, such as a family member, a friend, neighbor, or other volunteer. A person who provides a support service for pay is a paid support. A person who provides a volunteer support service is a natural support. (3-30-07)

09__*11*__**.** **Support Broker**. An individual who advocates on behalf of the participant and who is hired by the participant to provide support broker Services. (3-30-07)

1*0*__*2*__**.** **Support Broker Services**. Services provided by a support broker to assist the participant with planning, negotiating, and budgeting. (3-30-07)

__*13.*__ __***Traditional HCBS DD Waiver Services***__*. A program option for participants eligible for the Home and Community-Based Services Developmental Disabilities (HCBS-DD) Waiver consisting of the specific Medicaid Enhanced Plan Benefits described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsections 703.01 through 703.12.* ( )

__*14.*__ __**Waiver Services**__. A collective term that refers to services provided under *a Medicaid Waiver program*. ( )

011. -- 099. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

101. ELIGIBILITY.

01. Determination of Medicaid and Home and Community Based Services - DD Requirements. In order to choose the SDCS option, the participant must first be determined Medicaid-eligible and must be determined to meet existing (HCBS-DD) waiver program requirements as outlined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (3-30-07)

02. Participant Agreement Form. The participant, and his legal representative, if one exists, must agree in writing using a Department-approved form to the following: (3-30-07)

a. Accept the guiding principles for the SDCS option, as defined in Section 010 of these rules; (3-30-07)

b. Agree to meet the participant responsibilities outlined in Section 120 of these rules; (3-30-07)

c. Take responsibility for and accept potential risks, and any resulting consequences, for their support choices. (3-30-07)

03. Legal Representative Agreement. The participant's legal representative, if one exists, must agree in writing to honor the choices of the participant as required by the guiding principles for the SDCS option. (3-30-07)

102. -- 109. (RESERVED).

110. PAID SELF-DIRECTED COMMUNITY SUPPORTS.
The participant must purchase Financial Management Services *(FMS)* and support broker services to participate in the SDCS option. The participant must purchase goods and community supports through the fiscal employer agent *who is providing the FMS.* ~~*(3-30-07)*~~*( )*

01. ~~*Fiscal*~~ *Financial* Management Services. The Department will ~~*contract with a*~~ enter into a provider agreement with a qualified fiscal employer agent, as defined in Section 010 of these rules, to provide financial management services to a participant who chooses the self-directed option. ~~*(3-30-07)*~~*( )*

02. Support Broker. Support broker services are provided by a qualified support broker. (3-30-07)

03. Community Support Worker. The community support worker provides identified supports to the participant. If the identified support requires specific licensing or certification within the state of Idaho, the identified community support worker must obtain the applicable license or certification. Identified supports include activities that address the participant's preference for: (3-30-07)

a. Job support to help the participant secure and maintain employment or attain job advancement; (3-30-07)

b. Personal support to help the participant maintain health, safety, and basic quality of life; (3-30-07)

c. Relationship support to help the participant establish and maintain positive relationships with immediate family members, friends, spouse, or others in order to build a natural support network and community; (3-30-07)

d. Emotional support to help the participant learn and practice behaviors consistent with his goals and wishes while minimizing interfering behaviors; (3-30-07)

e. Learning support to help the participant learn new skills or improve existing skills that relate to his identified goals; (3-30-07)

f. Transportation support to help the participant accomplish his identified goals; (3-30-07)

g. Adaptive equipment identified in the participant's plan that meets a medical or

accessibility need and promotes his increased independence; and (3-30-07)

h. Skilled nursing support identified in the participant's plan that is within the scope of the Nurse Practice Act and is provided by a licensed professional (RN) nurse or licensed practical nurse (LPN) under the supervision of an RN, licensed to practice in Idaho. (3-30-07)

111. -- 119. (RESERVED).

120. PARTICIPANT RESPONSIBILITIES.
With the assistance of the support broker and the legal representative, if one exists, the participant is responsible for the following: (3-30-07)

01. Guiding Principles. Accepting and honoring the guiding principles for the SDCS option found in Section 010 of these rules. (3-30-07)

02. Person-Centered Planning. Participating in the person-centered planning process in order to identify and document support and service needs, wants, and preferences. (3-30-07)

03. Rates. Negotiating payment rates for all paid community supports he wants to purchase, ensuring rates negotiated for supports and services do not exceed the prevailing market rate, and including the details in the employment agreements. (3-30-07)

04. Agreements. Completing and implementing agreements for the fiscal employer agent, the support broker and community support workers and submitting the agreements to the fiscal employer agent. These agreements must be submitted on Department-approved forms. (3-30-07)

05. Agreement Detail. Ensuring that employment agreements specifically identify the type of support being purchased, the rate negotiated for the support, and the frequency and duration of the scheduled support or service. The participant is responsible for ensuring that each employment agreement: clearly identifies the qualifications needed to provide the support or service; includes a statement signed by the hired worker that he possesses the needed skills; and the signature of the participant that verifies the same. Additionally, each employment agreement will include statements that: the participant is the employer even though payment comes from a third party; employees are under the direction and control of the participant; and no employer-related claims will be filed against the Department. (3-30-07)

06. Plan. Developing a comprehensive support and spending plan based on the information gathered during the person-centered planning. (3-30-07)

07. Time ~~s~~Sheets and Invoices. Reviewing and verifying that supports being billed were provided and indicating that he approves of the bill by signing the timesheet or invoice. ~~*(3-30-07)*~~( )

08. Quality Assurance and Improvement. Providing feedback to the best of his ability regarding his satisfaction with the supports he receives and the performance of his workers. (3-30-07)

121. -- 129. (RESERVED).

130. FISCAL EMPLOYER AGENT REQUIREMENTS AND LIMITATIONS.

01. Requirements. The fiscal employer agent must meet the requirements outlined in its ~~*contract*~~ provider agreement with the Department, and Section 3504 of the Internal Revenue Code (26 USC 3504). ~~*(3-30-07)*~~( )

02. Limitations. The fiscal employer agent must not: (3-30-07)

a. Provide any other direct services to the participant, to ensure there is no conflict of interest; or (3-30-07)

b. Employ the guardian, parent, spouse, payee or conservator of the participant or have direct control over the participant's choice. (3-30-07)

131. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES.
The fiscal employer agent performs Financial Management Services for each participant. Prior to providing Financial Management Services the participant and the fiscal employer agent must enter into a written agreement. Financial Management Services include: (3-30-07)

01. Payroll and Accounting. Providing payroll and accounting supports to participants that have chosen the Self-Directed Community Supports option; (3-30-07)

02. Financial Reporting. Performing financial reporting for employees of each participant. (3-30-07)

03. Information Packet. Preparing and distributing a packet of information, including Department-approved forms for agreements, for the participant hiring his own staff. (3-30-07)

04. Time Sheets and Invoices. Processing and paying time sheets for community support workers and support brokers, as authorized by the participant, according to the participant's Department-authorized support and spending plan. (3-30-07)

05. Taxes. Managing and processing payment of required state and federal employment taxes for the participant's community support worker and support broker. (3-30-07)

06. Payments for Goods and Services. Processing and paying invoices for goods and services, as authorized by the participant, according to the participant's support and spending plan. (3-30-07)

07. Spending Information. Providing each participant with reporting information that will assist the participant with managing the individualized budget. (3-30-07)

08. Quality Assurance and Improvement. Participating in Department quality assurance activities. (3-30-07)

132. -- 134. (RESERVED).

135. SUPPORT BROKER REQUIREMENTS AND LIMITATIONS.

01. Initial Application to Become a Support Broker. Individuals interested in becoming a support broker must complete the Department-approved application to document that he: (3-30-07)

a. Is eighteen (18) years of age or older; (3-30-07)

b. Has skills and knowledge typically gained by completing college courses or community classes or workshops that count toward a degree in the human services field; and (3-30-07)

c. Has at least two (2) years verifiable experience with the target population and knowledge of services and resources in the developmental disabilities field. (3-30-07)

02. Application Exam. Applicants that meet the minimum requirements outlined in this section will receive training materials and resources to prepare for the application exam. Applicants must earn a score of seventy percent (70%) or higher to pass. Applicants may take the exam up to three (3) times. After the third time, the applicant will not be allowed to retest for twelve (12) months from the date of the last exam. Applicants who pass the exam, and meet all other requirements outlined in these rules, will be eligible to enter into a provider agreement with the Department. (3-30-07)

03. Required Ongoing Training. All support brokers must document a minimum of twelve (12) hours per year of ongoing, relevant training in the provision of support broker services. Up to six (6) hours of the required twelve (12) hours may be obtained through independent self-study. The remaining hours must consist of classroom training. (3-30-07)

04. Termination. The Department may terminate the provider agreement when the support broker: (3-30-07)

a. Is no longer able to pass a criminal history background check as outlined in Section 009 of these rules. (3-30-07)

b. Puts the health or safety of the participant at risk by failing to perform job duties as outlined in the employment agreement. (3-30-07)

c. Does not receive and document the required ongoing training. (3-30-07)

05. Limitations. The support broker must not: (3-30-07)

a. Provide or be employed by an agency that provides paid community supports under Section 150 of these rules to the same participant; and (3-30-07)

b. Be the guardian, parent, spouse, payee, or conservator of the participant, or have direct control over the participant’s choices. Additionally, the support broker must not be in a position to both influence a participant's decision making and receive undue financial benefit

from the participant's decisions. (3-30-07)

136. SUPPORT BROKER DUTIES AND RESPONSIBILITIES.

01. Support Broker Initial Documentation. Prior to beginning employment for the participant, the support broker must complete the packet of information provided by the fiscal employer agent and submit it to the fiscal employer agent. This packet must include documentation of: (3-30-07)

a. Support broker application approval by the Department; (3-30-07)

b. A completed criminal history check, including clearance in accordance with IDAPA 16.05.06, "Criminal History and Background Checks"; and (3-30-07)

c. A completed employment agreement with the participant that identifies the specific tasks and services that are required of the support broker. The employment agreement must include the negotiated hourly rate for the support broker, and the type, frequency, and duration of services. The negotiated rate must not exceed the maximum hourly rate for support broker services established by the Department. (3-30-07)

02. Required Support Broker Duties. Support broker services may include only a few required tasks or may be provided as a comprehensive service package depending on the participant's needs and preferences. At a minimum, the support broker must: (3-30-07)

a. Participate in the person-centered planning process; (3-30-07)

b. Develop a written support and spending plan with the participant that includes the supports that the participant needs and wants, related risks identified with the participant's wants and preferences, and a comprehensive risk plan for each potential risk that includes at least three (3) backup plans should a support fail. This plan must be authorized by the Department; (3-30-07)

c. Assist the participant to monitor and review his budget; (3-30-07)

d. Submit documentation regarding the participant's satisfaction with identified supports as requested by the Department; (3-30-07)

e. Participate with Department quality assurance measures, as requested; (3-30-07)

f. Assist the participant to complete the annual re-determination process as needed, including updating the support and spending plan and submitting it to the Department for authorization; (3-30-07)

g. Assist the participant, as needed, to meet the participant responsibilities outlined in Section 120 of these rules and assist the participant, as needed, to protect his own health and safety; and (3-30-07)

h. Complete the Department-approved criminal history check waiver form when a

participant chooses to waive the criminal history check requirement for a community support worker. Completion of this form requires that the support broker provide education and counseling to the participant and his circle of support regarding the risks of waiving a criminal history check and assist with detailing the rationale for waiving the criminal history check and how health and safety will be protected. (3-30-07)

03. Additional Support Broker Duties. In addition to the required support broker duties, each support broker must be able to provide the following services when requested by the participant: (3-30-07)

a. Assist the participant to develop and maintain a circle of support; (3-30-07)

b. Help the participant learn and implement the skills needed to recruit, hire, and monitor community supports; (3-30-07)

c. Assist the participant to negotiate rates for paid community support workers; (3-30-07)

d. Maintain documentation of supports provided by each community support worker and participant's satisfaction with these supports; (3-30-07)

e. Assist the participant to monitor community supports; (3-30-07)

f. Assist the participant to resolve employment-related problems; and (3-30-07)

g. Assist the participant to identify and develop community resources to meet specific needs. (3-30-07)

04. Termination of Support Broker Services. If a support broker decides to end services with a participant, he must give the participant at least thirty (30) days' written notice prior to terminating services. The support broker must assist the participant to identify a new support broker and provide the participant and new support broker with a written service transition plan by the date of termination. The transition plan must include an updated support and spending plan that reflects current supports being received, details about the existing community support workers, and unmet needs. (3-30-07)

137. -- 139. (RESERVED).

140. COMMUNITY SUPPORT WORKER LIMITATIONS.
A paid community support worker must not be the spouse of the participant and must not have direct control over the participant's choices, must avoid any conflict of interest, and must not receive undue financial benefit from the participant's choices. A legal guardian can be a paid community support worker but must not be paid from the individualized budget for the following: (3-30-07)

01. Participant Responsibilities. The legal guardian must not be paid to perform or to assist the participant in meeting the participant responsibilities outlined in Section 120 of these rules. (3-30-07)

02. Legal Guardian Obligations. The legal guardian must not be paid to fulfill any obligations he is legally responsible to fulfill as outlined in the guardianship or conservator order from the court. (3-30-07)

141. -- 149. (RESERVED).

150. PAID COMMUNITY SUPPORT WORKER DUTIES AND RESPONSIBILITIES.

01. Initial Documentation. Prior to providing goods or services to the participant, the community support worker must complete the packet of information provided by the fiscal employer agent and submit it to the fiscal employer agent. When the community support worker will be providing services, this packet must include documentation of: (3-30-07)

a. A completed criminal history check, including clearance in accordance with IDAPA 16.05.06, "Criminal History and Background Checks," or documentation that this requirement has been waived by the participant. This documentation must be provided on a Department-approved form and must include the rationale for waiving the criminal history check and describe how health and safety will be assured in lieu of a completed criminal history check. Individuals listed on a state or federal provider exclusion list must not provide paid supports; (3-30-07)

b. A completed employment agreement with the participant that specifically defines the type of support being purchased, the negotiated rate, and the frequency and duration of the support to be provided. If the community support worker is provided through an agency, the employment agreement must include the specific individual who will provide the support and the agency's responsibility for tax-related obligations; (3-30-07)

c. Current state licensure or certification if identified support requires certification or licensure; and (3-30-07)

d. A statement of qualifications to provide supports identified in the employment agreement. (3-30-07)

02. Employment Agreement. The community support worker must deliver supports as defined in the employment agreement. (3-30-07)

03. Documentation of Supports. The community support worker must track and document the time required to perform the identified supports and accurately report the time on the time sheets provided by the participant's fiscal employer agent or complete an invoice that reflects the type of support provided, the date the support was provided, and the negotiated rate for the support provided, for submission to the participant's fiscal employer agent. (3-30-07)

04. Time ~~s~~Sheets and Invoices. The community support worker must obtain the signature of the participant or his legal representative on each completed timesheet or invoice prior to submitting the document to the fiscal employer agent for payment. Time sheets or invoices that are not signed by the community support worker and the participant or his legal representative will not be paid. ~~(3-30-07)~~(____)

151. -- 159. (RESERVED).

160. SUPPORT AND SPENDING PLAN DEVELOPMENT.

01. Support and Spending Plan Requirements. The participant, with the help of his support broker, must develop a comprehensive support and spending plan based on the information gathered during the person-centered planning. The support and spending plan is not valid until authorized by the Department and must include the following: (3-30-07)

a. The participant's preferences and interests by identifying all the supports and services, both paid and non-paid, the participant wants and needs to live successfully in his community. (3-30-07)

b. Paid or non-paid self-directed community supports that focus on the participant's wants, needs, and goals in the following areas: (3-30-07)

i. Personal health and safety including quality of life preferences; (3-30-07)

ii. Securing and maintaining employment; (3-30-07)

iii. Establishing and maintaining relationships with family, friends and others to build the participant's circle of supports; (3-30-07)

iv. Learning and practicing ways to recognize and minimize interfering behaviors; and (3-30-07)

v. Learning new skills or improving existing ones to accomplish set goals. (3-30-07)

c. Support needs such as: (3-30-07)

i. Medical care and medicine; (3-30-07)

ii. Skilled care including therapies or nursing needs; (3-30-07)

iii. Community involvement; (3-30-07)

iv. Preferred living arrangements including possible roommate(s); and (3-30-07)

v. Response to emergencies including access to emergency assistance and care. This plan should reflect the wants, preferences, and needs of the whole person, regardless of payment source, if any. (3-30-07)

d. Risks or safety concerns in relation to the identified support needs on the participant's plan. The plan must specify the supports or services needed to address the risks for each issue listed, with at least three (3) backup plans for each identified risk to implement in case the need arises; (3-30-07)

e. Sources of payment for the listed supports and services, including the frequency, duration, and main task of the listed supports and services; and (3-30-07)

f. The budgeted amounts planned in relation to the participant's needed supports. Community support worker employment agreements submitted to the fiscal employer agent must identify the negotiated rates agreed upon with each community support worker along with the specific support being purchased, the frequency and duration that the support will be provided, and the payment increment; that is, hourly or daily. The fiscal employer agent will compare and match the employment agreements to the appropriate support categories identified on the initial spending plan prior to processing time sheets or invoices for payment. (3-30-07)

02. Support and Spending Plan Limitations. Support and spending plan limitations include: (3-30-07)

a. Traditional Medicaid waiver and traditional rehabilitative or habilitative services must not be purchased under the SDCS option. Because a participant cannot receive these traditional services and self-directed services at the same time, the participant, the support broker, and the Department must all work together to assure that there is no interruption of required services when moving between traditional services and the SDCS option; (3-30-07)

b. Paid community supports must not be provided in a group setting with recipients of traditional Medicaid waiver, rehabilitative or habilitative services. This limitation does not preclude a participant who has selected the self-directed option from choosing to live with recipients of traditional Medicaid services; (3-30-07)

c. All paid community supports must fit into one (1) or more types of community supports described in Section 110 of these rules. Community supports that are not medically necessary or that do not minimize the participant's need for institutionalization must only be listed as non-paid supports. Additionally, the support and spending plan must not include supports or services that are illegal, that adversely affect the health and safety of the participant, that do harm, or that violate or infringe on the rights of others; (3-30-07)

d. Support and spending plans that exceed the approved budget amount will not be authorized; and (3-30-07)

e. Time sheets or invoices that are submitted to the fiscal employer agent for payment that exceed the authorized support and spending plan amount will not be paid by the fiscal employer agent. (3-30-07)

161. -- 169. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

180. CIRCLE OF SUPPORTS.
The circle of support is a means of natural supports for the participant and consists of people who

encourage and care about the participant. Work or duties the circle of supports performs on behalf of the participant are not paid. ~~*(3-30-07)*~~*( )*

01. Focus of the Circle of Support. The participant's circle of support should be built and operate with the primary goal of working in the interest of the participant. The group's role is to give and get support for the participant and to develop a plan of action, along with and on behalf of the participant, to help the participant accomplish his personal goals. (3-30-07)

02. Members of the Circle of Support. A circle of support may include family members, friends, neighbors, co-workers, and other community members. When the participant's legal guardian is selected as a community support worker, the circle of support must include at least one (1) non-family member that is not the support broker. For the purposes of this chapter a family member is anyone related by blood or marriage to the participant or to the legal guardian. (3-30-07)

03. Selection and Duties of the Circle of Support. Members of the circle of support are selected by the participant and commit to work within the group to: (3-30-07)

a. Help promote and improve the life of the participant in accordance with the participant's choices and preferences; and (3-30-07)

b. Meet on a regular basis to assist the participant to accomplish his expressed goals. (3-30-07)

04. Natural Supports. A natural support may perform any duty of the support broker as long as the support broker still completes the required responsibilities listed in Subsection 136.02 of these rules. Additionally, any community support worker task may be performed by a qualified natural support person. Supports provided by a natural support person must be identified on the participant's support plan, but time worked does not need to be recorded or reported to the fiscal employer agent. (3-30-07)

181. -- 189. (RESERVED).

190. INDIVIDUALIZED BUDGET.

The Department sets an individualized budget for each participant according to an individualized measurement of the participant's functional abilities, behavioral limitations, medical needs, and other individual factors related to the participant's ~~*disability*~~ assessed needs. Using these specific participant factors, the budget-setting methodology will correlate a participant's characteristics with the participant's individualized budget amount, so participants with higher needs will be assigned a higher individualized budget amount. The participant must work within the identified budget and acknowledge that he understands the budget figure is a fixed amount. ~~*(3-30-07)*~~*( )*

~~***01. Implementation of Budget Setting Methodology**. During the implementation phase of using the new individualized budget-setting methodology, the budget calculation will include reviewing the participant's previous year's budget. When the calculated budget is less than five percent (5%) above or below the previous year's budget, the participant's set budget amount is the calculated budget amount. When the calculated budget is greater than five percent (5%) above or below the previous year's budget, the participant's set budget amount is the*~~

~~*previous year's budget amount. The Department will collect information on discrepancies between the calculated budget and the previous year's budget as part of the ongoing assessment and improvement process of the budget-setting methodology.* *(3-30-07)*~~

0~~2~~1. Budget Amount Notification and Request for Reconsideration. The Department notifies each participant of his set budget amount. The notification will include how the participant may request reconsideration of the set budget amount. (3-30-07)

0~~3~~2. Annual Re-Evaluation of Individualized Budgets. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes in the participant's individualized needs and it is demonstrated that these additional needs cannot be supported by the current budget. (3-30-07)

191. -- 199. (RESERVED).

200. QUALITY ASSURANCE.
The Department will implement quality assurance processes to assure: access to self-directed services, participant direction of plans and services, participant choice and direction of providers, safe and effective environments, and participant satisfaction with services and outcomes. (3-30-07)

01. Participant Experience Survey (PES). Each participant will have the opportunity to provide feedback to the Department about his satisfaction with self-directed services utilizing the PES. (3-30-07)

02. Participant Experience Outcomes. Participant experience information will be gathered at least annually in an interview by the Department, and will address the following participant outcomes: (3-30-07)

a. Access to care; (3-30-07)

b. Choice and control; (3-30-07)

c. Respect and dignity; (3-30-07)

d. Community integration; and (3-30-07)

e. Inclusion. (3-30-07)

03. Fiscal Employer Agent Quality Assurance Activities. The fiscal employer agent must participate in quality assurance activities identified by the Department such as readiness reviews, periodic audits, maintaining a list of criminal history check waivers, and timely reporting of accounting and satisfaction data. (3-30-07)

04. Community Support Workers and Support Brokers Quality Assurance Activities. Community support workers and support brokers must participate and comply with quality assurance activities identified by the Department including performance evaluations,

satisfaction surveys, quarterly review of services provided by a legal guardian, if applicable, and spot audits of time sheets and billing records. (3-30-07)

05. Participant Choice of Paid Community Support Worker. Paid community support workers must be selected by the participant, or his chosen representative, and must meet the qualifications identified in Section 150 of this rule. (3-30-07)

06. Complaint Reporting and Tracking Process. The Department will maintain a complaint reporting and tracking process to ensure participants, workers, and other supports have the opportunity to readily report instances of abuse, neglect, exploitation, or other complaints regarding the HCBS program. (3-30-07)

07. Quality Oversight Committee. A Quality Oversight Committee consisting of participants, family members, community providers, and Department designees will review information and data collected from the quality assurance processes to formulate recommendations for program improvement. (3-30-07)

08. Quarterly Quality Assurance Reviews. On a quarterly basis, the Department will perform an enhanced review of services for those participants who have waived the criminal history check requirement for a community support worker or who have their legal guardian providing paid services. These reviews will assess ongoing participant health and safety and compliance with the approved support and spending plan. (3-30-07)

201. -- 209. (RESERVED).

210. CONTINUATION OF THE SELF-DIRECTED COMMUNITY SUPPORTS (SDCS) OPTION.
The following requirements must be met or the Department may require the participant to discontinue the SDCS option: (3-30-07)

01. Required Supports. The participant is willing to work with a support broker and a fiscal employer agent. (3-30-07)

a. *The participant can only change FEA services by providing a written request to his current FEA provider at least sixty (60) days in advance, and this change must occur at the end of a fiscal quarter. The request must include the name of the new FEA chosen by the participant and provide the specific date the change will occur.* *( )*

b. *When a participant provides a written request to his current FEA provider to change to a different FEA provider, the current FEA provider must notify the participant of the specific date that the last payroll run will occur at the end of the fiscal quarter.* *( )*

02. Support and Spending Plan. The participant's support and spending plan is being followed. (3-30-07)

03. Risk and Safety Back-Up Plans. Back-up plans to manage risks and safety are being followed. (3-30-07)

04. Health and Safety Choices. The participant's choices do not directly endanger his health, welfare and safety or endanger or harm others. (3-30-07)

211. -- ~~9~~9299. (RESERVED).

FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES (Sections 300 through 314)

300. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES - DEFINITIONS.

For purposes of Sections 300 through 314, the following definitions apply: ( )

01. Employee. A community support worker employed by a participant receiving services under the SDCS option. ( )

02. Employer. A participant receiving services under the SDCS option. ( )

03. Provider. The term "provider" specifically refers to the fiscal employer agent providing financial management services to individuals participating in self-direction. ( )

04. SFTP. Secure *F*ile *T*ransfer *P*rotocol. A secure means of transferring data that allows certain Department staff to access information regarding self-direction participants. *( )*

05. Vendor. Provides goods and services rendered by agencies and independent contractors in accord with a participant's support and spending plan. ( )

06. *Medicaid Billing Report*. A report generated every payroll period by the provider; it provides a list and count of unduplicated *participants* and payroll expenditures by service code, based on the date of service time frame specified by the user. *( )*

301. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES - SELF-DIRECTED COMMUNITY SUPPORTS.

01. Federal Tax ID Requirement. The fiscal employer *agent must* obtain a separate Federal Employer Identification Number (FEIN) specifically to file tax forms and to make tax payments on behalf of program participants under Section 3504 of the Internal Revenue Code (26 USC 3504). In addition, the provider must: *( )*

a. Maintain copies of the participant's FEIN, IRS FEIN notification letter, and Form SS-4 Request for FEIN in the participant's file. ( )

b. Retire participant's FEIN when the participant is no longer an employer under *self-directed community supports (SDCS).* *( )*

02. Requirement to Report Irregular Activities or Practices. The provider must report to the Department any facts regarding irregular activities or practices that may conflict with

federal or state rules and regulations; ( )

03. ***Procedures Restricting FMS to DD Waiver Participant***. The provider must not act as a fiscal employer agent and provide fiscal management services to a*n HCBS DD waiver* participant for whom it also provides any other services funded by the Department. ( )

04. **Policies and Procedures**. The provider must maintain a current manual containing comprehensive policies and procedures. The provider must submit the manual and any updates to the Department for approval. ( )

05. **Key Contact Person**. The provider must provide a key contact person and at least (2) two other people for backup who are responsible for answering calls and responding to e-mails from Department staff and ensure these individuals respond to the Department within one (1) business day. ( )

06. **Face-to-Face Transitional Participant Enrollment**. The provider must conduct face-to-face transitional participant enrollment sessions in group settings *or* with individual participants in their homes or other designated locations. The provider *must* work with the regional Department staff to coordinate and conduct enrollment sessions. *( )*

07. **SFTP Site**. The provider must provide a*n* SFTP site for the Department to access. The site *must* have the capability of allowing participants and their employees to access individual specific information such as time cards and account statements. The site must be user name and password protected. The provider must have the site accessible to the Department upon commencement of the readiness review. *( )*

08. **Required IRS Forms**. The provider must prepare, submit, and revoke the following IRS forms in accordance with IRS requirements and must maintain relevant documentation in each participant's file including: ( )

a. IRS Form 2678; ( )

b. IRS Approval Letter; ( )

c. IRS Form 2678 revocation process; ( )

d. Initial IRS Form 2848; and ( )

e. Renewal IRS Form 2848. ( )

09. **Requirement to Obtain Power of Attorney**. The provider must obtain an Idaho State Tax Commission Power of Attorney (Form TC00110) from each participant it represents and must maintain the relevant documentation in each participant's file. ( )

10. **Requirement to Revoke Power of Attorney**. The provider must revoke the Idaho State Tax Commission Power of Attorney (Form TC00110) when the provider no longer represents the participant and must maintain the relevant documentation in the participant's file. ( )

302. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES - CUSTOMER SERVICE.

01. Customer Service System. The provider must provide a customer service system to respond to all inquiries from participants, employees, agencies, and vendors. The provider must: ( )

a. Provide staff with customer service training with an emphasis on self-direction. ( )

b. Ensure staff are trained and have the skills to assist participants with enrollment and to help them understand their account statements. ( )

c. Ensure that fiscal employer agent personnel are available during regular business hours, 8 a.m. to 5 p.m. Mountain Time, Monday through Friday, excluding state holidays. *( )*

d. Provide translation and interpreter services (i.e., American Sign Language and services for persons with limited English proficiency). ( )

e. Provide prompt and consistent response to verbal and written communication. Specifically: ( )

i. All voice mail messages must be responded to within one (1) business day; and ( )

ii. All written and electronic correspondence must be responded to within five (5) business days. ( )

f. Maintain a toll-free phone line where callers speak to a live person during business hours and are provided the option to leave voice mail at any time, all day, every day. ( )

g. Maintain a toll-free fax line that is available all day, every day, exclusively for participants and their employees. ( )

02. Complaint Resolution and Tracking System. The provider is responsible for receiving, responding to, and tracking all complaints from any source under this agreement. A complaint is defined as a verbal or written expression of dissatisfaction about fiscal employer agent services. The provider must: ( )

a. Respond to all written and electronic correspondence within five (5) days. ( )

b. Respond to verbal complaints within one (1) business day. ( )

c. Maintain an electronic tracking system and log of complaints and resolutions. The electronic log of complaints and resolutions must be accessible for Department review through the SFTP site. ( )

d. Log and track complaints received from the Department pertaining to fiscal employer agent services. ( )

e. Compile a summary report and analyze complaints received on a quarterly basis to determine the quality of services to participants and to identify any corrective action necessary. ( )

f. *Post* the complaint to the SFTP site within twenty-four (24) hours *any day a complaint is received Monday through Friday.* Saturday and Sunday complaints must be posted to the SFTP site by close of business the following Monday. Failure to comply will result in a *fifty dollar (*$50*)* penalty payable to Medicaid within ninety (90) days of incident. *( )*

303. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES - PERSONAL AND CONFIDENTIAL INFORMATION.

The provider must implement and enforce policies and procedures regarding documents that are mailed, faxed, or e-mailed to and from the provider to ensure documents are tracked and that confidential information is not compromised, is stored appropriately and not lost, and is traceable for historical research purposes. ( )

304. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES - ENROLLMENT PROCESS.

01. Submission of Participant Enrollment and Employee Packets for Department Approval. The provider must submit the following for participant enrollment and employee packets to the Department for approval. ( )

a. The participant enrollment packet must include: ( )

i. Fiscal employer agent authorization form; ( )

ii. Employer Appointment of Agent - IRS Form; ( )

iii. Tax Information Form; and ( )

iv. Employer information. The employer information must include: ( )

(1) Instructions for completing forms; ( )

(2) Payroll schedule, including deadlines for submission of time cards; ( )

(3) Sample employment agreements; ( )

(4) Sample Request for Vendor Payment form; ( )

(5) Sample independent provider agreement; and ( )

(6) Other sample employment agreements as needed. ( )

b. The employee enrollment packet must contain: ( )

i. Employee Information Form; ( )

ii. I-9 Employment Eligibility Form; ( )

iii. W-4 Employee Withholding Allowance Certificate; ( )

iv. Pay selection agreement; ( )

v. Direct deposit authorization (optional); ( )

vi. Sample time sheets and instructions for completion; and ( )

vii. IRS Form W-5. ( )

02. Distribution of Participant Enrollment and Employee Packets to Participant after Department Approval. The provider must distribute Department-approved participant enrollment packets and employment packets to the participant within two (2) business days after the participant requests the packets. ( )

a. To enroll a participant, the provider must: ( )

i. Enroll the participant within two (2) business days of receipt of completed paperwork; and ( )

ii. Log and maintain an electronic record of all enrollment paperwork, which includes participant support and spending plan cost and authorization sheets. ( )

b. To enroll an employee, the provider must: ( )

i. Enroll the employee within two (2) business days of receipt of completed paperwork; and ( )

ii. Log and maintain an electronic record of all the employee's paperwork that includes the employment agreements. ( )

305. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES - PAYMENT PROCESS.

01. Process Payroll. The provider must process payroll, including time sheets and taxes, in accordance with the participant's support and spending plan. The payroll process must include: ( )

a. Payment of employer and withholding taxes to State Tax Commission and Internal Revenue Service. ( )

b. Payment of invoices to vendors. ( )

c. Management of participant budget funds as per authorized support and spending plan. ( )

d. Garnishment of wages as per court orders. ( )

e. Preparation of year-end federal and state tax forms. ( )

f. Payment of worker's compensation insurance premiums. ( )

02. Requirement to Track and Log Time Sheet Billing Errors. The provider must track and log time sheet billing errors or time sheets that cannot be paid due to late arrival, missing, or erroneous information. The provider must notify the employee and participant within one (1) business day of when errors are identified on the time sheets. ( )

03. Requirement to Track and Log Improperly Cashed or Improperly Issued Checks. The provider must track and log occurrences of improperly cashed or improperly issued checks and must stop payment on checks when necessary. The provider must reissue lost, stolen, or improperly issued checks at no expense to the participant or the Department within *fourteen (14) calendar days* of when the error occurred. *( )*

04. Process Employee Payments. The provider must verify employees' documentation and process employees' payments via check, direct deposit, or pay cards as per preference of employees. The employee payment process includes: ( )

a. Receipt of time cards from employees via mail, fax, or website by specified due dates. ( )

b. Review time cards for accuracy and verify that timecards contain the following information: ( )

i. Employer name and ID number. ( )

ii. Employee name and ID number. ( )

iii. Hours of work. ( )

iv. Code for service. ( )

c. Match codes to employment agreement to verify rate of pay. ( )

d. Verify that rate of pay multiplied by the hours worked per each pay period is equal to the gross pay. ( )

e. Calculate all taxes and other withholding. ( )

f. Pay employees every two (2) weeks or semi-monthly. ( )

g. Contact participant and representative if there are problems with timecards or other documents in order to resolve issues prior to pay-date, if possible. ( )

h. Maintain an electronic complaint log of payroll issues and resolutions. ( )

i. The provider must verify there is money remaining in each participant's *budget* and specific service category prior to issuing a check. ( )

05. Process Vendor Payments. When participants submit requests for payment to vendors, the provider must: ( )

a. Review, and maintain on file, the vendor payment request with attached voided vendor receipt submitted by the participant. ( )

b. Ensure item or payment is authorized on the participant's support and spending plan. ( )

c. Issue a check made out to the vendor and mail to participant for distribution. Vendor payments are made on the same schedule as payroll. ( )

06. Process Independent Contractor or Outside Agency Payments. When the participant hires an independent contractor or outside agency, in accordance with the support and spending plan, the provider must: ( )

a. Obtain a W-9 from the contractor or agency. ( )

b. Review, and maintain on file, the independent contractor or agency agreement submitted by the participant. ( )

c. Review, and maintain on file, the independent contractor or agency invoice for services submitted by the participant. ( )

d. Ensure service or payment is authorized on the support and spending plan. ( )

e. Issue payment directly to the independent contractor or agency. ( )

07. End-of-Year Processing. For purposes of end-of-year processing, the provider must maintain relevant documentation and must: ( )

a. Refund over-collected *Federal Insurance Contributions Act tax (*FICA*)* to applicable employees, or to state government; ( )

b. Prepare, file, and distribute IRS Form W-2 for each employee; ( )

c. Prepare and file IRS Form W-3 for each participant represented; ( )

d. Prepare and file State Form 957 for state income taxes for each employer; ( )

e. Report and pay any Unclaimed Property per Idaho State Tax Commission rules; and ( )

f. Report and pay all state and federal unemployment insurance premiums. ( )

08. Transition to New FEA*. The following items must be addressed if a participant transitions to a new FEA provider. For the purposes of a smooth transition between FEA providers, the two providers must work closely with one another to transfer the participant from the services one is no longer providing to the services the other is providing. The following items must be transferred:* ( )

a. *Participant's Federal Employer Identification Number (FEIN).* ( )

b. *Mailing address for FEIN.* ( )

c. *IRS Form 2678 Agent/Payer Authorization.* ( )

d. *Depositing taxes and filing report. This includes Federal and State tax withholdings and Federal Unemployment Tax Act tax (FUTA).* ( )

e. *Participant's FUTA Liability Status.* ( )

f. *FICA Exemption Status of Participant Employees.* ( )

g. *FUTA Exemption Status of Participant Employees.* ( )

h. *Unemployment Insurance (U/I).* ( )

i. *Unemployment Insurance Experience Rate and Taxable Wage Base.* ( )

j. *Unemployment Insurance Taxable Wage Base.* ( )

k. *State Unemployment Insurance Liability Status of the Participant.* ( )

l. *State Unemployment Insurance Liability Status of Exempt Employees.* ( )

m. *Unemployment Insurance Filing and Depositing.* ( )

n. *State Income Tax - Account Number.* ( )

o. *State Income Tax - Agent Authorization.* ( )

p. *State Income Tax - Filing and Depositing.* ( )

q. *Budget Authorization - authorized services.* ( )

r. *Budget Authorization - spent and remaining.* ( )

s. *Budget Authorization - authorized providers.* ( )

t. *Budget Authorization - authorized provider rates.* ( )

u. *Participant's Demographic information.* ( )

v. *Participant's Representative demographic information.* ( )

w. *Participant's Employee and provider demographic information.* ( )

x. *Participant's Employee tax and other information.* ( )

y. *Participant's Independent contract and other information.* ( )

z. *Participant's Employee New Hire Reporting.* ( )

aa. *Participant's Employee Liens and Garnishments.* ( )

306. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES - ANNUAL PARTICIPANT SURVEY.

01. Requirement to Conduct Annual Participant Satisfaction Survey. Starting October 1 of each calendar year, each provider who has been providing services for at least six (6) months must conduct an annual participant satisfaction survey. ( )

a. Three (3) weeks prior to the survey launch, the provider must present the questions to the Department staff for approval. ( )

b. Once the questions are approved by the Department, the provider can send out the survey. ( )

c. The provider must survey its participants who receive services under consumer-directed services, such as participants with disabilities, family members of participants, and participants whose primary language is other than English. ( )

d. The provider must provide options for participants to respond to the surveys, other than by mail, for those participants who may not be able to respond by that method. ( )

02. Requirement to Provide Results of Annual Participant Satisfaction Survey. The provider must provide the results of the surveys to the Department in a comprehensive report, along with the completed surveys, by the 15th of December of each calendar year. ( )

307. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES - QUALITY ASSURANCE.

01. Required Elements of Quality Insurance Process. The provider must provide a quality assurance process that includes: ( )

a. Implementation of a quality management plan; ( )

b. Preparation of a quarterly, quality management analysis report; ( )

c. Distribution, collection, and analysis of an annual participant satisfaction survey; and ( )

d. A review of the monthly complaint summary and resolutions, monitoring of standards, and implementation of program improvements as needed. ( )

02. Requirement for Formal Quality Assurance Review. Every two (2) years, the provider must participate in a formal quality assurance review conducted in collaboration with the Department. ( )

308. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES - DISASTER RECOVERY PLAN.

01. Disaster Recovery Plan. The provider must develop and maintain a Disaster Recovery Plan for electronic and hard copy files that includes restoring software and data files, and hardware backup if management information systems are disabled or servers are inoperative. The results of the Disaster Recovery Plan *must* ensure the continuation of payroll and invoice payment systems. The provider must submit the Disaster Recovery Plan for Department approval during the readiness review. *( )*

02. Requirement to Report a Disaster. The provider must report to the Department if management information systems are disabled or servers are inoperative within twenty-four (24) hours of the event. ( )

309. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES - TRANSITION PLAN.

01. Transition Plan Objectives. The provider must provide a transition plan to the Department within ninety (90) days after successful completion of the readiness review. The objectives of the transition plan are to minimize the disruption of services and provide an orderly and controlled transition of the provider's responsibilities to a successor at the conclusion of the agreement period or for any other reason the provider cannot complete responsibilities described in this chapter of rules. ( )

02. Transition Plan Requirements. The transition plan must: ( )

a. Be updated at least ninety (90) days prior to termination of the provider agreement. ( )

b. Include tasks, and subtasks for transition, a schedule for transition, operational resource requirements, and training to be provided. ( )

c. Provide for transfer of data, documentation, files, and other records relevant to the agreement in an electronic format accepted by the Department. ( )

d. Provide for the transfer of any current, Idaho-specific policy and procedure manuals, brochures, pamphlets, and all other written materials developed in support of agreement activity to the Department. ( )

310. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES - PERFORMANCE METRICS.

01. Readiness Review. The provider must complete a readiness review conducted by the Department with the provider prior to providing fiscal employer agent services. ( )

a. Required Level of Expectation: The provider must complete one hundred percent (100%) of the readiness review. ( )

b. Method of Monitoring: The Department will access SFTP site for review of provider documents and conduct an onsite review. ( )

02. Compliance with Tax Regulations and Labor Laws. The provider must ensure each participant's compliance with regulations for both federal taxes and state taxes, as well as all applicable labor laws. ( )

03. Fiscal Support and *Financial* Consultation. *( )*

a. The provider must provide each participant with fiscal support and *financial* consultation. *( )*

b. Required Level of Expectation: The provider must respond to ninety-five percent (95%) of participant calls within two (2) business days and to e-mails within five (5) days. ( )

04. Federal and State Forms Submitted. The provider must ensure each participant's compliance with regulations for both federal taxes and state taxes, including preparation and submission of all federal and state forms for each participant and his employees. ( )

05. Mandatory Reporting, Withholding, and Payment. The provider must perform all mandatory reporting, withholding, and payment actions according to the compliance requirements of the state and federal agencies. ( )

06. Payroll Checks. The provider must issue payroll checks within the two (2) week or semi-monthly payroll cycle, after receipt of completed, approved time sheets. ( )

07. Adherence to Support and Spending Plan. The provider must distribute payments to each participant employee in accordance with participant's support and spending plan. ( )

08. Record Activities. The provider must record all activities in an individual file for each participant and his employees. ( )

09. Records in Participant File. The provider must maintain complete records in

each participant's file. ( )

10. Manage Phone, Fax, and E-mail for Fiscal and Financial Questions. ( )

a. The provider must manage toll-free telephone line, fax, and e-mail related to participant fiscal and financial questions. ( )

b. Required Level of Expectation: The provider must respond to ninety-five percent (95%) of participant queries within two (2) business days. ( )

11. Tracking of Complaints and Complaint Resolution. ( )

a. The provider must maintain a register of complaints from participants, participant employees, and others, with corrective action implemented by the provider within one (1) day of the complaint. ( )

b. Required Level of Expectation: The provider must respond to ninety-five percent (95%) of complaints within one (1) business day. ( )

12. Web Access to Electronic Time Sheet Entry. The provider must maintain web access to electronic time sheet entry for participants. ( )

13. Participant Enrollment Packets and Employment Packets. The provider must prepare and distribute participant enrollment packets and employment packets to each participant. ( )

14. Payroll Spending Summaries. The provider must provide each participant with payroll spending summaries and information about how to read the payroll spending summary each time payroll is executed. ( )

15. Quarterly Reconciliation. Each fiscal quarter after initiating service, the provider must reconcile its *Medicaid Billing* Report to a zero dollar ($0) balance with the Medicaid Bureau of Financial Operations. The provider has ninety (90) days to comply with reconciling each participant's spending plan balance to a zero dollar ($0) balance with Medicaid's reimbursements. ( )

a. Required Level of Expectation: The provider must have one hundred percent (100%) compliance with the required quarterly reconciliation of the *Medicaid Billing* Report. ( )

b. Strategy for Correcting Noncompliance: The provider *must* notify the Department immediately if an issue is identified that may result in the provider not reconciling the *Medicaid Billing* Report. The Department will notify the provider when a performance issue is identified. The Department may require the provider to submit a written corrective action plan for Department approval within two (2) business days after notification. If the provider fails to reconcile within ninety (90) days after the end of each quarter, the provider will be penalized fifty dollars ($50) each week until the provider has reconciled with Medicaid to a zero dollar ($0) balance. ( )

16. **Cash *Management Plan***. Each provider's cash *management plan* must equal one point five (1.5) times the monthly payroll cycle amount. *The cash management plan can be forms of liquid cash and lines of credit.* For example, in the case that the a provider's current payroll minimum has averaged one hundred thousand dollars ($100,000) per payroll cycle, the provider would be required to have *one* hundred fifty thousand dollars ($150,000) in *a cash management plan. The Department must be listed on the notification list if any lines of credit are decreased in the amount accessible or terminated. The expectation is to provide a seamless payroll cycle to the participant, without loss of pay to their employees.* *( )*

311. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES - REPORTS.

01. **Account Summary Statements**. This report provides an overview of each participant account and includes the services accessed and the remaining dollar amount in the budget. In addition to the provider providing this report each month, a participant may request this report for a specified timeframe. Each month, the provider must mail a hard copy of the report to each participant and must also make the report available on a secure website for those who prefer to access the information electronically. The provider must generate the report after every payroll and post it on a secure SFTP site for the Department to access. This SFTP site must have a user name and password protection. ( )

a. Report Format: The provider must provide the account summary statement in Microsoft Excel. ( )

b. Report Due Date: The provider must post the account summary statement by the 10th day of each month. ( )

02. **Medicaid Billing Report**. This report provides a detailed breakdown of *community support worker* services rendered by service date per employee, per employer. Each line on this report must provide, at a minimum, the following information: employee name, employee ID number, hours worked, period start, period end, pay rate, service date, check number, check date, participant's name, participant's date of birth, participant's ID number, service code, taxes, and billing amount. This report collects information based on the timeframe specified by the user. The provider must generate the report after every payroll and post it on a secure SFTP site for the Department to access. This SFTP site must have a user name and password protection. *( )*

a. Report Format: The provider must provide the Medicaid *B*illing *R*eport in Microsoft Excel. *( )*

b. Report Due Date: The provider must post the Medicaid *B*illing *R*eport by the 10th day of each month. *( )*

03. **Demographic Report**. This report provides general client demographics in the region and the employee count per participant for each participant in the database. The provider must generate the report after every payroll and post it on a secure SFTP site for the Department to access. This SFTP site *must* have a user name and password protection. *( )*

a. Report Format: The provider must provide the demographic report in Microsoft Excel. ( )

b. Report Due Date: The provider must post the demographic report by the 10th day of each month. ( )

04. Criminal History Check Report. This report provides a breakdown, by participant, of which employees the participant waived the background check, which employees passed or failed the background check, the criminal history reference number, and the date the background check was submitted. This report does not include support brokers. The provider must generate the report after every payroll and post it on a secure SFTP site for the Department to access. This SFTP site *must* have a user name and password protection. *( )*

a. Report Format: The provider must provide the criminal history report in Microsoft Word, *Microsoft* Excel, *or PDF.* *( )*

b. Report Due Date: The provider must post the criminal history report by the 10th day of each month. ( )

05. *Medicaid Billing* Report. This report provides a list and count of the unduplicated participants and expenditures by services code based on the time frame specified by the user. The provider must generate the report after every payroll and post it on a SFTP site. Additionally, the provider must provide a quarterly *Medicaid Billing* Report that can been reconciled quarterly and must work with the Department to reconcile the annual report. *( )*

a. Report Format: The provider must provide the *Medicaid Billing* Report in Microsoft Excel. *( )*

b. Report Due Date: The provider must post the *Medicaid Billing* Report by 10th day of each month. *( )*

06. Complaint and Resolution Summary Report. The provider must analyze complaints received on a quarterly basis to determine the quality of services to participants and must identify any corrective actions and program improvements needed and implemented. The provider must post the report on a secure SFTP site for Department review. ( )

a. Report Format: The provider must provide the complaint and resolution summary report in Microsoft Word, *Microsoft* Excel, *or PDF.* *( )*

b. Report Due Date: The provider must post the complaint and resolution summary report by the 10th day of the month following the end of each annual quarter. ( )

07. Customer Satisfaction Survey Report. The provider must provide a comprehensive report summarizing the results of the customer satisfaction survey completed by each participant. ( )

a. Report Format: The provider must provide the customer satisfaction survey report in Microsoft Word, *Microsoft* Excel, *or PDF.* *( )*

b. Report Due Date: The provider must post the customer satisfaction survey report by December 1 of each year. ( )

08. Quarterly Financial Statements. The provider must provide the Department a quarterly balance sheet and income statement that shows the provider's quarterly *financial status and cash management plan* cash reserve. *( )*

a. Report Format: The provider must provide the quarterly balance sheet and income statement in Microsoft Word, *Microsoft* Excel, *or PDF.* *( )*

b. Report Due Date: The provider must provide the quarterly balance sheet and income statement on the 25th day of the month following the end of each annual quarter. ( )

312. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES - PAYMENT REQUIREMENTS.

01. Requirement to Accept a Per Member Per Month (PMPM) Payment. The Department will pay, and the provider must accept a per member per month (PMPM) payment that covers a comprehensive set of fiscal employer agent services. *The Department will set allowable reimbursement rates for PMPM based on a methodology approved by CMS in the DD HCBS Waiver.* The provider can only bill the PMPM rate for the months services are actually provided for participants, The provider must provide transition, training, and closeout services during the active agreement, at no additional cost to the Department. *( )*

02. PMPM Payment Process Requirements. The payment (PMPM) *must* include all administrative costs, travel, transition, training, and closeout services. The Department will not pay for participants who do not have a support and spending plan. For the purposes of PMPM payment, one (1) month *must* include all payroll batch dates within that specific calendar month. *( )*

03. Requirement to Complete a Readiness Review. The provider must complete a readiness review prior to billing for services. ( )

313. TERMINATION OF FISCAL EMPLOYER AGENT *PROVIDER AGREEMENTS*.

01. Termination of the Provider Agreement*. The following must occur i*n the event of termination of the provider agreement: *( )*

a. *T*he provider must ensure continuation of services to participants for the period in which a Per Member per Month (PMPM) payment has been made, and must submit the information, reports and records, including the *Medicaid Billing Report* (reconciliation) as specified in Section 310 of these rules. *( )*

b. *The provider must provide to the Department a written notice ninety (90) days in advance and the change notification must occur at the end of the next calendar quarter.* *( )*

02. Termination of Service to Participant*. In the event of termination of the provider*

agreement, the provider must provide to the participant a written notice ninety (90) days in advance. The change notification must occur at the end of the next calendar quarter. *( )*

314. REMEDIES TO NONPERFORMANCE OF A FISCAL EMPLOYER AGENT SERVICE PROVIDER.

01. Remedial Action. If any of the services do not comply with the performance metrics under Section 310 of these rules, the Department will consult with the provider and may, at its sole discretion, require any of the following remedial actions, taking into account the scope and severity of the noncompliance, compliance history, the number of noncompliances, the integrity of the program, and the potential risk to participants. ( )

a. Require the provider to take corrective action to ensure that performance meets the performance metrics under Section 310 of these rules; ( )

b. Reduce payment to reflect the reduced value of services received; ( )

c. Require the provider to subcontract all or part of the service at no additional cost to the Department; or ( )

d. Terminate the provider agreement with notice. ( )

02. Direct Monetary Action. If any of the performance metrics under Section 310 of these rules are not met, the Department will enforce a fifty dollar ($50) a week penalty for each performance metric not met. The penalty will be captured prior to any payment from the Department to the provider. ( )

315. -- 999. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.22 - RESIDENTIAL CARE OR ASSISTED LIVING FACILITIES IN IDAHO

DOCKET NO. 16-0322-0901

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 Section 39-3305, 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 from the proposed text based on comments received during the comment period and at the public hearing. Definitions for "call system" and "exploitation" have been clarified, an interim care plan has been added for both Department clients and private-pay residents, "non-sterile exam gloves" have been added to the list of basic supplies furnished by the facility, added that a call system must provide the resident's right to privacy, amended that the facility must provide written notice of a fee change within five days of the fee change when a resident needs additional care and services.

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 2, 2009, Idaho Administrative Bulletin, Vol. 09-9, pages 139 through 156.

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: NA

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Randy May at (208) 334-5747.

DATED this 19th day of November, 2009.

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

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency and the Board of Health and Welfare has initiated proposed rulemaking procedures. This action is authorized pursuant to Section 39-3305, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held:

WEDNESDAY - SEPTEMBER 9, 2009 - 2:00 p.m.

DHW - MEDICAID CENTRAL OFFICE
3232 Elder Street
Conference Room D
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:

The 2009 Idaho Legislature passed House Bill 146 relating to the Idaho Residential Care or Assisted Living Act. This bill amended payment level requirements for residents who are not clients of the Department (private-pay). This law requires a facility to assess a private-pay resident for his needs and types of services and supports through the assessment and individual negotiated service agreement. The rate charged for a private-pay resident will be determined based on his needs including furnishings, equipment, supplies and basic services that he requires.

These rule changes require that certain information be provided by the facility to the resident prior to admissions that discloses how an assessment is made for needed services, rates and fee structure, how fee increases must be handled, and discharge or transfer of residents due to change in condition of resident and fee increases.

These rules are also being amended to update the Department's unit responsible for Licensing and Certification, as well as the website. Only sections that are being published in this rule docket have the underline/strike out text for this update.

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. 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 April 1, 2009, Idaho Administrative Bulletin, Vol. 09-4, Page 17.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Randy May at (208) 334-5747.

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 23, 2009.

DATED this 31st day of July, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

003. ADMINISTRATIVE APPEALS AND CONTESTED CASES.

01. Administrative Appeals and Contested Cases. Administrative appeals and contested cases are governed by IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (3-30-06)

02. Informal Dispute Resolution Meeting. If a facility disagrees with a deficiency cited for a core issue, it may request an informal dispute resolution meeting to the ~~*Bureau of Facility Standards*~~ Licensing and Certification Unit. The policy and procedure for requesting informal dispute resolution is posted on the Licensing and ~~*Survey Agency*~~ Certification website at http://www.~~*facilitystandards*~~healthandwelfare.idaho.gov/Medical/LicensingCertification/tabid/124/Default.aspx. ~~*(3-30-06)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- 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. (3-30-06)

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. (3-30-06)

03. Street Address. The business office of the Idaho Department of Health and

Welfare is located at 450 West State Street, Boise, Idaho 83702. (3-30-06)

04. Telephone. (208) 334-5500. (3-30-06)

05. Internet Website Address. The Department Internet website address is: http://www.healthandwelfare.idaho.gov. (3-30-06)

06. Licensing and ~~*Survey Agency*~~ Certification Unit. The Department's Licensing and ~~*Survey Agency*~~ Certification Unit, 3232 Elder Street, Boise, ID 83705; Phone: 208 334-6626. ~~*(3-30-06)*~~( )

07. Licensing and ~~*Survey Agency*~~ Certification Unit Website. http://www.~~*facilitystandards*~~healthandwelfare.idaho.gov/Medical/LicensingCertification/tabid/124/Default.aspx. ~~*(3-30-06)*~~( )

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS REQUESTS.

01. Confidential Records. Any information about an individual covered by these rules and contained in Department records must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records." (3-30-06)

02. Public Records. The Department of Health and Welfare will comply with Sections 9-337 through 9-350, Idaho Code, when requests for the examination and copying of public records are made. Public records in the custody of the Department of Health and Welfare are subject to disclosure, unless otherwise exempted by state and federal law. (3-30-06)

03. Disclosure of Resident Identity. Information received by the Department through filed reports, inspections, or as otherwise authorized under the law, will not be disclosed publicly in such a manner as to identify individual residents except as necessary in a proceeding involving a question of licensure. (3-30-06)

04. Public Availability of Deficiencies. The survey documents relating to a facility will be available to the public upon written request to the Department and posted on the Licensing and ~~*Survey Agency*~~ Certification website at http://www.healthandwelfare.idaho.gov/Medical/LicensingCertification/tabid/124/Default.aspx ~~*(3-30-06)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

010. DEFINITIONS AND ABBREVIATIONS A THROUGH E.

01. Abuse. The non-accidental act of sexual, physical or mental mistreatment, or injury of a resident through the action or inaction of another individual. (3-30-06)

02. Accident. An unexpected, unintended event that can cause a resident injury. (3-30-06)

03. Activities. All organized and directed social and rehabilitative services a facility provides, arranges, or cooperates with. (3-30-06)

04. Activities of Daily Living. The performance of basic self-care activities in meeting an individual's needs to sustain him in a daily living environment, including bathing, washing, dressing, toileting, grooming, eating, communicating, continence, and mobility. (3-30-06)

05. Administrator. An individual, properly licensed by the Bureau of Occupational Licensing, who is responsible for day to day operation of a residential care or assisted living facility. (3-30-06)

06. Adult. A person who has attained the age of eighteen (18) years. (3-30-06)

07. Advance Directive. A written instruction, such as a living will or durable power of attorney for health care, recognized under State Law, whether statutory or as recognized by the courts of the State, and relates to the provision of medical care when the individual is unable to communicate. (3-30-06)

08. Advocate. An authorized or designated representative of a program or organization operating under federal or state mandate to represent the interests of a population group served by a facility. (3-30-06)

09. Ambulatory Person. A person who, unaided by any other person, is physically and mentally capable of walking a normal path to safety, including the ascent and descent of stairs. (3-30-06)

10. Assessment. The conclusion reached using uniform criteria which identifies resident strengths, weaknesses, risks and needs, to include functional, medical and behavioral needs. (3-30-06)

11. Authentication. Proof of authorship. (3-30-06)

12. Authorized Provider. An individual who is a nurse practitioner or clinical nurse specialist or physician assistant. (3-30-06)

13. Basement. That portion of a building that is partly or completely below grade plane. A basement will be considered as a story above grade plane where the finished surface of the floor above the basement is: (1) More than six (6) feet (1829 mm) above grade plane; (2) More than six (6) feet (1829 mm) above the finished ground level for more than fifty percent (50%) of the total building perimeter; or (3) More than twelve (12) feet (3658 mm) above the finished ground level at any point. International Building Code-2003. (3-30-06)

14. Behavioral Plan. A written plan which decreases the frequency or intensity of maladaptive behaviors and increases the frequency of adaptive behaviors and introduces new skills. (3-30-06)

15. Call System. A signaling system whereby a resident can contact staff directly

from their sleeping room, toilet room, and bathing area. The system may be voice communication; an audible or visual signal; and, may include wireless technology. *The call system cannot be configured in such a way as to breach a resident's right to privacy at the facility. including but not limited to, the resident's living quarters, common areas, medical treatment and other services, written and telephonic communications, or in visits with family, friends, advocates, and resident groups.* ~~*(3-30-06)*~~*( )*

16. Chemical Restraint. A medication used to control behavior or to restrict freedom of movement and is not a standard treatment for the resident's condition. (3-30-06)

17. Client of the Department. Any person who receives financial aid, or services, or both from an organized program of the Department. (3-30-06)

18. Complaint. A formal expression of dissatisfaction, discontent, or unhappiness by or on behalf of a resident concerning the care or conditions at the facility. This expression could be oral, in writing, or by alternative means of communication. (3-30-06)

19. Complaint Investigation. A survey to investigate the validity of allegations of noncompliance with applicable state requirements. (3-30-06)

20. Core Issue. A core issue is any one (1) of the following: abuse; neglect; exploitation; inadequate care; a situation in which the facility has operated for more than thirty (30) days without a licensed administrator designated the responsibility for the day to day operations of the facility; inoperable fire detection or extinguishing systems with no fire watch in place pending the correction of the system; or surveyors denied access to records, residents or facilities. (3-30-06)

21. Criminal Offense. Any crime as defined in Section 18-111, Idaho Code, in 18 U.S.C. Section 4A1.2(o), and 18 U.S.C. Sections 1001 through 1027. (3-30-06)

22. Deficiency. A determination of non-compliance with a specific rule or part of a rule. (3-30-06)

23. Dementia. A chronic deterioration of intellectual function and other cognitive skills severe enough to interfere with the ability to perform activities of daily living and instrumental activities of daily living. (3-30-06)

24. Department. The Idaho Department of Health and Welfare. (3-30-06)

25. Developmental Disability. A developmental disability, as defined in Section 66-402, Idaho Code, means chronic disability of a person which appears before the age of twenty-two (22) years of age and: (3-30-06)

a. Is attributable to an impairment, such as mental retardation, cerebral palsy, epilepsy, autism, or other conditions found to be closely related to or similar to one (1) of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments; and (3-30-06)

b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity; self-care, receptive and expressive language, learning, mobility, self-direction, capacity of independent living, or economic self-sufficiency; and (3-30-06)

c. Reflects the need for a combination and sequence of special, interdisciplinary or direct care, treatment or other services which are of life-long or extended duration and individually planned and coordinated. (3-30-06)

26. Director. The Director of the Idaho Department of Health and Welfare or his designee. (3-30-06)

27. Electronic Signature, E-Signature. The system for signing electronic documents by entering a unique code or password that verifies the identity of the person signing and creates an individual "signature" on the record. (3-30-06)

28. Exit Conference. A meeting with the facility administrator or designee to: (1) provide review, discussion and written documentation of non-core issues (Punch List), and (2) to provide preliminary findings of core issues. (3-30-06)

29. Exploitation. The misuse of a resident's funds, property, resources, identity or person for profit or advantage~~.~~, *for example*: ~~*(3-30-06)*~~*( )*

a. Charging a resident for services or supplies not provided; or ( )

b. Charging a resident for services or supplies not disclosed in the written admission agreement between the resident and the facility. ( )

011. DEFINITIONS AND ABBREVIATIONS F THROUGH M.

01. Follow-Up Survey. A survey conducted to confirm that the facility is in compliance and has the ability to remain in compliance. (3-30-06)

02. Functional Abilities Assessment. An assessment of the resident's degree of independence with which the resident performs activities of daily living and instrumental activities of daily living. (3-30-06)

03. Governmental Unit. The state, any county, municipality, or other political subdivision or any Department, division, board, or other agency thereof. (3-30-06)

04. Grade Plane. A reference plane representing the average of finished ground level adjoining the building at exterior walls. Where the finished ground level slopes away from the exterior walls, the reference plane will be established by the lowest points within the area between the building and the lot line or, where the lot line is more that six (6) feet (1829 mm) from the building, between the building and a point six (6) feet (1829 mm) from the building. International Building Code - 2003. (3-30-06)

05. Hands On. Physical assistance to the resident beyond verbal prompting. (3-30-06)

06. Hourly Adult Care. Nonresident daily services and supervision provided by a facility to individuals who are in need of supervision outside of their personal residence for a portion of the day. (3-30-06)

07. Immediate Danger. Any resident is subject to an imminent or substantial danger. (3-30-06)

08. Inadequate Care. When a facility fails to provide the services required to meet the terms of the Negotiated Service Agreement, or provide for room, board, activities of daily living, supervision, first aid, assistance and monitoring of medications, emergency intervention, coordination of outside services, a safe living environment, or engages in violations of resident rights or takes residents who have been admitted in violation of the provisions of Section 39-3307, Idaho Code. (3-30-06)

09. Incident. An event that can cause a resident injury. (3-30-06)

10. Incident, Reportable. A situation when a facility is required to report information to the Licensing and ~~*Survey Agency*~~ Certification Unit. ~~*(3-30-06)*~~( )

a. Resident injuries of unknown origin. This includes any injury, the source of which was not observed by any person or the source of the injury could not be explained by the resident; or the injury includes severe bruising on the head, neck, or trunk, fingerprint bruises anywhere on the body, laceration, sprains, or fractured bones. Minor bruising and skin tears on the extremities need not be reported. (3-30-06)

b. Resident injury resulting from accidents involving facility-sponsored transportation. Examples: falling from the facility's van lift, wheel chair belt coming loose during transport, or an accident with another vehicle. (3-30-06)

c. Resident elopement of any duration. Elopement is when a resident who is unable to make sound decisions physically leaves the facility premises without the facility's knowledge. (3-30-06)

d. An injury due to resident-to-resident incident. (3-30-06)

e. An incident that results in the resident's need for hospitalization, treatment in a hospital emergency room, fractured bones, IV treatment, dialysis, or death. (3-30-06)

11. Independent Mobility. A resident's ability to move about freely of their own choice with or without the assistance of a mobility device such as a wheelchair, cane, crutches, or walker. (3-30-06)

12. Instrumental Activities of Daily Living. The performance of secondary level of activities that enables a person to live independently in the community, including preparing meals, access to transportation, shopping, laundry, money management, housework, and medication management. (3-30-06)

13. Legal Guardian or Conservator. A court-appointed individual who manages the

affairs or finances or both of another who has been found to be incapable of handling his own affairs. (3-30-06)

14. **License**. A permit to operate a facility. (3-30-06)

15. **Licensing and ~~*Survey Agency*~~ Certification Unit**. The section of the Department responsible for licensing and surveying residential care or assisted living facilities.
~~*(3-30-06)*~~( )

16. **Medication**. Any substance or drug used to treat a disease, condition, or symptom, which may be taken orally, injected, or used externally and is available through prescription or over-the-counter. (3-30-06)

17. **Medication Administration**. It is a process where a prescribed medication is given to a resident by one (1) of several routes by licensed nurses. (3-30-06)

18. **Medication Assistance**. The process whereby a non-licensed care provider is delegated tasks by a licensed nurse to aid a person who cannot independently self-administer medications. IDAPA 23.01.01. "Rules of the Idaho State Board of Nursing," Section 010.
(3-30-06)

19. **Medication Dispensing**. The act of filling, labeling and providing a prescribed medication to a resident. (3-30-06)

20. **Medication, Self-Administration**. The act of a resident taking a single dose of his own medication from a properly labeled container and placing it internally in, or externally on, his own body as a result of an order by a authorized provider. (3-30-06)

21. **Mental Disorders**. Health conditions that are characterized by alterations in thinking, mood or behavior (or some combination thereof), that are all mediated by the brain and associated with distress and or impaired functioning. (3-30-06)

22. **Mental Illness**. Refers collectively to all diagnosable mental disorders. (3-30-06)

23. **Monitoring Visit**. A visit by a representative of the Licensing and ~~*Survey Agency*~~ Certification Unit for the purpose of assuring residents are not in immediate danger.
~~*(3-30-06)*~~( )

24. **Neglect**. Failure to provide food, clothing, shelter, or medical care necessary to sustain the life and health of a resident. (3-30-06)

25. **Negotiated Service Agreement**. The plan reached by the resident and/or their representative and the facility based on the assessment, physician or authorized provider's orders, admission records, and desires of the resident, and which outlines services to be provided and the obligations of the facility and the resident. (3-30-06)

26. **Non-Core Issue**. Any finding of deficiency that is not a core issue. (3-30-06)

(BREAK IN CONTINUITY OF SECTIONS)

215. REQUIREMENTS FOR A FACILITY ADMINISTRATOR.
Each facility must be organized and administered under one (1) licensed administrator assigned as the person responsible for the operation of the facility. Multiple facilities under one (1) administrator may be allowed by the Department based on an approved plan of operation. (3-30-06)

01. Administrator Responsibility. The administrator is responsible for assuring that policies and procedures required in Title 39, Chapter 33, Idaho Code and IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho" are implemented. (3-30-06)

02. Availability of Administrator. The facility's administrator must be on site sufficiently to provide for safe and adequate care of the residents to meet the terms in the Negotiated Service Agreement. The facility's administrator or his designee must be available to be on-site at the facility within two (2) hours. (3-30-06)

03. Thirty Day Operation Limit. The facility may not operate for more than thirty (30) days without a licensed administrator. (3-30-06)

04. Representation of Residents. The administrator, his relatives, or employees cannot act as or seek to become the legal guardian of, or have power of attorney for any resident. Specific limited powers of attorney to address emergency procedures where competent consent cannot otherwise be obtained are permitted. (3-30-06)

05. Responsibility for Acceptable Admissions. The administrator must assure that no resident is knowingly admitted or retained who requires care as defined in Section 39-3307, Idaho Code, and Subsection 152.05 of these rules. (3-30-06)

06. Sexual Offender. The administrator must assure that a non-resident on the sexual offender registry is not allowed to live or work in the facility. The registry may be accessed at http://www.isp.state.id.us/sor_id/. (3-30-06)

07. Notification of Adult Protection and Law Enforcement. The administrator must assure that adult protection and law enforcement are notified in accordance with Section 39-5310, Idaho Code. (3-30-06)

08. Procedures for Investigations. The administrator must assure the facility procedures for investigation of incidents, accidents, and allegations of abuse, neglect, or exploitation are implemented to assure resident safety. (3-30-06)

09. Notification of Reportable Incidents. The administrator must assure notification to the Licensing and ~~*Survey Agency*~~ Certification Unit of reportable incidents. ~~*(3-30-06)*~~( )

10. Administrator's Designee. A person authorized in writing to act in the absence of the administrator and who is knowledgeable of facility operations, the residents and their needs, emergency procedures, the location and operation of emergency equipment, and how the

administrator can be reached in the event of an emergency. (3-30-06)

11. Ability to Reach Administrator or Designee. The administrator or his designee must be reachable and available at all times. (3-30-06)

12. Minimum Age of Personnel. The administrator will assure that no personnel providing hands-on care or supervision services will be under eighteen (18) years of age unless they have completed a certified nursing assistant (CNA) certification course. (3-30-06)

13. Notification to Licensing and Certification Unit. The facility must notify the Licensing and Certification Unit, in writing, within three (3) business days of a change of administrator. ( )

216. -- 21~~9~~8. (RESERVED).

219. REQUIREMENTS FOR ADMISSION AGREEMENTS FOR DEPARTMENT CLIENTS.

01. Initial Resident Assessment. Prior to or on the day of admission each resident must be assessed *by the facility* to ensure the resident is appropriate for placement in a residential care or assisted living facility. *( )*

02. *Interim Care Plan*. *The facility must develop an interim care plan to guide services until the Department's assessment outlined in Section 660 of these rules is complete. The Department will complete a resident assessment w*ithin twelve (12) *business* days of *receiving notification that the participant is financially eligible for waiver services*. The result of the assessment will determine the need for specific services and supports and establish the reimbursement rate for those services. *( )*

03. Written Agreement. The admission agreement may be integrated within the Negotiated Service Agreement, provided that all requirements for the Negotiated Service Agreement in Section 320 of these rules are met. ( )

220. REQUIREMENTS FOR ADMISSION AGREEMENTS FOR PRIVATE-PAY RESIDENTS.

01. *Initial* Resident Assessment *and Care Plan*. Prior to or on the day of admission, each private-pay resident must be assessed *by the facility to ensure the resident is appropriate for placement in their residential care or assisted living facility. The facility must develop an interim care plan to guide services until the facility can complete the resident assessment process outlined* in Section 650 of these rules. The result of the assessment will determine the need for specific services and supports. *( )*

02. Written Agreement. Prior to or on the day of admission, the facility and each resident or the resident's legal guardian or conservator ~~*will*~~ must enter into a written admission agreement that is transparent, understandable, and is translated into a language the resident or his representative understands. The admission agreement will provide a complete reflection of the facility's charges, commitments agreed to by each party, and the actual practices that will occur in

the facility. The agreement must be signed by all involved parties, and a complete copy provided to the resident and the resident's legal guardian or conservator prior to or on the day of admission. The admission agreement may be integrated within the Negotiated Service Agreement, provided that all requirements for the Negotiated Service Agreement in Section 320 of these rules and the admission agreement are met. Admission agreements must include all items described under Subsections 220.0~~1~~3 through 220.1~~3~~8 of ~~these~~ this rule~~s~~. ~~(3-30-06)~~( )

0~~1~~3. Services ~~Provided~~, Supports, and Rates. ~~Services t~~The facility ~~provides including: room, board, assistance with activities of daily living, supervision, assistance and monitoring of medications, laundering of linens owned by the facility, coordination of outside services, arrangement for routine, urgent, and emergency medical and dental services, emergency interventions, housekeeping services, maintenance, utilities, access to basic television in common areas, maintenance of self help skills, recreational activities, and provisions for trips to social functions.~~ must identify the following services, supports, and applicable rates: ~~(3-30-06)~~( )

a. *Unless otherwise negotiated with the resident, the resident's legal guardian or conservator, b*asic services must, at a minimum, include: *( )*

i. Rent; ( )

ii. Utilities; ( )

iii. Food; ( )

iv. Activities of daily living services; ( )

v. Supervision; ( )

vi. First aid; ( )

vii. Assistance with and monitoring of medications; ( )

viii. Laundering of linens owned by the facility; ( )

ix. Emergency interventions and coordination of outside services; ( )

x. *Routine h*ousekeeping and maintenance *of common areas*; and *( )*

xi. Access to basic television in common areas. ( )

b. The resident's monthly charges must be specific and describe the services that are included in the basic services rate and the charged rate. ( )

c. The facility must disclose all prices, formulas, and calculations used to determine the resident's basic services rate including: ( )

i. Service packages; ( )

ii. Fee-for-service rates; ( )

iii. Assessment forms; ( )

iv. Price per assessment point; ( )

v. Charges for levels of care determined with an assessment; and ( )

vi. Move-in fees or other similar charges. ( )

d. Services or amenities that are not contained in the description of basic services are considered additional services. The facility must describe the services and rates charged for additional or optional services, supplies, or amenities that are available through the facility or arranged for by the facility for which the resident will be charged additional fees. ( )

e. Services or rates that are impacted by an updated assessment of the resident must be identified, as well as the assessment tool, the assessor, and the frequency of the assessment, when the facility uses this assessment to determine rate changes. ( )

f. The facility may charge residents for the use of personal furnishings, equipment, and supplies provided by the facility for private-pay residents. The facility must provide a detailed itemization of furnishings, equipment, supplies, and the rate for those items the resident will be charged. ( )

02~~3~~4. Staffing. *The facility must identify s*taffing patterns and qualification of staff on duty during a normal day. *~~(3-30-06)~~( )*

03~~4~~5. Notification of Liability Insurance Coverage. The administrator of a residential care or assisted living facility must disclose in writing at the time of admission or before a resident's admission if the facility does not carry professional liability insurance. If the facility cancels the professional liability insurance all residents must be notified of the change in writing. (3-30-06)

04~~5~~6. Medication Responsibilities. The facility's and resident's roles and responsibilities relating to assistance with medications including the reporting of missed doses or those taken on a PRN basis. (3-30-06)

05~~6~~7. Resident Personal Fund Responsibilities. Who is responsible for the resident's personal funds. (3-30-06)

06~~7~~8. Resident Belongings Responsibility. *The agreement must identify ~~R~~r*esponsibility for protection and disposition of all valuables belonging to the resident and provision for the return of resident's valuables if the resident leaves the facility. *~~(3-30-06)~~( )*

07~~8~~9. *~~Fee Description and~~* Emergency Transfers. *~~Fee description and~~ The agreement must identify* conditions under which emergency transfers will be made as provided in Section 152 of these rules. *~~(3-30-06)~~( )*

10. **Billing Practices, Notices, and Procedures for Payments and Refunds**. The facility must provide a description of the facility's billing practices, notices, and procedures for payments and refunds. The following procedures must be included: ( )

a. Arrangement for payments; (3-30-06)

b. ~~*How*~~ Under what circumstances and time frame a partial month's resident fees are to be refunded when a resident no longer resides in the facility; ~~*(3-30-06)*~~( )

c. Written notice to vacate the facility must be given thirty (30) calendar days prior to transfer or discharge on the part of either party except in the ~~*following situations;*~~ ~~*(3-30-06)*~~

~~*i.*~~ ~~*In the*~~ case of the resident's emergency discharge or death~~*, fifteen (15) days notice is required. The date of death begins the fifteen (15) days notice requirement; and*~~ ~~*(3-30-06)*~~

~~*ii.*~~ ~~*In the case of an emergency condition that requires a resident's transfer, fifteen (15) days notice is required. The date of transfer starts*~~ the facility may charge up to fifteen (15) days ~~*notice requirement*~~ prorated rent from the date of the resident's emergency discharge or death. ~~*(3-30-06)*~~( )

~~*09*~~**11. Resident Permission to Transfer Information**. *The agreement must clarify* ~~*P*~~permission to transfer information from the resident's records to any facility to which the resident transfers. ~~*(3-30-06)*~~*( )*

~~*09*~~**12. Resident Responsibilities**. Resident responsibilities, as appropriate. (3-30-06)

1~~0~~3. Restrictions on Choice of Care or Service Providers. Any restriction on choice of care or service providers, such as pharmacy, home health agency, hospice agency, physician or authorized provider. (3-30-06)

1~~1~~4. Advance Directive. *The agreement must identify* ~~*W*~~*w*ritten documentation of the resident's preference regarding the formulation of an Advance Directive in accordance with Idaho state law. When a resident has an Advanced Directive, a copy must be immediately available for staff and emergency personnel. ~~*(3-30-06)*~~*( )*

1~~2~~5. Notification of Payee Requirements. Notification if the facility requires as a condition of admission that the administrator or an employee of the facility be named as payee~~*; and*~~. ~~*(3-30-06)*~~( )

16. Contested Charges. The facility must provide the methods by which a resident may contest charges or rate increases that include contacting the Ombudsman for the Elderly. The facility must respond as provided under Section 711.02 of these rules. ( )

17. Transition to Publicly-Funded Program. The facility must disclose the conditions under which the resident can remain in the facility, if payment for the resident shifts to a publicly-funded program. ( )

1~~3~~8. Other Information. *The agreement must identify* ~~*O*~~*o*ther information that the

facility may deem appropriate. ~~*(3-30-06)*~~*( )*

(BREAK IN CONTINUITY OF SECTIONS)

250. REQUIREMENTS FOR BUILDING CONSTRUCTION AND PHYSICAL STANDARDS.

01. Building Character. All buildings utilized as residential care or assisted living facilities must be of such character as to be suitable for such use. Facilities must be of such character as to enhance normalization and integration of residents into the community. (3-30-06)

02. Plans and Specifications. Plans and specifications for any proposed new facility construction, any addition or remodeling are governed by the following: (3-30-06)

a. Plans must be prepared by an architect or engineer licensed in the state of Idaho. A variance of this requirement may be granted by the Licensing and Survey Agency when the size of the project does not necessitate involvement of an architect or engineer; (3-30-06)

b. Plans and specifications must be submitted to the Licensing and Survey Agency to assure compliance with applicable construction standards, codes, and regulations; (3-30-06)

c. Newly constructed or converted buildings housing ~~*sixteen*~~ seventeen (1~~6~~7) or more residents must submit professionally prepared drawings or plans of the kitchen and a listing of all kitchen equipment for review and approval prior to construction. ~~*(3-30-06)*~~*( )*

03. Remodeling or Additions. Remodeling of or additions to a facility will be consistent with all applicable fire and life safety requirements. (3-30-06)

04. Approval. All buildings, additions and remodeling are subject to approval by the Licensing and Survey Agency and must meet applicable requirements. (3-30-06)

05. Walls and Floor Surfaces. Walls and floors must be of such character to permit cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have washable surfaces. (3-30-06)

06. Toilet and Bathrooms. Each facility must provide: (3-30-06)

a. A toilet and bathroom for resident use so arranged that it is not necessary for an individual to pass through another resident's room to reach the toilet or bath; (3-30-06)

b. Solid walls or partitions to separate each toilet and bathroom from all adjoining rooms; (3-30-06)

c. Mechanical ventilation to the outside from all inside toilets and bathrooms not provided with an operable exterior window; (3-30-06)

d. Each tub, shower, and lavatory with hot and cold running water; (3-30-06)

e. At least one (1) flush toilet for every six (6) residents; (3-30-06)

f. At least one (1) tub or shower for every eight (8) residents; (3-30-06)

g. At least one (1) lavatory with a mirror for each toilet; and (3-30-06)

h. At least one (1) toilet, tub or shower, and lavatory in each building in which residents sleep, with additional units if required by the number of persons. (3-30-06)

07. Accessibility for Persons With Mobility and Sensory Impairments. For residents with mobility or sensory impairments, the facility must provide a physical environment which meets the needs of the person for independent mobility and use of appliances, bathroom facilities, and living areas. New construction must meet the requirements of the Americans with Disabilities Act Accessibility Guidelines (ADAAG). Existing facilities must comply, to the maximum extent feasible, with 28 CFR Sections 36.304 and 36.305 regarding removal of barriers under the Americans with Disabilities Act, without creating an undue hardship or burden on the facility, and must provide as required, the necessary accommodations: (3-30-06)

a. Ramps for residents who require assistance with ambulation shall comply with the requirements of the ADAAG 4.8; (3-30-06)

b. Bathrooms and doors large enough to allow the easy passage of a wheelchair as provided for in the ADAAG 4.13; (3-30-06)

c. Grab bars in resident toilet and bathrooms in compliance with ADAAG 4.26; (3-30-06)

d. Toilet facilities in compliance with ADAAG 4.16 and 4.23; (3-30-06)

e. Non-retractable faucet handles in compliance with ADAAG 4.19, with the exception of self-closing valves under 4.19.5, and 4.27; and (3-30-06)

f. Suitable hand railing must be provided on both sides of all stairs leading into and out of a building for residents who require the use of crutches, walkers, or braces. (3-30-06)

08. Lighting. The facility must provide adequate lighting in all resident sleeping rooms, dining rooms, living rooms, recreation rooms, and hallways. (3-30-06)

09. Ventilation. The facility must be ventilated, and precautions shall be taken to prevent offensive odors. (3-30-06)

10. Plumbing. All plumbing in the facility must comply with local and state codes. All plumbing fixtures must be easily cleanable and maintained in good repair. The temperature of hot water at plumbing fixtures used by residents must be between one hundred five degrees (105°F) Fahrenheit and one hundred twenty degrees (120°F) Fahrenheit. (3-30-06)

11. Heating. A heating system must be provided for the facility that is capable of maintaining a minimum temperature of seventy degrees (70°F) Fahrenheit during the day and a minimum of sixty-two degrees (62°F) Fahrenheit during the night. Wood stoves are not be permitted as the sole source of heat and the thermostat for the primary source of heat must be remotely located away from any wood stove. (3-30-06)

12. Dining, Recreation, Shower, Bathing and Living Space. The total area set aside for these purposes must be no less than thirty (30) square feet per licensed bed. A hall or entry can not be included as living or recreation space. (3-30-06)

13. Resident Sleeping Rooms. The facility must assure that: (3-30-06)

a. Resident sleeping rooms are not in attics, stairs, halls, or any other room commonly used for other than bedroom purposes; (3-30-06)

b. A room with a window that opens into an exterior window well cannot be used for a resident sleeping room; (3-30-06)

c. Not more than four (4) residents can be housed in any multi-bed sleeping room in facilities licensed prior to July 1, 1991. New facilities or building converted to a licensed facility after July 1, 1992, cannot have more than two (2) residents in any multi-bed sleeping room. When there is any change in ownership of the facility, the maximum number of residents allowed in any room is two (2); (3-30-06)

d. Square footage requirements for resident sleeping rooms must provide for not less than one hundred (100) square feet of floor space per resident in a single-bed sleeping room and not less than eighty (80) square feet of floor space per resident in a multi-bed sleeping room; (3-30-06)

e. Each resident's sleeping room must be provided with an operable exterior window. An operable window is not required where there is a door directly to the outside from the sleeping room; (3-30-06)

f. The operable window sill height must not exceed thirty-six (36) inches above the floor in new construction, additions, or remodeling; (3-30-06)

g. The operable window sill height must not exceed forty-four (44) inches above the floor in existing buildings being converted to a facility; (3-30-06)

h. Each resident sleeping room must provide a total window space that equals at least eight percent (8%) of the room's total square footage; (3-30-06)

i. Window screens must be provided on operable windows; (3-30-06)

j. Resident sleeping rooms must have walls that run from floor to ceiling; have doors that will limit the passage of smoke; and provide the resident(s) with privacy; (3-30-06)

k. Ceiling heights in sleeping rooms must be at least seven (7) feet, six (6) inches;

and (3-30-06)

l. Closet space in each resident sleeping room must provide at least four (4) usable square feet per resident. Common closets used by two (2) or more residents must have substantial dividers for separation of each resident's clothing. All closets must be equipped with doors. Free-standing closets are deducted from the square footage of the sleeping room. (3-30-06)

14. Secure Environment. If the facility accepts and retains residents who have cognitive impairment, the facility must provide an interior environment and exterior yard which is secure and safe. (3-30-06)

15. Call System. The facility must have a call system *available for each resident to call for assistance and still be assured a resident's right to privacy at the facility, including but not limited to, the resident's living quarters, common areas, medical treatment and other services, written and telephonic communications, or in visits with family, friends, advocates, and resident groups*. The call system cannot be a substitute for supervision. For facilities licensed prior to January 1, 2006, when the current system is no longer operational or repairable the facility must install a call system as defined in *Section 010 of* these rules. *(3-30-06)( )*

16. Dietary Standards. Each facility must have a full service kitchen to meet the needs of the residents. Any satellite kitchen must meet all applicable requirements. (3-30-06)

(BREAK IN CONTINUITY OF SECTIONS)

430. REQUIREMENTS FOR FURNISHINGS, EQUIPMENT, SUPPLIES, AND BASIC SERVICES.

Each facility must provide *at no additional cost* to the resident: *(3-30-06)( )*

01. Common Shared Furnishings. Appropriately designed and constructed furnishings to meet the needs of each resident, including reading lamps, tables, and comfortable chairs or sofas*;*. *a*All items must be in good repair, clean, *and* safe, and provided at no additional cost to the resident. *(3-30-06)( )*

02. Resident Sleeping Room Furnishings. Comfortable furnishings and individual storage, such as a dresser, for personal items for each resident in each sleeping room*;*. *a*All items must be in good repair, clean, and safe. *(3-30-06)( )*

03. Resident Bed. Each resident must be provided his own bed, which will be at least thirty-six (36) inches wide, substantially constructed, clean, and in good repair. Roll-away beds, cots, futons, folding beds, or double bunks are prohibited. Bed springs must be in good repair*; and*, clean, and comfortable. Bed mattresses must be standard for the bed, clean, and odor free. A pillow must be provided. *(3-30-06)( )*

04. Resident Telephone Privacy. The facility must have at least one (1) telephone that is accessible to all residents, and provide local calls at no additional cost. The telephone must be placed in such a manner as to provide the resident privacy while using the telephone.

~~*(3-30-06)*~~( )

05. Basic Services. The following are basic services to be provided to the resident by the facility ~~*at no additional cost to the resident*~~ within the basic services rate: ~~*room, board*~~ ( )

a. Rent; ( )

b. Utilities; ( )

c. Food; ( )

d. Activities of daily living services~~,~~; ( )

e. ~~s~~Supervision; ( )

f. First aid; ( )

g. Assistance with and monitoring of medications; ( )

h. Laundering of linens owned by the facility; ( )

i. Emergency interventions and coordination of outside services~~, arrangement for emergency transportation, emergency interventions, first aid,~~ ( )

j. *Routine* ~~*H*~~*h*ousekeeping ~~*services,*~~ and maintenance *of common areas*~~, utilities,~~ and ( )

k. ~~*a*~~Access to basic television in common areas. ~~*(3-30-06)*~~( )

06. Basic Supplies. The following are to be supplied by the facility at no additional cost to the resident: linens, towels, wash cloths, liquid hand soap, ~~*shampoo, comb, hairbrush*~~ *non-sterile exam gloves*, toilet paper, ~~*sanitary napkins,*~~ and first aid supplies, ~~*electric razors or other means of shaving, toothbrush, and toothpaste*~~ unless the resident chooses to provide his own.
~~*(3-30-06)*~~( )

07. Personal Supplies. Soap, shampoo, hair brush, comb, electric razor or other means of shaving, toothbrush, toothpaste, sanitary napkins, and incontinent supplies must be provided by the facility unless the resident chooses to provide his or her own. The facility may charge the resident for personal supplies the facility provides and must itemize each item being charged to the resident. ( )

0~~7~~8. Resident Supplies and Furnishings. If a resident chooses to provide his or her own supplies or furnishings, the facility must assure that the resident's supplies or furnishings meet the minimum standards as identified in Subsections 430.01 through 430.06 of this rule.
~~*(3-30-06)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

550. REQUIREMENTS FOR RESIDENTS' RIGHTS.
The administrator must assure that policies and procedures are implemented to assure that residents' rights are observed and protected. (3-30-06)

01. Resident Records. The facility must maintain and keep current a record of the specific information on each resident. Upon request a resident must be provided access to information in his record. (3-30-06)

a. A copy of the resident's current Negotiated Service Agreement and physician or authorized provider's order; (3-30-06)

b. Written acknowledgement that the resident has received copies of the rights; (3-30-06)

c. A record of all personal property and funds that the resident has entrusted to the facility, including copies of receipts for the property; (3-30-06)

d. Information about any specific health problems of the resident that may be useful in a medical emergency; (3-30-06)

e. The name, address, and telephone number of an individual identified by the resident who should be contacted in the event of an emergency or death of the resident; (3-30-06)

f. Any other health-related, emergency, or pertinent information which the resident requests the facility to keep on record; and (3-30-06)

g. The current admission agreement between the resident and the facility. (3-30-06)

02. Privacy. Each resident must be assured the right to privacy with regard to accommodations, medical and other treatment, written and telephone communications, visits, and meetings of family and resident groups. (3-30-06)

03. Humane Care and Environment. (3-30-06)

a. Each resident has the right to humane care and a humane environment, including the following: (3-30-06)

i. The right to a diet that is consistent with any religious or health-related restrictions; (3-30-06)

ii. The right to refuse a restricted diet; and (3-30-06)

iii. The right to a safe and sanitary living environment. (3-30-06)

b. Each resident has the right to be treated with dignity and respect, including:

(3-30-06)

i. The right to be treated in a courteous manner by staff; (3-30-06)

ii. The right to receive a response from the facility to any request of the resident within a reasonable time; and (3-30-06)

iii. The right to be communicated with, orally or in writing, in a language they understand. If the resident's knowledge of English or the predominant language of the facility is inadequate for comprehension, a means to communicate in a language familiar to the resident must be available and implemented. There are many possible methods such as bilingual staff, electronic communication devices, family and friends to translate. The method implemented must assure the resident's right of confidentiality, if the resident desires. (3-30-06)

04. Personal Possessions. Each resident has the right to: (3-30-06)

a. Wear his own clothing; (3-30-06)

b. Determine his own dress or hair style; (3-30-06)

c. Retain and use his own personal property in his own living area so as to maintain individuality and personal dignity; and (3-30-06)

d. Be provided a separate storage area in his own living area and at least one (1) locked cabinet or drawer for keeping personal property. (3-30-06)

05. Personal Funds. Residents whose board and care is paid for by public assistance will retain, for their personal use, the difference between their total income and the applicable board and care allowance established by Department rules. (3-30-06)

a. A facility must not require a resident to deposit his personal funds with the facility; and (3-30-06)

b. Once the facility accepts the written authorization of the resident, it must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this paragraph. (3-30-06)

06. Management of Personal Funds. Upon a facility's acceptance of written authorization of a resident, the facility must manage and account for the personal funds of the resident deposited with the facility as follows: (3-30-06)

a. The facility must deposit any amount of a resident's personal funds in excess of five (5) times the personal needs allowance in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts and credit all interest earned on such separate account to such account. The facility must maintain any other personal funds in a non-interest bearing account or petty cash fund; (3-30-06)

b. The facility must assure a full and complete separate accounting of each resident's

personal funds, maintain a written record of all financial transactions involving each resident's personal funds deposited with the facility, and afford the resident (or a legal representative of the resident) reasonable access to such record; and (3-30-06)

c. Upon the death of a resident with such an account, the facility must promptly convey the resident's personal funds (and a final accounting of such funds) to the individual administering the resident's estate. For clients of the Department, the remaining balance of funds must be refunded to the Department. (3-30-06)

07. Access and Visitation Rights. Each facility must permit: (3-30-06)

a. Immediate access to any resident by any representative of the Department, by the state ombudsman for the elderly or his designees, or by the resident's individual physician; (3-30-06)

b. Immediate access to a resident, subject to the resident's right to deny or withdraw consent at any time, by immediate family or other relatives; (3-30-06)

c. Immediate access to a resident, subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, by others who are visiting with the consent of the resident; and (3-30-06)

d. Reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time. (3-30-06)

08. Employment. Each resident must have the right to refuse to perform services for the facility except as contracted for by the resident and the administrator of the facility. If the resident is hired by the facility to perform services as an employee of the facility, the wage paid to the resident must be consistent with state and federal law. (3-30-06)

09. Confidentiality. Each resident must have the right to confidentiality of personal and clinical records. (3-30-06)

10. Freedom from Abuse, Neglect, and Restraints. Each resident must have the right to be free from physical, mental or sexual abuse, neglect, corporal punishment, involuntary seclusion, and any physical or chemical restraints. (3-30-06)

11. Freedom of Religion. Each resident must have the right to practice the religion of his choice or to abstain from religious practice. Residents must also be free from the imposition of the religious practices of others. (3-30-06)

12. Control and Receipt of Health-Related Services. Each resident must have the right to control his receipt of health related services, including: (3-30-06)

a. The right to retain the services of his own personal physician, dentist, and other health care professionals; (3-30-06)

b. The right to select the pharmacy or pharmacist of his choice so long as it meets the statute and rules governing residential care or assisted living and the policies and procedures of the residential care or assisted living facility; (3-30-06)

c. The right to confidentiality and privacy concerning his medical or dental condition and treatment; and (3-30-06)

d. The right to refuse medical services based on informed decision making. Refusal of treatment does not relieve the facility of its obligations under this chapter. (3-30-06)

i. The facility must document the resident and his legal guardian have been informed of the consequences of the refusal; and (3-30-06)

ii. The facility must document that the resident's physician or authorized provider has been notified of the resident's refusal. (3-30-06)

13. Grievances. Each resident must have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. (3-30-06)

14. Participation in Resident and Family Groups. Each resident must have the right to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility. (3-30-06)

15. Participation in Other Activities. Each resident must have the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility. (3-30-06)

16. Examination of Survey Results. Each resident must have the right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Licensing and ~~*Survey Agency*~~ Certification Unit with respect to the facility and any plan of correction in effect with respect to the facility. ~~*(3-30-06)*~~( )

17. Access by Advocates and Representatives. A residential care or assisted living facility must permit advocates and representatives of community legal services programs, whose purposes include rendering assistance without charge to residents, to have access to the facility at reasonable times in order to: (3-30-06)

a. Visit, talk with, and make personal, social, and legal services available to all residents; (3-30-06)

b. Inform residents of their rights and entitlements, and their corresponding obligations, under state, federal and local laws by distribution of educational materials and discussion in groups and with individuals; (3-30-06)

c. Assist residents in asserting their legal rights regarding claims for public assistance, medical assistance and social security benefits, and in all other matters in which

residents are aggrieved, that may be provided individually, or in a group basis, and may include organizational activity, counseling and litigation; (3-30-06)

d. Engage in all other methods of assisting, advising, and representing residents so as to extend to them the full enjoyment of their rights; (3-30-06)

e. Communicate privately and without restrictions with any resident who consents to the communication; and (3-30-06)

f. Observe all common areas of the facility. (3-30-06)

18. Access by Protection and Advocacy System. A residential care or assisted living facility must permit advocates and representatives of the protection and advocacy system designated by the governor under 42 U.S.C. Section 15043 and 42 U.S.C. Section 10801 et seq., access to residents, facilities, and records in accordance with applicable federal statutes and regulations. (3-30-06)

19. Access by the Long Term Care Ombudsman. A residential care or assisted living facility must permit advocates and representatives of the long term care ombudsman program pursuant to 42 U.S.C. Section 3058, Section 67 5009, Idaho Code, and IDAPA 15.01.03, "Rules Governing the Ombudsman for the Elderly Program," access to residents, facilities and records in accordance with applicable federal and state law, rules, and regulations. (3-30-06)

20. Transfer or Discharge. Each resident must have the right to be transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay. In non-emergency conditions, the resident must be given at least thirty (30) calendar days notice of discharge. A resident has the right to appeal any involuntary discharge. (3-30-06)

21. Citizenship Rights. Each resident has a right to be encouraged and assisted to exercise rights as a citizen, including the right to be informed and to vote. (3-30-06)

22. Advanced Directives. Each ~~*R*~~resident~~*s have*~~ has the right to be informed, in writing, regarding the formulation of an advanced directive~~ *to include applicable State law,*~~ as provided under Section 39-4510, Idaho Code. ~~*(3-30-06)*~~( )

23. Fee *Changes*. Each resident has the right to written notice of any fee *change* not less than thirty (30) days prior to the proposed effective date of the fee *change*, except: *( )*

a. *When a resident needs additional care, services, or supplies, the facility must provide to t*he resident, the resident's legal guardian, or conservator *written notice within five (5) days of any fee change taking place*; and *( )*

b. The *resident, the resident's legal guardian, or conservator must be given the opportunity to agree to an amended* negotiated service agreement. *If the two parties do not reach an agreement on the proposed fee change, the facility is entitled to charge the changed rate after five (5) days have elapsed from the date of the facility's written notice.* *( )*

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.04.10 - RULES GOVERNING THE COMMUNITY SERVICES BLOCK GRANT PROGRAM

DOCKET NO. 16-0410-0902

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 and 56-203, Idaho Code; the Community Services Block Grant Act, 42 USC 9901, et seq.; and the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5, Title VIII (3).

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 pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 7, 2009, Idaho Administrative Bulletin, Vol. 09-10, pages 449 through 455.

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 the rulemaking. Community Services Block Grant (CSBG) Program monies are 100% federal.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Chris Baylis at (208) 334-5742.

DATED this 6th day of November, 2009.

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

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is September 1, 2009.

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 and 56-203, Idaho Code; the Community Services Block Grant Act, 42 USC 9901, et seq.; and the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5, Title VIII (3).

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 Wednesday, October 21, 2009.

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 Community Services Block Grant (CSBG) is a federal grant that is administered by the Department; its funds are managed under contracts with local Community Action Agencies. Block grant funds are used for the reduction of poverty, the revitalization of low-income communities, and the empowerment of low-income families and individuals in rural and urban areas to become fully self-sufficient.

Since federal statute allows states to set some of the parameters of income eligibility for the CSBG Program, the Department is changing the rule to exclude child support income from being counted when determining program eligibility. This change will align CSBG Program income eligibility with that of similar programs (e.g., the U.S. Department of Energy's Weatherization Assistance Program) since many of the same families who are eligible for the Weatherization Program would benefit from programs offered under the Community Services Block Grant. This alignment of income eligibility criteria reduces administrative overhead, reduces error, and better serves those most in need in our communities.

This rulemaking also increases the income limit for CSBG Program eligibility from 125% to 200% of the federal poverty guidelines, as provided under the American Recovery and Reinvestment Act of 2009 (ARRA). This increase in the income limit will allow the program to reach many more Idaho families with help urgently needed in this recession.

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

benefit.

FEE SUMMARY: Pursuant to Section 67-5226(2), Idaho Code, 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 related to the rulemaking. Community Services Block Grant (CSBG) Program monies are 100% federal.

The increase in eligibility to 200% of the Federal Poverty Guideline will allow the Department to fully obligate and spend the Community Services Block Grant economic stimulus award made available under the American Reinvestment and Recovery Act (ARRA). The spending authority for this award was provided to the Department by the 2009 Legislature.

Excluding child support income in eligibility determination would increase the number of eligible families by approximately 23% to the equivalent of 170% of Federal Poverty Limits. This change would not have an effect on the program but would make all the programs have the same child support income guidelines.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because the rule changes are being made to implement provisions of the ARRA.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Chris Baylis at (208) 334-5742.

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 Wednesday, October 28, 2009.

DATED this 19th day of August, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

000. LEGAL AUTHORITY.
Sections 56-202 and 56-203, Idaho Code, authorize the Idaho Department of Health and Welfare to enter into contracts with the federal government to carry out the purposes of the Community Services Block Grant Act, 42 USC 9901, et seq. ~~*(3-30-01)*~~( )

001. TITLE AND SCOPE.

01. Title. The~~se~~ title of these rules ~~*are cited as Idaho Department of Health and Welfare,*~~ is IDAPA 16.04.10, "Rules Governing the Community Services Block Grant Program." ~~*(3-30-01)*~~ ( )

02. Scope. These rules provide standards for the administration of the Community Services Block Grant Program, as authorized by the Community Services Block Grant Act, as amended under 42 USC 9901, et seq. ~~*(3-30-01)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

003. ADMINISTRATIVE APPEALS.
Administrative ~~*A*~~appeals are governed by ~~*Idaho Department of Health and Welfare Rules,*~~ the provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ~~*(3-30-01)*~~( )

004. INCORPORATION BY REFERENCE.
~~*There are none in this chapter*~~ No documents have been incorporated by reference into these rules. ~~*(3-30-01)*~~( )

Existing Section 005 has been moved to Section 010.

005. OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE -- 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 found at http://www.healthandwelfare.idaho.gov. ( )

~~***006. ABBREVIATIONS.***~~

~~***01. CSBG.*** *Community Services Block Grant.*~~ ~~*(3-30-01)*~~

~~*02. HHS. The United States Department of Health and Human Services.* (3-30-01)~~

~~*03. SEOG. Supplemental Education Opportunity Grants.* (3-30-01)~~

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS REQUESTS.

01. Confidential Records. Disclosure of 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).

~~005~~010.DEFINITIONS.

01. CSBG. Community Services Block Grant. ( )

0~~1~~2. Community Action Agency. A private, non-profit organization serving the low-income population in specified counties of the state with which the Idaho Department of Health and Welfare has contracted for the provision of CSBG services. (3-30-01)

0~~2~~3. Department. The Idaho Department of Health and Welfare. (3-30-01)

0~~3~~4. Earned Income. Cash or in-kind payment derived from employment or self-employment. Receipt of a service, benefit, or durable goods instead of wages is in-kind income. Earned income is gross earnings before deductions for taxes or any other purposes. (3-30-01)

0~~4~~5. Eligible Entity. A private, non-profit organization which is a community action agency or a migrant or seasonal farm worker organization receiving CSBG funding before October 27, 1998, or designated by the Department as an eligible entity for an unserved area after October 27, 1998, and which is governed by a tripartite board, as defined in ~~*Subsection 005.06*~~ this rule. ~~*(3-30-01)*~~( )

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 web site at http://aspe.hhs.gov/poverty/index.shtml. ( )

07. HHS. The United States Department of Health and Human Services. ( )

0~~5~~8. Low-Income and Poor Participants. Those persons receiving or eligible to receive CSBG services who live in households having an income at or below ~~*one*~~ two hundred ~~*twenty-five*~~ percent (~~*125*~~ 200%) of the federal poverty guidelines. ~~*(3-30-01)*~~( )

0~~6~~9. Tripartite Board. A board, selected by an eligible entity, which participates in the development, planning, implementation, and evaluation of the community services block grant program, composed as follows: (3-30-01)

a. One-third (1/3) of the board members are elected public officials, currently holding office, or their representatives. Appointed public officials or their representatives will meet this requirement if the number of elected officials available and willing to serve is less than one-third (1/3) of the board membership. (3-30-01)

b. At least one-third (1/3) of the board members are representatives of low-income individuals and families, living in the neighborhoods they serve, chosen by democratic selection procedures. (3-30-01)

c. The remaining board members are officials or members of business, industry, labor, religious, law enforcement, education, or other major groups and interests in the community served. (3-30-01)

***0~~7~~*10. Unearned Income**. Income received from sources other than employment or self-employment, such as Social Security, unemployment insurance, and workers' compensation. (3-30-01)

0~~7~~11. -- 126. (RESERVED).

127. INCOME ELIGIBILITY REQUIREMENTS.
Assistance under this program is limited to participant households with countable income at or below ~~*one*~~ two hundred ~~*twenty-five*~~ percent (~~*125*~~ 200%) of the federal poverty guidelines updated annually in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(~~*s*~~2)~~*, effective thirty (30) days after publication*~~. ~~*(3-30-01)*~~( )

01. Countable Income. All earned and unearned income is counted in determining eligibility, unless specifically excluded by rule. (3-30-01)

02. Income Not Counted. For eligibility purposes, the following types of income are not counted. (3-30-01)

a. Benefit payments from Medicare Insurance. (3-30-01)

b. State cash assistance payments. (3-30-01)

c. Child care subsidy payments. (3-30-01)

d. Private loans made to the participant or the household. (3-30-01)

e. Assets withdrawn from a personal bank account. (3-30-01)

f. Sale of real property if reinvested within three (3) calender months. (3-30-01)

g. Lump sum payments from an IRA. (3-30-01)

h. Income tax refunds. (3-30-01)

i. Income from capital gains. (3-30-01)

j. Infrequent, irregular or unpredictable income from gifts or lottery winnings of less than one hundred dollars ($100). (3-30-01)

k. Wages or allowances paid to a live-in attendant for care of a disabled person. (3-30-01)

l. Interest posted to a bank account. (3-30-01)

m. Monies for educational purposes from ~~*NSDL*~~ the federal Perkins/National Direct Student Loan program, college work-study programs, state student incentive grants, ~~*SEOG*~~ Supplemental Education Opportunity Grants, Pell, guaranteed student loans, and supplemental grants funded under Title IV, A-2. ~~*(3-30-01)*~~( )

n. Monies from the VA-GI Bill for Education. (3-30-01)

o. Department of Health and Welfare adoption subsidies. (3-30-01)

p. Compensation to volunteers under the Older Americans Act or Foster Grandparent Program, including Green Thumb and Vista volunteers, and the Title V Senior Employment Program. (3-30-01)

q. Payments made by a third party, non-household member for the household, such as for child care, energy assistance, shelter, food and clothing assistance. (3-30-01)

r. Value of food stamps or donated food. (3-30-01)

s. Utility allowance. (3-30-01)

t. Child support income. ( )

(BREAK IN CONTINUITY OF SECTIONS)

203. DESIGNATION AND REDESIGNATION OF ELIGIBLE ENTITIES IN UNSERVED AREAS.

01. Qualified Organization in or near Area. The following organizations may apply for and be designated as eligible entities to provide services in any geographic area which stops being served by an eligible entity. (3-30-01)

a. An eligible entity or other private, nonprofit organization in the unserved area,

capable of providing a broad range of services designed to eliminate poverty and foster self-sufficiency, and that meets the requirements of this program. (3-30-01)

b. A private, nonprofit eligible entity located adjacent to or near the unserved area that is already providing related services in the unserved area. If designated, such entity would have to add additional board members to ensure adequate representation of the unserved area. (3-30-01)

02. Special Consideration. An organization with demonstrated effectiveness in meeting the goals and purposes of this program will receive the designation. Eligible entities providing related services in the unserved area, consistent with the needs identified by a community-needs assessment, may be given priority. (3-30-01)

03. No Qualified Organization in or near Area. A political subdivision of the State may serve as an eligible entity for the area if no qualified private, nonprofit organization is available. The entity must administer the program through a tripartite board, as defined in S~~*ubs*~~ection ~~*004.06*~~ 010 of these rules, or through another approved mechanism to assure decision making and participation by low-income individuals in the development, planning, implementation, and evaluation of this program. ~~*(3-30-01)*~~( )

204. -- 299. (RESERVED).

300. APPLICATION PROCESS.
Applications ~~*will*~~ must be received by the Department of Health and Welfare, Division of Welfare, P.O. Box 83720, 450 W. State Street, Boise, ID 83720-0036, no later than 5 p.m., ninety (90) days before the beginning of the federal fiscal year. Projects ~~*shall*~~ must be designed and funded to operate for one (1) twelve-month period. ~~*(3-30-01)*~~( )

301. -- 374. (RESERVED).

375. APPLICATION.
An original and one (1) copy of an application ~~*shall*~~ must be submitted to the Department's Division of Welfare and ~~*shall*~~ must include the following items: ~~*(3-30-01)*~~( )

01. Face Sheet. CSBG Application Face Sheet, describing general information about the entity and the application. (3-30-01)

02. Budget. A budget for the period of the grant, on forms provided by the Department. (3-30-01)

03. Causes of Poverty. The results of the most recent community-needs assessment. (3-30-01)

04. Service Plan. A description of how the agency will carry out the program. (3-30-01)

05. Work Program. Services to be performed and estimated number of participants. (3-30-01)

06. Client Characteristics Report. Demographic data on participants. (3-30-01)

07. Outcome Measures. How the entity will determine the success of services. (3-30-01)

08. Assurances and Certifications. Pledge by the entity to meet program requirements. (3-30-01)

376. -- 399. (RESERVED).

400. AUDIT.
Projects funded by CSBG ~~*shall be*~~ are subject to an annual audit of a scope and depth defined by the Department. The Department may join with other interested parties to obtain a single audit of the eligible entity. ~~*(3-30-01)*~~( )

401. -- 599. (RESERVED).

600. CORRECTIVE ACTION, TERMINATION, OR REDUCTION OF FUNDING.

01. Determination. If an eligible entity fails to comply with the terms of an agreement, or the State ~~*p*~~Plan, to provide services~~,~~ or to meet appropriate standards, goals, and other requirements, including performance objectives, the Department ~~*shall*~~ must inform the entity of the deficiency to be corrected and may take one (1) or more of the following steps. ~~*(3-30-01)*~~( )

a. Require the entity to correct the deficiency. (3-30-01)

b. Offer training and technical assistance, if appropriate, to help correct the deficiency, and submit a report to HHS describing the training and technical assistance offered, or stating the reasons why it was not offered. (3-30-01)

c. If feasible, allow the entity sixty (60) days to develop and implement a quality improvement plan to correct the deficiency within a reasonable period of time. (3-30-01)

d. After providing adequate notice and an opportunity for a hearing, initiate proceedings to terminate the designation of or reduce the funding of the eligible entity unless the entity corrects the deficiency. (3-30-01)

02. Review. The Secretary of HHS may review any decision to terminate the designation or reduce the funding of an eligible entity. (3-30-01)

601. -- 699. (RESERVED).

700. COMMUNITY FOOD AND NUTRITION PROGRAM.
Funds may be used to coordinate private and public food assistance resources, where such coordination is inadequate, to better serve low-income populations~~;~~, to assist low-income communities to identify potential sponsors of child nutrition programs and ~~*to*~~ initiate such

programs in underserved or unserved areas~~;~~, and to develop innovative approaches to meet the nutrition needs of low-income individuals. ~~*(3-30-01)*~~( )

701. -- 99~~*6*~~9. (RESERVED).

~~***997. CONFIDENTIALITY OF RECORDS.***~~
~~*Any disclosure of information obtained by the Department is subject to the restrictions contained in Idaho Department of Health and Welfare Rules, IDAPA 16.05.01, "Use and Disclosure of Department Records."* *(3-30-01)***~~

~~***998. -- 999. (RESERVED).***~~

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.04.11 - DEVELOPMENTAL DISABILITIES AGENCIES (DDA)

DOCKET NO. 16-0411-0901

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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: 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 pending rule, amending the renewal of certification for Developmental Disabilities Agencies to three (3) years and removing references to the Idaho State School and Hospital ISSH Waiver, is being adopted as proposed. The complete text of the proposed rule was published in the September 2, 2009, Idaho Administrative Bulletin, Vol.09-9, pages 167 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:

This rulemaking will have little or no fiscal impact due to the change in renewal of certification from two to three years. The change for certification renewals will be implemented as each certification becomes due over a two year period.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Chad Cardwell at (208) 334-5536.

DATED this 19th day of November, 2009.

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

THE FOLLOWING NOTICE 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 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 September 16, 2009.

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 is amending these rules to change the renewal of certification for Developmental Disabilities Agencies from the current two (2) years to three (3) years. This change will align the Department's certification period with the Commission on Accreditation of Rehabilitative Facilities (CARF), and will help meet legislative intent to encourage service providers to obtain national accreditation.

These rules are also being amended to delete references to the Idaho State School and Hospital ISSH Waiver that expired July 1, 2009.

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 will have little or no fiscal impact due to the change in renewal of certification from two to three years. These will be implemented as each certification becomes due over a two year period.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, informal negotiated rulemaking was held with the Idaho Association of Developmental Disability Agencies (IADDA), but no notice of intent to negotiate rulemaking was published in the Idaho Administrative Bulletin.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Chad Cardwell at (208) 334-5536.

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 23, 2009.

DATED this 21st day of July, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

010. DEFINITIONS -- A THROUGH O.
For the purposes of these rules, the following terms are used as defined below: (7-1-06)

01. Adult. A person who is eighteen (18) years of age or older ~~*or an Idaho State School and Hospital (ISSH) Waiver participant*~~. ~~*(7-1-06)*~~( )

02. Agency. A developmental disabilities agency (DDA) as defined in Section 010 of this rule. (7-1-06)

03. Annual. Every three hundred sixty-five (365) days except during a leap year which equals three hundred sixty-six (366) days. (7-1-06)

04. Baseline. A baseline is pre-intervention or annual data used to gauge a participant's level of independent performance as a basis for initiating therapeutic intervention. (7-1-06)

05. Board. The Idaho State Board of Health and Welfare. (7-1-06)

06. Communicable Disease. A disease that may be transmitted from one (1) person or an animal to another person either by direct contact or through an intermediate host, vector, inanimate object, or other means that may result in infection, illness, disability, or death. (7-1-06)

07. Comprehensive Assessment. An assessment used for diagnostic and evaluation purposes that contains uniform criteria used to contribute to the determination of a person's eligibility for DDA services and the need for those services. (7-1-06)

08. Deficiency. A determination of non-compliance with a specific rule or part of rule. (7-1-06)

09. Department. The Idaho Department of Health and Welfare. (7-1-06)

10. Developmental Disabilities Agency (DDA). A DDA is an agency that is: (7-1-06)

a. A type of developmental disabilities facility, as defined in Section 39-4604(7), Idaho Code, that is non-residential and provides services on an outpatient basis; (7-1-06)

b. Certified by the Department to provide DDA services to people with

developmental disabilities, in accordance with these rules; (7-1-06)

c. A business entity, open for business to the general public; and (7-1-06)

d. Primarily organized and operated to provide developmental therapy and other DDA services and the corresponding assessments to people with developmental disabilities. (7-1-06)

11. DDA Services. A DDA provides services that are rehabilitative and habilitative in nature. DDA services include assessment, diagnostic, and treatment services that are provided on an outpatient basis to persons with developmental disabilities and may be community-based, home-based, or center-based in accordance with the requirements of this chapter. Each DDA is required to provide developmental therapy, and, in addition, also must provide or make available the following services: psychotherapy, occupational therapy, physical therapy, and speech and hearing therapy. A DDA may also opt to provide pharmacological management, psychiatric diagnostic interviews, community crisis supports, collateral contact, and Intensive Behavioral Intervention (IBI). (7-1-06)

12. Developmental Disability. A developmental disability, as defined in Section 66-402, Idaho Code, means a chronic disability of a person which appears before the age of twenty-two (22) years of age and: (7-1-06)

a. Is attributable to an impairment, such as mental retardation, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one (1) of these impairments, which requires similar treatment or services or is attributable to dyslexia resulting from such impairments; and (7-1-06)

b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity; self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (7-1-06)

c. Reflects the need for a combination or sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and individually planned and coordinated. (7-1-06)

13. Developmental Specialist. A person qualified to conduct developmental assessments and developmental therapy under these rules. (7-1-06)

14. Developmental Therapy. Developmental therapy is the use of therapeutic intervention and positive behavioral techniques that result in measurable skill acquisition or prevent regression where documentation shows that regression is anticipated in the following areas: (7-1-06)

a. Self-care; (7-1-06)

b. Receptive and expressive language; (7-1-06)

c. Learning; (7-1-06)

d. Mobility; (7-1-06)

e. Self-direction; (7-1-06)

f. Capacity for independent living; and (7-1-06)

g. Economic self-sufficiency. (7-1-06)

15. Habilitation. The process of developing skills and abilities. (7-1-06)

16. Individualized Family Service Plan (IFSP). An initial or annual plan of service, developed by the Department or its designee, for providing early intervention services to children birth to age three (3). This plan must meet the provisions of the Individuals with Disabilities Education Act (IDEA), Part C. (7-1-06)

17. Individual Program Plan (IPP). An initial or annual plan of service developed by the DDA for providing DDA services to: (7-1-06)

a. Children from three (3) through seventeen (17) years of age; (7-1-06)

b. Participants up to age twenty-one (21) who are receiving IBI or additional DDA services under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program; or (7-1-06)

c. Participants eighteen (18) years of age or older receiving DDA services and who are using the Home and Community Based Services (HCBS) Waiver for the Aged and Disabled (A&D), State Plan PCS, or are living in a nursing facility. (7-1-06)

18. Individual Service Plan (ISP). An initial or annual plan of service for persons eighteen (18) years of age or older ~~*or ISSH waiver participants,*~~ that identifies all services and supports developed under a person-centered planning process. The Department authorizes each ISP at least once every three hundred sixty-five (365) days. This type of plan is referred to as the "plan of service" in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 507 through 515. ~~*(7-1-06)*~~( )

19. Integration. The process of promoting a life for individuals with developmental disabilities that is as much as possible like that of other citizens of the community, including living in the community and having access to community resources. A further goal of this process is to enhance the social image and personal competence of individuals with developmental disabilities. (7-1-06)

20. Intensive Behavioral Intervention (IBI). Individualized, comprehensive interventions that have been shown to be effective and are used on a short term, one-to-one basis that: (7-1-06)

a. Produce measurable outcomes that diminish behaviors that interfere with the development and use of language and appropriate social interaction skills; or (7-1-06)

b. Broaden an otherwise severely restricted range of interest; and (7-1-06)

c. Increase the child's ability to participate in other therapies and environments. (7-1-06)

21. Medical/Social History. An assessment completed by a licensed social worker or other qualified professional working within the scope of his license. This assessment of the participant's history, home, family, and physical environment is part of the process used to determine his treatment needs. (7-1-06)

22. Medical, Social, and Developmental Assessment Summary. A form used by the Department to gather a participant's medical, social and developmental history and other summary information. It is required for all participants receiving DDA services under an ISP. The information is used in the assessment and authorization of a participant's services. (7-1-06)

23. Objective. A behavioral outcome statement developed to address a particular need identified for a participant. An objective is written in measurable terms that specify a target date for completion, no longer than one (1) year in duration, and include criteria for successful attainment of the objective. (7-1-06)

(BREAK IN CONTINUITY OF SECTIONS)

204. RENEWAL AND EXPIRATION OF THE CERTIFICATE.

01. Renewal of Certificate. The Department issues certificates that are in effect for a period of no ~~greater~~ longer than ~~*two*~~ three (~~2~~3) years. ~~*(7-1-06)*~~( )

a. To ensure that there is no lapse in certification, an agency must request renewal of its certificate no less than ninety (90) days before the expiration date of the certificate. The request must contain any changes in optional services provided and outcomes of the internal quality assurance processes in accordance with Section 900 of these rules. (7-1-06)

b. Each agency seeking renewal of its certificate must be surveyed by the Department. (7-1-06)

c. The Department must find an agency to be in substantial compliance with these rules in order to renew the certificate. (7-1-06)

02. Expiration Without Timely Request for Renewal. Expiration of a certificate without a timely request for renewal automatically rescinds all rights or privileges the agency previously had to deliver services under these rules. (7-1-06)

(BREAK IN CONTINUITY OF SECTIONS)

700. REQUIREMENTS FOR A DDA PROVIDING SERVICES TO PERSONS EIGHTEEN YEARS OF AGE OR OLDER *~~AND ISSH WAIVER PARTICIPANTS~~*.
Section 700 of these rules does not apply to adults who receive IBI or additional DDA services prior authorized under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." DDAs must comply with the requirements under Section 701 of these rules for those adults. *~~(7-1-06)~~*( )

01. Eligibility Determination. Prior to the delivery of any DDA services, the person must be determined to be eligible as defined under Section 66-402, Idaho Code, for DDA services. (7-1-06)

a. For persons seeking Medicaid-funded DDA services who are eighteen (18) years of age or older, *~~or are ISSH Waiver participants,~~* the Department or its designee determines eligibility for services. *~~(7-1-06)~~*( )

b. For persons eighteen (18) years of age or older who are not Medicaid participants, the DDA must follow the requirements under Subsection 701.01 of these rules. (7-1-06)

02. Intake. (7-1-06)

a. For participants eighteen (18) years of age or older *~~or who are ISSH Waiver Participants,~~* and who are not listed under Subsection 700.02.b., prior to the delivery of any Medicaid-funded DDA services: *~~(7-1-06)~~*( )

i. The Department or its designee will have provided the DDA with current medical, social, and developmental information; and (7-1-06)

ii. The participant must have an ISP that is authorized in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 507 through 515. (7-1-06)

b. Participants eighteen (18) years of age or older receiving DDA services and who are using the Home and Community Based Services (HCBS) Waiver for the Aged and Disabled (A&D), State Plan PCS, or are living in a nursing facility must: (7-1-06)

i. Have DDA services prior authorized by the Department or its designee; and (7-1-06)

ii. DDAs must complete an Individual Program Plan (IPP) that meets the standards described in Subsections 701.04 through 701.06 of these rules. IPPs for these individuals do not require the signature of a physician or other practitioner of the healing arts. (7-1-06)

c. For participants eighteen (18) years of age or older who are not Medicaid participants, the DDA must follow the requirements under Subsection 701.02 of these rules. (7-1-06)

03. Assessments. Requirements for assessments are found under Sections 600 through 605 of these rules. (7-1-06)

04. Individual Service Plan (ISP). For participants eighteen (18) years of age or older ~~*or for ISSH Waiver participants,*~~ any services provided by the DDA must be included on the plan of service and be prior authorized by the Department or its designee before a participant can receive the service from the agency. ~~*(7-1-06)*~~( )

05. Documentation of Plan Changes. Documentation of changes in the required plan of service or Program Implementation Plan must be included in the participant's record. This documentation must include, at a minimum, the reason for the change, the date the change was made, and the signature of the professional making the change complete with date, credential, and title. If there are changes to a Program Implementation Plan that affect the type or amount of service on the plan of service, an addendum to the plan of service must be completed. (7-1-06)

701. REQUIREMENTS FOR A DDA PROVIDING SERVICES TO CHILDREN AGES THREE THROUGH SEVENTEEN AND ADULTS RECEIVING IBI OR ADDITIONAL DDA SERVICES PRIOR AUTHORIZED UNDER THE EPSDT PROGRAM.
~~*Section 701 of these rules does not apply to participants receiving ISSH Waiver services. DDAs must comply with the requirements under Section 700 of these rules for all ISSH Waiver participants.*~~ ~~*(7-1-06)*~~

01. Eligibility Determination. Prior to the delivery of any DDA services, the DDA must determine and document the participant's eligibility in accordance with Section 66-402, Idaho Code. For eligibility determination, the following assessments must be obtained or completed by the DDA: (7-1-06)

a. Medical Assessment. This must contain medical information that accurately reflects the current status of the person and establishes categorical eligibility in accordance with Section 66-402(5)(a), Idaho Code; or (7-1-06)

b. Psychological Assessment. If the medical assessment does not establish categorical eligibility, the DDA must obtain or conduct a psychological assessment that accurately reflects the current status of the person and establishes categorical eligibility in accordance with Section 66-402(5)(a), Idaho Code. (7-1-06)

c. Standardized Comprehensive Developmental Assessment. This must contain developmental information regarding functional limitations that accurately reflects the current status of the person and establishes functional eligibility based on substantial limitations in accordance with Section 66-402(5)(b), Idaho Code. (7-1-06)

02. Intake. The DDA must obtain information that accurately reflects the current status and needs of the participant prior to the delivery of services. (7-1-06)

a. The person must have been determined by the DDA to be eligible for DDA services. (7-1-06)

b. The DDA must obtain or complete a comprehensive medical and medical/social

history. (7-1-06)

03. Assessments. Requirements for assessments are found under Sections 600 through 605 of these rules. (7-1-06)

04. Individual Program Plan (IPP) Definitions. The delivery of each service on a plan of service must be defined in terms of the type, amount, frequency, and duration of the service. (7-1-06)

a. Type of service refers to the kind of service described in terms of: (7-1-06)

i. Discipline; (7-1-06)

ii. Group, individual, or family; and (7-1-06)

iii. Whether the service is home, community, or center-based. (7-1-06)

b. Amount of service is the total number of service hours during a specified period of time. This is typically indicated in hours per week. (7-1-06)

c. Frequency of service is the number of times service is offered during a week or month. (7-1-06)

d. Duration of service is the length of time. This is typically the length of the plan year. For ongoing services, the duration is one (1) year; services that end prior to the end of the plan year must have a specified end date. (7-1-06)

05. Individual Program Plan (IPP). For participants three (3) through seventeen (17) years of age ~~*who do not use ISSH Waiver services,*~~ and for adults receiving EPDST services, the DDA is required to complete an IPP. ~~*(7-1-06)*~~(____)

a. The IPP must be developed following obtainment or completion of all applicable assessments consistent with the requirements of this chapter. (7-1-06)

b. The planning process must include the participant and his parent or legal guardian, if applicable, and others the participant or his parent or legal guardian chooses. The participant's parent or legal guardian must sign the IPP indicating their participation in its development. The parent or legal guardian must be provided a copy of the completed IPP. If the participant and his parent or legal guardian are unable to participate, the reason must be documented in the participant's record. A physician or other practitioner of the healing arts and the parent or legal guardian must sign the IPP prior to initiation of any services identified within the plan, except as provided under Subsection 700.02.b.ii. of these rules. (7-1-06)

c. The planning process must occur at least annually, or more often if necessary, to review and update the plan to reflect any changes in the needs or status of the participant. Revisions to the IPP requiring a change in type, amount, or duration of the service provided must be recommended by the physician or other practitioner of the healing arts prior to implementation of the change. Such recommendations must be signed by the physician or other practitioner of the

healing arts and maintained in the participant's file. A parent or legal guardian must sign the IPP prior to initiation of any services identified within the plan. (7-1-06)

d. The IPP must be supported by the documentation required in the participant's record under Section 705 of these rules. (7-1-06)

e. The IPP must promote self-sufficiency, the participant's choice in program objectives and activities, encourage the participant's participation and inclusion in the community, and contain objectives that are age-appropriate. The IPP must include: (7-1-06)

i. The participants name and medical diagnosis; (7-1-06)

ii. The name of the assigned Developmental Specialist, the date of the planning meeting, and the name and titles of those present at the meeting; (7-1-06)

iii. The dated signature of the physician or other practitioner of the healing arts indicating his recommendation of the services on the plan; (7-1-06)

iv. The type, amount, frequency and duration of therapy to be provided. For developmental therapy, the total hours of services provided cannot exceed the amount recommended on the plan. The amount and frequency of the type of therapy must not deviate from the IPP more than twenty percent (20%) over a period of a four (4) weeks, unless there is documentation of a participant-based reason; (7-1-06)

v. A list of the participant's current personal goals, interests and choices; (7-1-06)

vi. An accurate, current, and relevant list of the participant's specific developmental and behavioral strengths and needs. The list will identify which needs are priority based on the participant's choices and preferences. An IPP objective must be developed for each priority need; (7-1-06)

vii. A list of measurable behaviorally stated objectives, which correspond to the list of priority needs. A Program Implementation Plan must be developed for each objective; (7-1-06)

viii. The discipline professional or Developmental Specialist responsible for each objective; (7-1-06)

ix. The target date for completion of each objective; (7-1-06)

x. The review date; and (7-1-06)

xi. A transition plan. The transition plan is designed to facilitate the participant's independence, personal goals, and interests. The transition plan must specify criteria for participant transition into less restrictive, more integrated settings. These settings may include integrated classrooms, community-based organizations and activities, vocational training, supported or independent employment, volunteer opportunities, or other less restrictive settings. The implementation of some components of the plan may necessitate decreased hours of service or discontinuation of services from a DDA. (7-1-06)

06. Documentation of Plan Changes. Documentation of required plan of service or Program Implementation Plan changes must be included in the participant's record. This documentation must include, at a minimum: (7-1-06)

a. The reason for the change; (7-1-06)

b. Documentation of coordination with other services providers, where applicable; (7-1-06)

c. The date the change was made; and (7-1-06)

d. The signature of the professional making the change complete with date, credential, and title. Changes to the IPP require documented notification of the participant or the participant's parent or legal guardian, if applicable. Changes in type, amount, or duration of services require written authorization from a physician or other practitioner of the healing arts and the participant or the participant's parent or legal guardian prior to the change. If the signatures of the participant or the parent or legal guardian cannot be obtained, then the agency must document in the participant's record the reason the signatures were not obtained. (7-1-06)

(BREAK IN CONTINUITY OF SECTIONS)

704. PROGRAM DOCUMENTATION REQUIREMENTS.
Each DDA must maintain records for each participant the agency serves. Each participant's record must include documentation of the participant's involvement in and response to the services provided. (7-1-06)

01. General Requirements for Program Documentation. For each participant the following program documentation is required: (7-1-06)

a. Daily entry of all activities conducted toward meeting participant objectives. (7-1-06)

b. Sufficient progress data to accurately assess the participant's progress toward each objective; and (7-1-06)

c. A review of the data, and, when indicated, changes in the daily activities or specific implementation procedures by the qualified professional. The review must include the qualified professional’s dated initials. (7-1-06)

d. When a participant receives developmental therapy, documentation of six (6) month and annual reviews by the Developmental Specialist that includes a written description of the participant's progress toward the achievement of therapeutic goals, and why he continues to need services. (7-1-06)

02. Additional Requirements for Participants Eighteen Years or Older *~~and for ISSH Waiver Participants~~*. For participant's eighteen (18) years of age or older *~~and ISSH Waiver Participants~~*, DDAs must also submit provider status reviews to the plan monitor in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 507 through 515.
~~(7-1-06)~~( )

03. Additional Requirements for Participants Seven Through Sixteen. For participants ages seven (7) through sixteen (16), the DDA must also document that the child has been referred to the local school district in accordance with Subsection 706.01 of these rules.
(7-1-06)

04. Additional Requirements for Participants Birth to Three Years of Age. For participants birth to age three (3), the following are required in addition to those requirements in Subsection 702.01 of these rules: (7-1-06)

a. Documentation of the six (6) month and annual reviews; (7-1-06)

b. Documentation of participation in transition planning at the IFSP developed closest to the child's second birthday to assure service continuity and access to community services as early intervention services end at age three (3); (7-1-06)

c. Documentation that participant rights have been met in accordance with Subsection 905.03.d.; (7-1-06)

d. Documentation of participation in the transition meeting with the school district; and (7-1-06)

e. Documentation of consultation with other service providers who are identified on the IFSP. (7-1-06)

(BREAK IN CONTINUITY OF SECTIONS)

723. COMMUNITY CRISIS SUPPORTS.
Community crisis supports are interventions for adult participants ~~who are adults *or who are on the ISSH Waiver,*~~ who have been determined eligible for developmental disability services and who are at risk of losing housing, employment or income, or are at risk of incarceration, physical harm, family altercation, or other emergencies. DDAs that choose to provide these services must do so in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 507 through 515. *~~(7-1-06)~~*( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.04.14 - RULES GOVERNING THE LOW INCOME HOME ENERGY ASSISTANCE PROGRAM

DOCKET NO. 16-0414-0901

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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, and 42 U.S.C. Sections 8621 to 8629, also known as the Low Income Home Energy Assistance Act of 1981.

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.

This rule changed the income eligibility for the Low Income Home Energy Assistance Program (LIHEAP) to 60% of Idaho's State Median Income and excludes child support income as countable income which aligns the LIHEAP program with the Community Services Block Grant Program and the U.S. Department of Energy's Weatherization Assistance Program.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 7, 2009, Idaho Administrative Bulletin, Vol. 09-10, pages 457 through 459.

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:

This rulemaking increases the LIHEAP eligibility income limits to 60% of the 2009 Idaho State Median Income and adds child support income to the list of income not counted. This will result in approximately 6,460 more families being eligible for LIHEAP, an increase of approximately 20%. Last year, approximately 45,000 families received LIHEAP benefits, with the average benefit for each family being $386 annually. To accommodate the increased number of eligible families, the benefit amount for each case will be decreased by approximately $50, to about $336 annually. The LIHEAP program is 100% federally-funded and does not spend any state general funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Chris Baylis at (208) 334-5742.

DATED this 6th day of November, 2009.

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

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is September 1, 2009.

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, and 42 U.S.C. Sections 8621 to 8629, also known as the Low Income Home Energy Assistance Act of 1981.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2009.

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:

Last year federal statute mandated that states use 160% of the 2009 Federal Poverty Guidelines (FPG) for the Low Income Home Energy Assistance Program (LIHEAP) income eligibility determination. States were also mandated to return to 150% of FPG for federal fiscal year 2010 or to use 60% of the federally-established Idaho State Median Income. This rule change will use 60% of State Median Income.

This rule change will also exclude child support income as countable income. This aligns the LIHEAP program with the Community Services Block Grant Program and the U.S. Department of Energy's Weatherization Assistance Program. Many of the same families who apply and are eligible for the LIHEAP program would benefit from the programs offered by the Community Services Block Grant program and Weatherization. Aligning

income eligibility criteria across these programs reduces administrative overhead, reduces error, and better serves those most in need in our communities.

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:

With the increased funds for this program, more low-income families will benefit from this safety net by creating more economic stability through subsidizing their home heating costs.

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 increases the LIHEAP eligibility income limits to 60% of the 2009 Idaho State Median Income and adds child support income to the list of income not counted. This will result in approximately 6,460 more families being eligible for LIHEAP, an increase of approximately 20%. Last year, approximately 45,000 families received LIHEAP benefits, with the average benefit for each family being $386 annually. To accommodate the increased number of eligible families, the benefit amount for each case will be decreased by approximately $50, to about $336 annually. The LIHEAP program is 100% federally-funded and does not spend any state general funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because these rules confer a benefit.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Chris Baylis at (208) 334-5742.

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 28, 2009.

DATED this 14th day of August, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

151. INCOME ELIGIBILITY REQUIREMENTS.
Under 42 U.S.C. 8624(b)(2)(B)(ii), ~~*A*~~Assistance under this program is limited to participant households with countable income at or below ~~*one hundred fifty percent (150%) of the Poverty Guidelines updated annually in the Federal Register by the US Department of Health and Human Services under the authority of 42 U.S.C. 9902(s), effective at the beginning of each program year*~~ sixty percent (60%) of Idaho's "State Median Income Estimate." State median income is defined in 42 USC 8622(11). The federal "State Median Income Estimate" for Idaho is found at http://www.acf.hhs.gov/programs/ocs/liheap/guidance/information_memoranda/im09-05.html.

Participant households must provide proof of income for all members during the application process. ~~*(3-15-02)*~~( )

01. Income Not Counted. Income listed in Subsections 151.01.a. through 151.01.v. is not counted in determining LIHEAP eligibility or benefit level. All other income is counted in determining LIHEAP eligibility and benefit level. (3-15-02)

a. Benefit payments from Medicare Insurance. (4-5-00)

b. Private loans made to the participant or the household. (4-5-00)

c. Assets withdrawn from a personal bank account. (4-5-00)

d. Sale of real property, if the funds are reinvested within three (3) calendar months. (3-15-02)

e. Income tax refunds. (4-5-00)

f. Infrequent, irregular or unpredictable income from gifts or lottery winnings of less than thirty dollars ($30) during the three (3) month period before application for LIHEAP. (4-5-00)

g. Wages or allowances for attendant care when the attendant resides in the household of the disabled member. (4-5-00)

h. Interest income of thirty dollars ($30) or less received during the three (3) month period before application for LIHEAP. (4-5-00)

i. Legal fees or settlements from Workman's Compensation paid in a lump sum. (4-5-00)

j. Monies received for educational purposes from NSDL, College work-study programs, State Student Incentive grants, SEOG, Pell, Guaranteed Student Loans and Supplemental grants funded under Title IV, A-2. (3-15-02)

k. Monies from VA-GI Bill for Education. (4-5-00)

l. Department of Health and Welfare Adoption subsidies. (4-5-00)

m. Compensation provided volunteers in the Older American Act or Foster Grandparent Program, including Green Thumb and Vista volunteers, Title V Senior Employment Program. (4-5-00)

n. Third party payments made by a non-household member on behalf of the household. Third party payments include child care, energy assistance funds, shelter, food and clothing assistance. (4-5-00)

o. Value of food stamps or donated food to household. (4-5-00)

p. Utility allowance. (4-5-00)

q. TAFI lump sum payments. (3-15-02)

r. Tribal crop or land payments. (3-15-02)

s. AmeriCorps stipend. (3-15-02)

t. Child support income. ( )

02. Income Received Monthly. To determine LIHEAP eligibility and benefit amount, when participant household income is received at least monthly, use the three (3) month's income prior to the date of application. (4-5-00)

03. Income Received Less Often Than Monthly. For household income received less often than monthly convert the income into a three (3) month amount: (4-5-00)

a. Multiply income received weekly by twelve and nine tenths (12.9). (4-5-00)

b. Multiply income received every two (2) weeks by six and forty-five hundredths (6.45). (4-5-00)

c. Multiply income received twice each month by six (6). (4-5-00)

04. Seasonal and Self-Employment Income. For households with seasonal or self-employment income divide the annual income by four (4). (4-5-00)

05. Treatment of Undocumented Resident Income. If a household includes eligible and ineligible undocumented resident participants, and one (1) or more of the ineligible participants had income during the reporting period, count the ineligible participants' income and exclude the undocumented resident from the household count. (3-15-02)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.04.16 - WEATHERIZATION ASSISTANCE PROGRAM IN IDAHO

DOCKET NO. 16-0416-0901

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 and 56-203, 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 pending rule, updating the income eligibility criteria for weatherization assistance as provided in the federal American Recovery and Reinvestment Act of 2009, is being adopted as proposed. The complete text of the proposed rule was published in the June 3, 2009, Idaho Administrative Bulletin, Vol. 09-6, pages 48 through 53.

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 state general funds associated with this rulemaking. Funds for this program are provided by the Federal Department of Energy.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Chris Bayliss at (208) 334-5742.

DATED this 28th day of September, 2009.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
P.O. Box 83720
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THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORAY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is April 1, 2009.

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 and 56-203, 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 17, 2009.

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 chapter of rules is being updated with income eligibility criteria from the American Recovery and Reinvestment Act of 2009. The income level has been changed to 200% of the federal poverty level for weatherization assistance through this program governed by the Federal Department of Energy.

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

This change will confer a benefit and help more low-income residents be able to utilize the weatherization programs funds.

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 state general funds associated with this rulemaking. Funds for this program are provided by the Federal Department of Energy.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the change is conferring a benefit to Idaho residents.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN

COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Genie Sue Weppner (208) 334-5656.

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 June 24, 2009.

DATED this 3rd day of April, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

010. DEFINITIONS AND ABBREVIATIONS.
For purposes of this chapter of rules, the following terms and abbreviations are used as defined. (5-8-09)

01. Community Action Agency (CAA). A private corporation or public agency established according to the Economic Opportunity Act of 1964, 42 USC 2701, et seq., which is authorized to administer funds received from federal, state, local, or private funding entities to assess, design, operate, finance, and oversee anti-poverty programs. (5-8-09)

02. Contractor. A weatherization project entity at the sub-state level which receives a contract from the Department to carry out activities of this program. (5-8-09)

03. Cosmetic Items. Items which, when installed, will not reduce energy costs in a cost effective manner, such as finishes, decorative materials, elevation materials, aluminum siding, board and bat, clapboard, brick, shakes, or asphalt siding. (5-8-09)

04. Department. The Idaho Department of Health and Welfare or its designee. (5-8-09)

05. DOE. The U.S. Department of Energy. (5-8-09)

06. Dwelling Unit. A house, including a stationary mobile home, an apartment, a group of rooms or a single room occupied as separate living quarters. (5-8-09)

a. Rental Dwelling Unit. A dwelling unit occupied by a person who pays rent for use of the dwelling unit. (5-8-09)

b. Single-Family Dwelling Unit. A structure containing no more than one (1) dwelling unit. (5-8-09)

07. Elderly Person. A person who is sixty (60) years of age or older. (5-8-09)

08. EPA. The U.S. Environmental Protection Agency. (5-8-09)

09. Family Unit. All persons living together in a dwelling unit. (5-8-09)

10. Grantee. The Idaho Department of Health and Welfare. (5-8-09)

11. Household. All persons living together in a dwelling unit. (5-8-09)

12. Heating or Cooling Sources. A device which raises or lowers the temperature within a dwelling unit that is part of the permanent heating, ventilating and air-conditioning system installed in the dwelling unit. Examples of a heating or cooling system are: furnaces, heat pumps, stoves, boilers, heaters, fireplaces, air-conditioners, fans, or solar devices. (5-8-09)

13. Low-Income. Income as it relates to family size which is: (5-8-09)

a. ~~*At or below one hundred twenty-five percent (125%) of the poverty level as d*~~Determined using criteria established by the Director of the Office of Management and Budget, ~~*or*~~ unless a higher level has been established by the Secretary and is necessary to carry out the purpose of this part and is consistent with the eligibility criteria established for the weatherization program under Section 222(a)(12) of the Economic Opportunity Act of 1964; ~~*(5-8-09)*~~( )

b. The basis on which cash assistance payments have been paid during the preceding twelve (12) month period under Titles IV and XVI of the Social Security Act, 42 USC 301, or applicable state or local law; or (5-8-09)

c. The basis for eligibility for assistance under the Low Income Home Energy Assistance Act of 1981~~*, provided that such basis is at least one hundred twenty-five percent (125%) of the poverty level determined in accordance with criteria established by the Director of the Office of Management and Budget*~~. ~~*(5-8-09)*~~( )

14. Mechanical Equipment. A control device or apparatus which is primarily designed to improve the heating or cooling efficiency of a dwelling unit, and which will permanently be affixed to an existing heating or cooling source, such as flue dampers, clock thermostats, filters, and replacements limit switches. (5-8-09)

15. Occupants. A single family, one (1) person living alone, two (2) or more families living together, or any other group of related or unrelated persons who share living arrangements. (5-8-09)

16. Persons with Disabilities. Any individual who is: (5-8-09)

a. Handicapped as defined in Section 7(6) of the Rehabilitation Act of 1973; (5-8-09)

b. Under a disability as defined in Section 1614(a)(3)(A) or 223(d)(1) of the Social Security Act or in Section 102(7) of the Developmental Disabilities Services and Facilities Construction Act; or (5-8-09)

c. Receiving benefits under Chapter 11 or 15 of Title 38, U.S.C. (5-8-09)

17. Regional Representative. A Regional Representative of the U.S. Department of

Energy. (5-8-09)

18. Secretary. The Secretary of the U.S. Department of Energy. (5-8-09)

19. Separate Living Quarters. Living quarters in which the occupants do not live and eat with any other persons in the structure and have direct access from the outside of the building or through a common hall or complete kitchen facilities for the exclusive use of the occupants. The occupants may be related or unrelated persons who share living arrangements, and includes shelters for homeless persons. (5-8-09)

20. Shelter. A dwelling unit or units whose principal purpose is to house on a temporary basis individuals who may or may not be related to one another and who are not living in nursing homes, prisons, or similar institutional care facilities. (5-8-09)

21. Subgrantee. An entity managing a weatherization project which receives a grant or contract of funds awarded under this program from the Department or CAA. (5-8-09)

22. Weatherization Project. A project conducted in a single geographical area which undertakes to weatherize dwelling units which are energy inefficient. (5-8-09)

23. Weatherization Materials. Items used to improve the heating or cooling efficiency of a dwelling unit, such as: (5-8-09)

a. Caulking and weatherstripping of doors and windows; (5-8-09)

b. Furnace efficiency modifications which include replacement burners, furnaces, or boilers or any combination thereof; (5-8-09)

c. Devices for minimizing energy loss through heating system, chimney, or venting devices; (5-8-09)

d. Electrical or mechanical furnace ignition systems which replace standing gas pilot lights; and (5-8-09)

e. Cooling efficiency modifications that include replacement air conditioners, ventilation equipment, screening and window films, and shading devices. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

100. MINIMUM PROGRAM REQUIREMENTS.

01. Dwelling Units Eligible for Weatherization. A dwelling unit will be eligible under these rules if it is occupied by a family unit: (5-8-09)

a. Whose income is at or below ~~*one*~~ two hundred ~~*twenty-five*~~ percent (~~*125*~~200%) of

the poverty level, ~~*as specified in Section 101 of this rule,*~~ determined ~~*in accordance with*~~ according to criteria established by the Director of the Office of Management and Budget;
~~*(5-8-09)*~~( )

b. Which contains a member who had received cash assistance payments under Title IV or XVI of the Social Security Act or applicable state or local law paid during the twelve (12) months preceding the determination of eligibility for weatherization assistance; or (5-8-09)

c. Is eligible for assistance under the Low-Income Home Energy Assistance Act of 1981~~*, provided that such basis is at least one hundred twenty-five percent (125%) of the poverty level determined in accordance with*~~ according to criteria established by the Director of the Office of Management and Budget. ~~*(5-8-09)*~~( )

02. Rental Dwelling Units Eligible for Weatherization. A Subgrantee may weatherize a building containing rental dwelling units using financial assistance for dwelling units eligible for weatherization assistance when: (5-8-09)

a. The subgrantee has obtained the written permission of the owner or his agent; (5-8-09)

b. Not less than sixty-six percent (66%) of the dwelling units in the building, or fifty percent (50%) for duplexes and four-unit buildings are eligible dwelling units, or will become eligible dwelling units within one hundred eighty (180) days under a federal, state, or local government program for rehabilitating the building or making similar improvements to the building; (5-8-09)

c. The grantee has established procedures for dwellings which consist of rental units to ensure that the benefits of the weatherization assistance in connection with such rental units, including units where the tenants pay for their energy through their rent, will benefit the low-income tenants residing in such units; (5-8-09)

d. For a reasonable period of time after weatherization work has been completed on a dwelling containing a unit occupied by an eligible household, the tenants in that unit, including households paying for their energy through their rent, will not be subjected to rent increases unless those increases are related to matters other than the weatherization work performed. (5-8-09)

e. A subgrantee may weatherize shelters and to determine how many dwelling units exist in a shelter, a subgrantee may count each 800 square feet of the shelter as a dwelling unit or it may count each floor of the shelter as a dwelling unit. (5-8-09)

03. Documentation of Eligibility. No dwelling unit can be weatherized without documentation that the dwelling unit is an eligible dwelling unit. The subgrantee must determine that the family unit is eligible using as proof any of the following: (5-8-09)

a. Wage stubs; (5-8-09)

b. Supplemental Security Income; (5-8-09)

c. Medicaid card; or (5-8-09)

d. W-2 Wage and Tax Statement. (5-8-09)

04. Documents Unavailable. If the documents listed in Subsections 100.03.a. through 100.03.d.of this rule are not available, the head of family must sign and date a declaration of income eligibility and provide it to the subgrantee identifying the following: (5-8-09)

a. The family unit's name; (5-8-09)

b. The family unit's address; (5-8-09)

c. Their income level, per year or month; and (5-8-09)

d. The sources from which the income is derived. (5-8-09)

e. The subgrantee must spot check the information provided on at least ten percent (10%) of the declarations received to insure eligibility. (5-8-09)

05. Proof of Documentation. Copies of the proof documents are to be retained and made available by the subgrantee to the Department or its agents for inspection and audit for at least three (3) years. (5-8-09)

~~***101. POVERTY INCOME ELIGIBILITY LIMITS.***~~
~~*Maximum income guidelines for the weatherization program are based on guidelines established for assistance under the Low Income Home Energy Assistance Act of 1981.* (5-8-09)~~

10~~2~~1. -- 199. (RESERVED).

200. ALLOWABLE EXPENDITURES.
The items listed in Subsections 200.01 through 200.14 of this rule are allowable expenditures for the Weatherization Assistance Program. (5-8-09)

01. Cost of Weatherization Materials. The cost to purchase and deliver weatherization materials. (5-8-09)

02. Labor Costs. The following labor costs are allowable expenditures: (5-8-09)

a. Payments permitted by the Department of Labor to supplement wages paid to training participants, public service employment workers, or other Federal or State training programs; and (5-8-09)

b. Payments to employ labor or to engage a contractor, particularly a nonprofit organization or a business owned by disadvantaged individuals which performs weatherization services, provided a grantee has determined an adequate number of volunteers, training participants, public service employment workers, or other federal or state training programs are not available to weatherize dwelling units for a subgrantee under the supervision of qualified

supervisors. (5-8-09)

03. Transportation of Materials, Tools, and Work Crews. Transportation of weatherization material, tools, and work crews to a storage site and to the site of weatherization work. (5-8-09)

04. Vehicle Maintenance, Operation, and Insurance. Maintenance, operation, and insurance of vehicles used to transport weatherization materials. (5-8-09)

05. Maintenance of Tools and Equipment. (5-8-09)

06. Cost of Vehicles. Purchase of any vehicle must be referred to DOE for prior approval in every instance before cost of a vehicle is allowed as an expenditure. (5-8-09)

07. Employment of On-Site Supervisory Personnel. (5-8-09)

08. Incidental Repairs. The cost of incidental repairs if such repairs are necessary to make the installation of weatherization materials effective. (5-8-09)

09. Cost of Liability Insurance. The cost of liability insurance for weatherization projects for personal injury and for property damage; (5-8-09)

10. Low-Cost Weatherization Activities. The cost of carrying out low-cost/no-cost weatherization activities in accordance with 10 CFR Part 440.20. (5-8-09)

11. Financial Audits.The cost of weatherization program financial audits as required by 10 CFR Part 440.23(d). (5-8-09)

12. Administrative Expenses. Allowable administrative expenses under 10 CFR Part 440.18(d). (5-8-09)

13. Leveraging Activities. Funds used for leveraging activities in accordance with 10 CFR Part 440.14(b)(9)(xiv). (5-8-09)

14. Elimination of Health and Safety Hazards. The cost of eliminating health and safety hazards, elimination of which is necessary before, or because of, installation of weatherization materials. (5-8-09)

15. Limitations. No grant funds are awarded under the Weatherization Assistance Program when used for any of the following purposes: (5-8-09)

a. To install or otherwise provide weatherization materials for a dwelling unit which has been weatherized previously with grant funds authorized under these rules, except as provided under 10 CFR Part 440.20 low-cost or no-cost weatherization activities. If such dwelling unit has been damaged by fire, flood, or an act of God; and repair of the damage to weatherization materials is not paid for by insurance the Weather Assistance Program may award funds for repair. (5-8-09)

b. To weatherize a dwelling unit which is vacant or designated for acquisition or clearance by a federal, state, or local program within twelve (12) months of the date weatherization of the dwelling unit would be scheduled to be completed. (5-8-09)

c. Dwelling units partially weatherized under 10 CFR Part 440 or under other federal programs during the period of September 30, 1975, through September 30, 199~~3~~4, may receive further financial assistance for weatherization under 10 CFR Part 440. These homes must be reported separately, but may be counted as completions for the purposes of compliance with the per-home expenditure limit in 10 CFR Part 440.18. Each dwelling unit must receive a new energy audit which takes into account any previous energy conservation improvements to the dwelling. ~~*(5-8-09)*~~( )

d. Cosmetic items as defined in Section 010 of these rules. (5-8-09)

16. Additional Funds. Additional funds for administration, tools, and transportation of materials, work crews, and equipment to work sites can be allocated by the Department on the basis of need and availability. (5-8-09)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.06.01 - CHILD AND FAMILY SERVICES

DOCKET NO. 16-0601-0901

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 16-1629, 16-2102, 39-1209 through 1211, 39-5603, 39-7501, 56-202(b), 56-204A, 56-803, 56-1003, 56-1004, and 56-1004A, Idaho Code; also Public Law 110-351, Section 402 (1)(B) re: changes related to international adoptions affecting Part E of Title IV of the Social Security Act, Section 473 (Adoption and Guardianship Program) (42 USC 673).

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 pending rule is being adopted as proposed. The complete text of the proposed rule was published in the September 2, 2009, Idaho Administrative Bulletin, Vol. 09-9, pages 176 through 182.

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 as a result of this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Kathy Morris at (208) 334-5706 or Shirley Alexander at (208) 334-6618.

DATED this 19th day of November, 2009.

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

THE FOLLOWING NOTICE 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 16-1629, 16-2102, 39-1209 through 1211, 39-5603, 39-7501, 56-202(b), 56-204A, 56-803, 56-1003, 56-1004, and 56-1004A, Idaho Code; also Public Law 110-351, Section 402 (1)(B) re: changes related to international adoptions affecting Part E of Title IV of the Social Security Act, Section 473 (Adoption and Guardianship Program) (42 USC 673).

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 16, 2009.

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 service of "professional foster care" is being renamed and its rules replaced with "treatment foster care" rules that align with the treatment foster care rules under IDAPA 16.07.37, "Children's Mental Health Services." Alignment between these two chapters will help eliminate confusion for foster parents providing treatment foster care who may be participating in either Child and Family Services or Children's Mental Health programs.

In addition, new rules are being proposed to clarify and resolve reimbursement issues related to contract payments to foster parents for additional services beyond regular or specialized foster care. This will be accomplished by setting out in rule the expectations for service and how payments will be structured. These new rules will increase accountability for treatment foster parents and improve services to children and youth in foster care who need a higher level of care due to behavioral and other mental health issues. The outcome of these new rules will be to increase the stability of foster care placements for children and youth who are hard to place and hard to maintain in foster care, and will better address their treatment needs.

Finally, changes are being made to update the adoption rules to increase regional efficiencies and to align rules with changes to federal law made under Public Law 110-351.

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. NA

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated

rulemaking was not conducted because this rulemaking is being done to align with the Treatment Foster Care rules found under IDAPA 16.07.37, "Children's Mental Health Services," with changes being made under Docket No. 16-0737-0901, and with changes to federal statute.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Kathy Morris at (208) 334-5706 or Shirley Alexander at (208) 334-6618.

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 Wednesday, September 23, 2009.

DATED this 31st day of July, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

485. ~~*PROFESSIONAL*~~ TREATMENT FOSTER CARE.

~~*Placement in professional foster care for children who require professional care for clinically diagnosed emotional, behavioral, or physical problems must be based upon the documented needs of each child, including the inability of less restrictive settings to meet the child's needs and a determination that the child would require a more restrictive setting if professional foster care were not available.*~~ A family home setting in which treatment foster parents provide twenty-four (24) hour room and board as well as therapeutic services and a high level of supervision. Services provided in treatment foster care are at a more intense level than provided in foster care and at a lower level than provided in residential care. Services may include the following: participation in the development and implementation of the child's treatment plan, behavior modification, community supports, crisis intervention, documentation of services and the child's behavior, participation as a member of a multi-disciplinary team, and transportation. Placement into a treatment foster home for children in the custody of the Department under the purview of the Child Protective Act, is based on the documented needs of the child, the inability of less restrictive settings to meet the child's needs, and the clinical judgement of the Department.

~~*(3-30-07)*~~( )

01. Qualifications. ~~*At least one (1) parent must possess a bachelor's degree or three (3) years of experience in a human service delivery setting or be otherwise licensed or certified to provide specialized social and medical care to children, and neither parent can be a Department employee.*~~ Prior to being considered for designation and reimbursement as a treatment foster parent, each prospective treatment foster parent must accomplish the following: ~~*(3-30-07)*~~( )

a. Meet all foster family licensure requirements as set forth in IDAPA 16.06.02, "Rules Governing Standards for Child Care Licensing"; ( )

b. Complete Department-approved treatment foster care initial training; and ( )

c. Provide a minimum of two (2) references in addition to those provided to be licensed to provide foster care. The additional references must be from individuals who have worked with the prospective treatment foster parent. The additional references must verify that the prospective treatment foster parent has: ( )

i. Training related to, or experience working with, children or youth with mental illness or behavior disorders; and ( )

ii. Demonstrated cooperation and a positive working relationship with families and providers of child welfare or mental health services. ( )

02. Continuing Education. Following designation as a treatment foster home, each treatment foster home parent must complete fourteen (14) hours of additional training per year as specified in an agreement developed between the treatment foster parents and the Department. ( )

03. Availability. At least one (1) treatment foster parent, in each treatment family home, must be available twenty-four (24) hours a day, seven (7) days a week to respond to the needs of the foster child. ( )

0~~2~~4. Payment. ~~*Payment will be made through a professional services contract with the Department for a basic rate and cost for social services total of one thousand dollars ($1,000) per month per child.*~~ The Department will pay treatment foster parents up to one thousand eight hundred ($1,800) dollars per month, per child, which includes the monthly payment rate specified in Sections 483 and 484 of these rules. The payment will be made to treatment foster parents in accordance with a contract with the Department. The purpose of the contract is to make clear that the treatment foster parents must fulfill the requirements for treatment foster parents under the child's treatment plan referenced in Subsection 485.06 of this rule. ~~*(3-30-07)*~~( )

05. Payment to Contractors. The Department may also provide treatment foster care through a contract with an agency that is a private provider of treatment foster care. The Department will specify the rate of payment in the contract with the agency. ( )

0~~3~~6. Treatment Plan. The ~~*professional*~~ treatment foster parent(s) must implement ~~*a*~~ the portions of the Department-approved treatment plan for which they are designated as responsible, ~~*developed in conjunction with the child's family services worker,*~~ for each child in their care. This plan is incorporated as part of the family services plan identified in Section 011.05 of these rules. ~~*(3-30-07)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

831. HOME STUDY, SUPERVISORY REPORTS, AND REPORTS OF THE COURT FEES.

A family who cares for a child, or children, with special needs ~~*through*~~ who is in the custody of the Department ~~*foster care program, who is not able to pay the costs associated with the pre-*~~

~~*placement home study, supervisory reports, or the report to the court, may apply to the regional Child and Family Services Program Manager for a waiver of some or all of the fees*~~ is not required to pay the costs of the Department adoption services identified in Section 832 of these rules for the adoption of that child, or children. A relative or kin family being considered by the Department for adoption of a child from foster care who is their relative or kin, is not required to pay the costs referenced in Section 832 of these rules. If a family who ~~*receives a waiver of the pre-placement home study fee*~~ did not pay the fee uses that home study to pursue adoption of a child not in the Department's custody, ~~*the Department will rescind the waiver and*~~ the family ~~*will be expected to*~~ must pay the Department for the full cost of the study and any other applicable fees identified in Section 832 of these rules. ~~*(5-8-09)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

861. PROGRESS REPORTS.
Progress reports will be prepared regularly and will be based on the family services worker's findings. (3-30-07)

01. Initial and Subsequent Reports. ~~*The first p*~~Progress reports must be made ~~*within two (2) weeks after placement, and subsequent progress reports must be made*~~ at intervals not to exceed thirty (30) days. These reports will include~~:~~ ~~*(3-30-07)*~~

~~***a.***~~ ~~*T*~~the family services worker's observation of ~~*the*~~ each child and the prospective adopting parent(s), with emphasis on: ~~*(5-3-03)*~~( )

~~***b***~~**a.** Special needs~~/~~, special circumstances, or both, of each child~~*(ren)*~~ at time of placement; ~~*(3-18-99)*~~( )

~~***c***~~**b.** Services provided to each child~~*(ren)*~~ and the family during the report period; ~~*(3-18-99)*~~( )

~~***d***~~**c.** Services to be provided to each child~~*(ren)*~~ and the family; ~~*(3-18-99)*~~( )

~~***e***~~**d.** General appearance and adjustment of each child~~*(ren)*~~ during the report period (may include eating, sleep patterns, responsiveness, bonding); ~~*(3-18-99)*~~( )

~~***f***~~**e.** Adjustment of each child to all of the following that apply: ~~*S*~~school~~/~~, daycare~~/~~, and day treatment program ~~*adjustment*~~; ~~*(3-18-99)*~~( )

~~***g***~~**f.** Health~~/~~ and developmental progress, and medical practitioner information for each child; ~~*(3-18-99)*~~( )

~~***h***~~**g.** Whether ~~*the*~~ each child~~*(ren) have*~~ has been accepted for coverage on the family's medical insurance, when coverage begins, and whether there will be any limitations~~/~~, exclusions, or both; ~~*(3-30-01)*~~( )

~~*i*~~**h.** Family's adjustment to adoptive placement; (3-18-99)

~~*j*~~**i.** ~~*Whether respite care is a need for the family*~~ Adoption assistance negotiation; ~~*(3-18-99)*~~( )

~~*k*~~**j.** Changes in family situation or circumstances; (3-18-99)

~~*l*~~**k.** Areas of concern during the report period as addressed by ~~*both*~~ each child~~*(ren)*~~ and the adoptive parent(s); and ~~*(5-3-03)*~~( )

~~*m*~~**l.** The ~~*D*~~date of the next required six (6) month review or twelve (12) month permanency hearing~~;~~. ~~*(3-18-99)*~~( )

02. Monthly Foster Care Payments -- Pre-Adoptive Placement. To receive Title IV-E monthly foster care payments during the period pending completion of adoption, the prospective adoptive parent(s) must have a foster care license. (3-20-04)

~~***03. Final Progress Report**. The final report must include pertinent information about the readiness of the child and the family for completion of the adoption. The family's decision to apply for adoption assistance benefits for the child should be documented. The family's attorney who will be handling the finalization of the adoption should be identified. The family's health insurance carrier should be identified, along with the date the child's medical coverage will begin. An up-to-date medical report on the child must be obtained from the child's physician, so that the Department will have current information about the health of the child. Any problem in placement must be brought to the attention of the Department.* ***(3-30-07)***~~

(BREAK IN CONTINUITY OF SECTIONS)

900. ADOPTION ASSISTANCE.

The purpose of the adoption assistance program is to encourage the legal adoption of children with special needs who would not be able to have the security of a permanent home without support payments. Applications are made through the Division of Family and Community Services, Resource Development Unit for a determination of eligibility. Once an application for adoption assistance is submitted to the Division of Family and Community Service's, the Division will respond with a determination of the child's eligibility within forty-five (45) days. (3-30-07)

01. Determination of Eligibility for Title IV-E Adoption Assistance. Child and Family Services will determine whether a child is a child with special needs. Children applying for adoption assistance benefits must meet Idaho's definition of a child with special needs according to Section 473 (c) of P.L. 96-272 (The Adoption Assistance and Child Welfare Act of 1980). There are five (5) ways a child can be eligible for Title IV-E adoption assistance: (5-8-09)

a. Child is Aid to Families with Dependent Children (AFDC) eligible, is in the

custody or care of the public child welfare agency or an Indian tribe with whom the state has a IV-E agreement and meets the definition of a child with special needs. For children whose adoption assistance eligibility is based on the child's AFDC eligibility, the child must meet the AFDC criteria at the time of removal from his home. (5-8-09)

i. If the child is removed from his home in accordance with the first judicial determination, such determination must indicate that it was contrary to the welfare of the child to remain in the home. (5-8-09)

ii. If the child is removed from the home in accordance with a voluntary out-of-home placement agreement, the child must receive at least one (1) Title IV-E foster care payment to be eligible for Title IV-E adoption assistance. (5-8-09)

b. Child is eligible for Supplemental Security Income (SSI) benefits and meets the definition of a child with special needs. (5-3-03)

i. A child is eligible for adoption assistance if, at the time the adoption petition is filed, the child has met the requirements for Title XVI (SSI) benefits; (5-3-03)

ii. The circumstances of a child's removal from his home or whether the public child welfare agency has responsibility for the child's placement and care is not relevant. (5-3-03)

c. Child has been voluntarily relinquished to a private non-profit adoption agency and meets the definition of a child with special needs. (5-3-03)

i. The child must meet the requirements, or would have met the requirements, of the AFDC program as such sections were in effect on July 16, 1996, in or for the month in which the relinquishment occurred, or court proceedings were held which lead to the removal of the child from his home; (5-3-03)

ii. At the time of the voluntary relinquishment, the court must make a judicial determination that it would be contrary to the welfare of the child for the child to remain in the home. (5-8-09)

d. Child is eligible for Title IV-E adoption assistance as a child of a minor parent and at the time of the adoption petition the child meets the definition of a child with special needs. (5-3-03)

i. The child's parent is in foster care and receiving Title IV-E foster care maintenance payments that cover both the minor parent and child at the time the adoption petition is filed; and (5-3-03)

ii. The child continues to reside in the foster home with his minor parent until the adoption petition has been filed. If the child and minor parent have been separated in foster care prior to the time of the adoption petition, the child's eligibility for Title IV-E adoption assistance must be determined based on the child's current and individual circumstances. (5-3-03)

e. Child is eligible due to prior Title IV-E adoption assistance eligibility and meets

the definition of a child with special needs. (5-3-03)

i. A child whose adoption later dissolves or the adoptive parent(s) die, may continue to be eligible for Title IV-E adoption assistance in a subsequent adoption. (5-3-03)

ii. The subsequent adoption of a child may be arranged through an independent adoption, private agency, or state agency. (5-3-03)

iii. No needs or eligibility redetermination is to be made upon a subsequent adoption. The child's need and eligibility remain unchanged from what they were prior to the initial adoption. (5-3-03)

iv. It is the responsibility of the placing state to determine whether the child meets the definition of special needs and to pay the subsidy in a subsequent adoption. (5-3-03)

02. Special Needs Criteria. The definition of special needs includes the following factors: (3-30-07)

a. The child cannot or should not be returned to the home of the parents as evidenced by an order from a court of competent jurisdiction terminating parents rights ~~*or an Abandonment Certificate*~~ or its equivalent ~~*issued by a governmental entity either domestic or foreign*~~; and ~~*(5-8-09)*~~( )

b. The child has a physical, mental, emotional, or medical disability, or is at risk of developing such disability based on known information regarding the birth family and child's history, or (3-18-99)

c. The child's age makes it difficult to find an adoptive home; or (3-18-99)

d. The child is a member of a sibling group that must not be placed apart; and (5-3-03)

e. State must make a reasonable but unsuccessful effort to place the child with special needs without a subsidy, except in cases where it is not in the best interests of the child due to his significant emotional ties with the foster parent(s) or relative(s) who are willing to adopt the child. (5-3-03)

03. Determination of Eligibility for State Funded Adoption Assistance. Children in state custody who meet the special needs criteria found in Subsection 900.02 of these rules and do not meet any of the criteria for Title IV-E adoption assistance found at Subsection 900.01 in these rules, may be eligible for state-funded adoption assistance benefits. If the child is determined ineligible for Title IV-E adoption assistance, the application will be evaluated for a state-funded subsidy. (3-30-07)

04. Interjurisdictional Adoptions. When a child's adoption is arranged through the care and placement of a private non-profit adoption agency in another state and the adoptive family are residents of Idaho, the state of Idaho is responsible for the eligibility determination, negotiation, and payment of any subsequent Title IV-E adoption assistance benefits. (3-30-07)

05. International Adoptions and Adoption Assistance. A child who meets the criteria for special needs under Subsection 900.02 of this rule, who is not a citizen or resident of the United States, and who was adopted outside of the United States or was brought into the United States for the purpose of being adopted, is not eligible to receive adoption assistance. This restriction does not prohibit adoption assistance payments for a child described in this Subsection who is placed in foster care subsequent to the failure, as determined by the State, of the initial adoption of the child by the adoptive parents. ( )

(BREAK IN CONTINUITY OF SECTIONS)

910. TYPES AND AMOUNTS OF ASSISTANCE.
The needs of the child and the family, including any other children in the family, will be considered in determining the amount and type of support to be provided. Assistance may include the following: (3-30-07)

01. Nonrecurring Adoption Reimbursement. Payment for certain one (1) time expenses necessary to finalize the adoption may be paid when a family adopts a special needs child. The child's eligibility must be determined and the contract for reimbursement must be fully executed prior to the finalization of the adoption. The reimbursement is paid only after the adoption finalizes. The expenses are defined as reasonable and necessary adoption fees, court costs, attorney fees and other expenses which are directly related to the legal adoption finalization of a child with special needs and which are not incurred in violation of state or federal law. They may include mileage and lodging involved in visiting the child before placement occurs. These expenses cannot be reimbursed if they are paid for the adoptive parents by other sources such as an employer. Documentation of expenses must be submitted. Costs are reimbursable up to two thousand dollars ($2,000) per child and are entered on the Adoption Assistance Program Agreement. ~~*Families applying for Nonrecurring Adoption Reimbursement separate from the regular Adoption Assistance program must submit an application for Nonrecurring Adoption Expenses Reimbursement, obtain a determination of eligibility, and negotiate a Nonrecurring Adoption Expenses Reimbursement Agreement prior to the finalization of the child's adoption. Families applying for Nonrecurring Adoption Expenses Reimbursement on behalf of a child who is adopted through an international adoption must submit an application for Nonrecurring Adoption Expenses Reimbursement, obtain a determination of eligibility, and negotiate a Nonrecurring Adoption Expenses Reimbursement Agreement prior to the family's departure to the foreign country and the child's adoption in the foreign country.~~* Children for whom the adoption has been finalized without a negotiated Nonrecurring Expenses Reimbursement Agreement are not eligible to apply for these benefits. ~~*(5-3-03)*~~( )

02. Monthly Cash Payment. Financial assistance in the form of a monthly cash payment may be established to assist the adoptive family in meeting the additional expenses of the child’s special needs. The amount of the payment must be negotiated with the family by the adoption worker and based on the family's circumstances and what additional resources are needed to incorporate the child into the adoptive family. The amount must not exceed the rate for family foster care which would be made if the child were in a family foster home in Idaho. For

children who meet the definition of special needs at Subsection 900.02 of these rules, no monthly cash payment is allowable until such time as the specific disability for which the child is known to be at risk becomes evident. For children who are currently eligible for Personal Care Services (PCS), the professional foster care rate may be used in negotiating the adoption assistance upon prior approval of the Department's Family and Community Services (FACS) Division Administrator. Benefits will continue until the child reaches eighteen (18) years, based upon an annual determination of continuing need. (3-30-07)

03. Title XIX -- Medicaid Coverage. Any child with special needs who has an adoption assistance agreement in effect is also eligible for medical coverage. A Title IV-E adoption assistance agreement provides Medicaid coverage in the state of Idaho and in all other states. Under a state-funded adoption assistance agreement, a child living in Idaho is eligible for Medicaid. If the family moves to another state, Medicaid may or may not be available. If Medicaid is not available in the new state, provisions for medical coverage must be contained in the adoption assistance agreement or in an amendment to the agreement. Families enrolled in a group health plan who plan to request to use Medicaid as the child's primary health care coverage must apply to the Idaho Health Insurance Premium Payment (HIPP) program at the time of benefit negotiation. Medicaid provides secondary coverage after the family's health insurance has reached its benefit limit. All services reimbursed by Medicaid must be determined to be medically necessary. Prior authorization may be required for some Medicaid reimbursable services. Medicaid benefits are available until the child reaches the age of eighteen (18), based upon an annual determination of continuing need. (3-30-07)

04. Title XX -- Social Services. Any child with special needs who has an Adoption Assistance Agreement is also eligible for state-authorized Title XX - Federal Social Services Block Grant funded services. (3-30-07)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.06.03 - RULES AND MINIMUM STANDARDS GOVERNING ALCOHOL/DRUG ABUSE PREVENTION AND TREATMENT PROGRAMS

DOCKET NO. 16-0603-0901 (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 2010 Idaho State Legislature for final approval. The pending rule becomes final and effective on May 1, 2010, 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 39-305, 39-306, 39-307, 39-311, 56-1003, and 56-1007, 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 pending rule is being adopted as proposed. The complete text of the proposed rule was published in the September 2, 2009, Idaho Administrative Bulletin, Vol. 09-9, page 215.

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:

This rulemaking has no anticipated fiscal impact to state general funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Sherry L. Johnson at (208) 334-5934.

DATED this 19th day of November, 2009.

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

THE FOLLOWING NOTICE 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 39-305, 39-306, 39-307, 39-311, 56-1003, and 56-1007, Idaho Code.

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

Tuesday - September 22nd 10:30am to 12:00pm	Tuesday - September 29th 10:00am to 12:00pm	Thursday - October 1st 1:00pm to 3:00pm
Dept. of Health & Welfare Grand Teton Conf. Rm. 3402 Franklin Road Caldwell, Idaho	State Office Building 3rd Floor Conf. Rm. 1118 F Street Lewiston, Idaho	Dept. of Health & Welfare 1st Floor Conf. Rm. 1070 Hiline Pocatello, Idaho

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 chapter of rule is being repealed to avoid duplication with a new chapter of rules being promulgated under IDAPA 16.07.20, "Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs," and being published in this Administrative Bulletin under Docket No. 16-0720-0901.**

FEE SUMMARY: Pursuant to Section 67-5226(2), Idaho Code, 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: This rulemaking has no anticipated fiscal impact to state general funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, informal negotiated rulemaking was conducted. Townhall meetings were held during the month of May 2008, in Coeur d'Alene, Boise, and Pocatello.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Sherry Johnson at (208) 334-5934. 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 5, 2009.

DATED this 27th day of July, 2009.

IDAPA 16.06.03 IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.07.01 - BEHAVIORAL HEALTH SLIDING FEE SCHEDULES

DOCKET NO. 16-0701-0901

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 16-2433, 19-2524, 20-520(i), 20-511A, 39-309, and 39-3137, 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:

This rulemaking changed the definition of family household to include all household members and their income except for persons on supplemental security income, disability income, or non-dependent adult siblings.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the September 2, 2009, Idaho Administrative Bulletin, Vol. 09-9, pages 216 through 218.

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 as a result of this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Chuck Halligan at (208) 334-6559.

DATED this 19th day of November, 2009.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
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(208) 334-5564 phone; (208) 334-6558 fax
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THE FOLLOWING NOTICE 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 16-2433, 19-2524, 20-520(i), 20-511A, 39-309, and 39-3137, 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 16, 2009.

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 changes the definition of family household to include all household members and their income except for persons on supplemental security income, disability income, or non-dependent adult siblings. This rule change will result in a consistent method of counting household members and their income for adult mental health, substance use disorders, and children's mental health programs when applying the sliding fee schedule. The consistency will also be fair to the consumer of services and accurately reflect their family situation.

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 as a result of this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because this change is very minor and has no potential for controversy.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Chuck Halligan at (208) 334-6559.

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 Wednesday, September 23, 2009.

DATED this 29th day of July, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

010. DEFINITIONS.
For the purposes of this chapter, the following definitions apply. (4-9-09)

01. Ability to Pay. The financial capacity that is available to pay for the program services after allowable deductions in relation to gross income and family size exclusive of any liability of third party payor sources. (4-9-09)

02. Adjusted Gross Income. Total family annual income less allowable annual deductions. (4-9-09)

03. Adult. An individual 18 years of age or older. (4-9-09)

04. Adult Mental Health Program. A program administered by the Idaho Department of Health and Welfare to serve severely and persistently mentally ill adults. (4-9-09)

05. Allowable Annual Deductions. In determining the family's ability to pay for behavioral health services, the following are allowable annual deductions: (4-9-09)

a. Court-ordered obligations; (4-9-09)

b. Dependent support; (4-9-09)

c. Child care payments necessary for parental employment; (4-9-09)

d. Medical expenses. (4-9-09)

e. Transportation; (4-9-09)

f. Extraordinary rehabilitative expenses; and (4-9-09)

g. State and federal tax payments, including FICA taxes. (4-9-09)

06. Behavioral Health Services. Services offered by the Department to improve behavioral health issues or alcohol and substance use disorders. (4-9-09)

07. Child. An individual who is under the age of eighteen (18) years. (4-9-09)

08. Children's Mental Health Program. A program as defined in IDAPA 16.07.37, "Children's Mental Health Services," administered by the Idaho Department of Health and Welfare. (4-9-09)

09. Client. The recipient of services. The term "client" is synonymous with the terms: patient, participant, resident, consumer, or recipient of treatment. (4-9-09)

10. Court-Ordered Obligations. Financial payments which have been ordered by a court of law. (4-9-09)

11. Court-Ordered Recipient. A person receiving behavioral health services under Sections 19-2524, 20-520(i), and 20-511A, Idaho Code. (4-9-09)

12. Department. The Idaho Department of Health and Welfare. (4-9-09)

13. Dependent Support. An individual that is dependent on his family's income for over fifty percent (50%) of his financial support. (4-9-09)

14. Extraordinary Rehabilitative Expenses. Those payments incurred as a result of the disability needs of the person receiving services. They include annual costs for items including, but not limited to, wheelchairs, adaptive equipment, medication, treatment, or therapy which were not included in the medical payments deduction and the annual estimate of the cost of services received. (4-9-09)

15. Family. A family is an adult, or married adults, or adult(s) with children, living in a common residence. (4-9-09)

16. Family Household. Persons in a family related by blood, marriage, or adoption. ~~*Step parents, step children, a*~~Adult siblings~~,~~ who are not claimed as dependents and individuals receiving Supplemental Security Income (SSI) or Supplemental Security Disability Income (SSDI)~~,~~ are excluded from consideration as a member of the household for income and counting purposes. Income from minor siblings is excluded from household income. The term "family household" is synonymous with the term "family unit." ~~*(4-9-09)*~~( )

17. 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/. (4-9-09)

18. Parent. The person who, by birth or through adoption, is legally responsible for a child. (4-9-09)

19. Recipient. The person receiving services. The term "recipient" is synonymous with the terms: "patient," "participant," "resident," "consumer," or "client." (4-9-09)

20. Sliding Fee Scale. A scale used to determine an individual's financial obligation for services based on Federal Poverty Guidelines and the number of persons in the family household. (4-9-09)

21. Substance Use Disorders Program. A program administered by the Idaho Department of Health and Welfare to serve adolescents and adults with alcohol or substance use disorders. (4-9-09)

22. Third-Party Payer. A payer other than a person receiving services or a responsible party who is legally liable for all or part of the person's care. (4-9-09)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.07.37 - CHILDREN'S MENTAL HEALTH SERVICES

DOCKET NO. 16-0737-0901

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 16-2404, 16-2406, 16-2423, 16-2433, 56-202(b), 56-203B, 56-204A, 56-1003, 56-1004, and 56-1004A, 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.

Since both Child and Family Services and the Children's Mental Health program use the same treatment foster care resources, the rules in this chapter pertaining to treatment foster care were aligned with the corresponding rules in the Department's "Child and Family Services" chapter. This will reduce confusion for treatment foster care providers, make training of providers more efficient, increase the stability of placements for children and youth who are hard to place and hard to maintain in foster care, and improve outcomes for children and youth in treatment foster care.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the September 2, 2009, Idaho Administrative Bulletin, Vol. 09-9, pages 297 and 298.

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 fiscal impact to the general fund as a result of this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Chuck Halligan at (208) 334-6559.

DATED this 18th day of November, 2009.

Tamara Prisock
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THE FOLLOWING NOTICE 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 16-2404, 16-2406, 16-2423, 16-2433, 56-202(b), 56-203B, 56-204A, 56-1003, 56-1004, and 56-1004A, 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 16, 2009.

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:

Since both Child and Family Services and the Children's Mental Health program use the same treatment foster care resources, the rules in this chapter pertaining to treatment foster care are being aligned with the corresponding rules in the Department's "Child and Family Services" chapter. This will reduce confusion for treatment foster care providers, make training of providers more efficient, increase the stability of placements for children and youth who are hard to place and hard to maintain in foster care, and improve outcomes for children and youth in treatment foster care.

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: N/A

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because this rulemaking is being done to align with the Treatment Foster Care rules proposed under IDAPA 16.06.01, "Child and Family Services," Docket No. 16-0601-0901.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN

COMMENTS: For assistance on technical questions concerning the proposed rule, contact Chuck Halligan at (208) 334-6559.

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 Wednesday, September 23, 2009.

DATED this 31st day of July, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

600. TREATMENT FOSTER CARE.
A family home setting in which treatment foster parents provide twenty-four (24) hour room and board as well as therapeutic services and a high level of supervision. Services provided in treatment foster care are at a more intense level than provided in foster care and at a lower level than provided in residential care. Services may include the following: participation in the development and implementation of the child's treatment plan, behavior modification, community supports, crisis intervention, documentation of services and the child's behavior, participation as a member of a multi-disciplinary team, and transportation. Placement into a treatment foster home for children eligible for services under Subsection 407 of these rules is based on the documented needs of the child, the inability of less restrictive settings to meet the child's needs, and the clinical judgement of the Department. ~~*(5-8-09)*~~( )

01. Qualifications. ~~*A treatment foster parent must*~~ Prior to being considered for designation and reimbursement as a treatment foster parent, each prospective treatment foster parent must accomplish the following: ~~*(5-8-09)*~~( )

a. Meet all foster family licensure requirements as set forth in IDAPA 16.06.02, "Rules Governing Standards for Child Care Licensing"; (5-8-09)

b. Complete Department-approved treatment foster care initial training; and (5-8-09)

c. ~~*Complete fourteen (14) hours of additional training per year thereafter. The fourteen (14) hours of additional training will be specified in an agreement developed between the treatment foster parents and the Department.*~~ Provide a minimum of two (2) references in addition to those provided to be licensed to provide foster care. The additional references must be from individuals who have worked with the prospective treatment foster parent. The additional references must verify that the prospective treatment foster parent has: ~~*(5-8-09)*~~( )

i. Training related to, or experience working with, children or youth with mental illness or behavior disorders; and ( )

ii. Demonstrated cooperation and a positive working relationship with families and providers of mental health services. ( )

02. **Continuing Education**. Following designation as a treatment foster home, each treatment foster home parent must complete fourteen (14) hours of additional training per year as specified in an agreement developed between the treatment foster parents and the Department. ( )

0~~2~~3. **Availability**. At least one (1) treatment foster parent in each treatment family home must be available twenty-four (24) hours a day, seven (7) days a week to respond to the needs of the foster child. ~~*(5-8-09)*~~( )

0~~3~~4. **Payment**. The Department will pay treatment foster parents up to one thousand eight hundred ($1,800) dollars per month per child, which includes the monthly payment rate specified in Sections 583 and 584 of these rules. The payment will be made to treatment foster parents in accordance with a contract with the Department. ~~*to enable them to*~~ The purpose of the contract is to make clear that the treatment foster parents must fulfill the requirements for treatment foster parents under the treatment plan referenced in Subsection 600.0~~5~~6 of this rule. ~~*(5-8-09)*~~( )

0~~4~~5. **Payment to Contractors**. The Department may also provide treatment foster care through a contract with an agency that is a private provider of treatment foster care. The Department will specify the rate of payment in the contract with the agency. (5-8-09)

0~~5~~6. **Treatment Plan**. The treatment foster parent(s) must implement ~~*a*~~ the portions of the Department-approved treatment plan for which they are designated as responsible~~*, developed in conjunction with the child's clinician,*~~ for each child in their care. This plan is incorporated as part of the treatment plan identified in Section 101 of these rules. ~~*(5-8-09)*~~( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.07.39 - APPOINTMENT OF DESIGNATED EXAMINERS AND DESIGNATED DISPOSITIONERS

DOCKET NO. 16-0739-0801 (NEW CHAPTER)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the amendments to the temporary rule is January 1, 2009. This pending rule has been adopted by the agency and is now pending review by the 2010 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 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Sections 16-2403, 66-317, 56-1003, and 56-1004, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the temporary 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:

In this new chapter of rules, the Department has defined the qualifications, appointment requirements, and appointment process for designated examiners and designated dispositioners. This will better ensure these professionals have the education, training, and experience needed to perform reliably and effectively the duties required by these roles.

The amendments to the temporary rule clarify the criminal history and background check requirement for individuals seeking reappointment as designated examiners and designated dispositioners, or both. Also, the term "board certified psychiatrist" was removed from the rule.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule. Only the sections that have changes from the proposed text are printed in this bulletin. The original text of the proposed rule was published in the Wednesday, January 7, 2009, Idaho Administrative Bulletin, Vol. 09-1, pages 366 through 374.

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: NA

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule and the amendment to temporary rule, contact Scott Tiffany at (208)

332-7243.

DATED this 6th day of November, 2009.

Tamara Prisock
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450 W. State Street - 10th Floor
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THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2009.

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 16-2403, 66-317, 56-1003, and 56-1004, 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 January 21, 2009.

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 Department is defining in rule the qualifications, appointment requirements, and appointment process for designated examiners and designated dispositioners. This will better ensure these professionals have the education, training, and experience needed to perform reliably and effectively the duties required by these roles.

A "designated examiner" assesses individuals in circumstances where they appear to be gravely disabled due to mental illness or pose a grave danger to themselves or others. The designated examiner provides the court with a report stating whether the person is (1) mentally ill, (2) likely to injure himself or others, or (3) lacks the capacity to make informed decisions about treatment.

A "dispositioner" is a designated examiner, typically employed by the Department, who determines the appropriate location for care and treatment of involuntary patients.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted in Coeur d'Alene on Thursday, November 13, 2008, in Pocatello on Friday, November 21, 2008, and in Boise on Monday, November 24, 2008. The Notice of Negotiated Rulemaking was published in the Wednesday, November 5, 2008, Administrative Bulletin (Vol. 08-11).

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Scott Tiffany at (208) 332-7243.

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 Wednesday, January 28, 2009.

DATED this 13th day of November, 2008.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

IDAPA 16
TITLE 07
CHAPTER 39

16.07.39 - APPOINTMENT OF DESIGNATED EXAMINERS AND DESIGNATED DISPOSITIONERS

000. LEGAL AUTHORITY.

Under Sections 16-2403 and 66-317, Idaho Code, the Department is authorized to promulgate

rules regarding who may be appointed as a designated examiner, a designated dispositioner, or both. Under Sections 56-1003 and 56-1004, Idaho Code, the Director is authorized to adopt rules to supervise and administer a mental health program. ( )

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.07.39, "Appointment of Designated Examiners and Designated Dispositioners." ( )

02. Scope. This chapter of rules sets forth the qualifications, appointment requirements, appointment process, duration of appointment, revocation of appointment, and requirements for reappointment for designated examiners and designated dispositioners in Idaho. ( )

03. Effective Date and Appointments Prior to January 1, 2009. This chapter of rules is applicable to all new applications for appointment as a designated examiner or designated dispositioner, or both, received by the Department's Division of Behavioral Health on or after January 1, 2009. If an individual was granted an appointment prior to January 1, 2009, and met the requirements at that time, he may continue to have his appointment recognized until it expires or until January 1, 2011, whichever occurs first. Notwithstanding any prior appointment, however, effective January 1, 2011, all designated examiners and designated dispositioners in Idaho must be in compliance with these rules. ( )

002. WRITTEN INTERPRETATIONS.
There are no written interpretations for these rules. ( )

003. ADMINISTRATIVE APPEALS.
Administrative appeals are governed by provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ( )

004. INCORPORATION BY REFERENCE.
American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) Washington, DC, American Psychiatric Association, 2000, is hereby incorporated by reference under this chapter of rules. 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. ( )

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE NUMBER -- INTERNET WEB SITE.

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 Web Site. The Department's internet web site is found at: http:// www.healthandwelfare.idaho.gov. ( )

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS REQUESTS.

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. -- 008. (RESERVED).

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.
~~All current Department employees, contract employees, and others~~ *Each individual who* work*~~ings~~* directly with children or vulnerable adults as described in Section 39-5302, Idaho Code, *and* who *~~are~~* *is* seeking appointment as a designated examiner or designated dispositioner, or both, must comply with the provisions in IDAPA 16.05.06, "Criminal History and Background Checks."
~~(1-1-09)T~~( )

01. Criminal History And Background Check Requirement -- Initial Appointment. *The criminal history and background check requirements for applicants seeking consideration for an initial appointment as a designated examiner, designated dispositioner, or both, are found under Subsection 400.02 of these rules.* *( )*

02. Criminal History And Background Check Requirement -- Reappointment. *The criminal history and background check requirements for applicants seeking consideration for reappointment as a designated examiner, designated dispositioner, or both, are found under Subsection 600.02 of these rules.* *( )*

010. DEFINITIONS.
For the purposes of these rules, the following terms are used as defined below: ( )

01. Clinical Nurse Specialist, Licensed. An individual licensed as a Clinical Nurse Specialist in accordance with Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." ( )

02. Clinical Professional Counselor, Licensed (LCPC). An individual licensed in accordance with Title 54, Chapter 34, Idaho Code, and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." ( )

03. Clinical Social Worker, Licensed (LCSW). An individual licensed in accordance with Title 54, Chapter 32, Idaho Code, and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners." ( )

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

05. Designated Dispositioner. In accordance with Section 66-317, Idaho Code, the practice of a designated dispositioner is professional in nature and requires specialized knowledge, training, and experience determining the appropriate location for care and treatment of involuntary patients. A designated dispositioner is a designated examiner employed by or under contract with the Department and designated by the Director. ( )

06. Designated Examination. An evaluation by an appointed mental health professional to determine if an individual is mentally ill and if the individual is either likely to injure himself or others or is gravely disabled due to mental illness. ( )

07. Designated Examiner. In accordance with Sections 16-2403 and 66-317, Idaho Code, the practice of a designated examiner is professional in nature and requires specialized knowledge, training, and experience in the diagnosis and treatment of mental illness. A designated examiner is a psychiatrist, psychologist, psychiatric nurse, social worker, or such other mental health professional as may be designated in accordance with these rules. ( )

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

09. Division. The Department's Division of Behavioral Health. ( )

10. Marriage and Family Therapist, Licensed (LMFT). An individual licensed in accordance with Title 54, Chapter 34, Idaho Code, and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." ( )

11. Masters of Social Work, Licensed (LMSW). An individual licensed in accordance with Title 54, Chapter 32, Idaho Code, and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners." ( )

12. Nurse Practitioner, Licensed. An individual licensed as a Nurse Practitioner in accordance with Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." ( )

13. Physician, Licensed. An individual licensed to practice medicine, under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.01, "Rules of the Board of Medicine for the Licensure to Practice Medicine and Surgery and Osteopathic Medicine and Surgery in Idaho." ( )

14. Professional Counselor, Licensed (LPC). An individual licensed in accordance with Title 54, Chapter 34, Idaho Code, and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." ( )

~~***15. Psychiatrist, Board Certified**. An individual licensed to practice medicine under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.01, "Rules of the Board of Medicine for the Licensure to Practice Medicine and Surgery and Osteopathic Medicine and Surgery" who is certified by the American Board of Psychiatry and Neurology in psychiatry.* (1-1-09)T~~

16*5*. Psychologist, Licensed. An individual 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." ( )

011. -- 199. (RESERVED).

200. MINIMUM QUALIFICATIONS AND REQUIREMENTS FOR APPOINTMENT AS A DESIGNATED EXAMINER.
To be appointed and practice as a designated examiner in Idaho, an applicant must meet the following minimum qualifications and requirements: ( )

01. Required License. Each applicant must maintain his professional licensure for the duration of his appointment and be one (1) of the following: ( )

a. Licensed Physician; ( )

~~***b.** Board-certified Psychiatrist;* (1-1-09)T~~

***cb*.** Licensed Psychologist; ( )

***dc*.** Licensed Clinical Nurse Specialist; ( )

***ed*.** Licensed Nurse Practitioner; ( )

***fe*.** Licensed Clinical Professional Counselor (LCPC); ( )

***gf*.** Licensed Professional Counselor (LPC); ( )

***hg*.** Licensed Clinical Social Worker (LCSW); ( )

***ih*.** Licensed Masters Social Worker (LMSW) with a supervision plan approved by the licensing board in accordance with IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners," Subsection 201.02; ( )

***ji*.** Licensed Marriage and Family Therapist (LMFT). ( )

02. Required Experience and Abilities. The Division will determine whether an applicant meets and demonstrates the following experience and abilities, based on the documentation provided by the applicant as required under Subsection 400.02 of these rules: ( )

a. At least two (2) years of post-master's degree experience in a clinical mental health setting which includes: ( )

i. Assessment of the likelihood of danger to self or others, grave disability, capacity to give informed consent, and capacity to understand legal proceedings; ( )

ii. Use of DSM-IV-TR diagnostic criteria; ( )

iii. Treatment of mental health disorders including knowledge of treatment modalities and experience applying treatment modalities in a clinical setting; and ( )

iv. An understanding of the differences between behavior due to mental illness which poses a substantial likelihood of serious harm to self or others or which may result in grave disability from behavior which does not represent such a threat or risk. ( )

b. Knowledge of and experience applying Idaho mental health law. This must include: ( )

i. Experience that demonstrates understanding of the judicial process, including the conduct of commitment hearings. ( )

ii. Experience preparing reports for the court and testifying before a court of law. Experience must demonstrate an ability to provide the court with a thorough and complete oral and written evaluation that addresses the standards and questions set forth in the law; and ( )

iii. Knowledge of a client's legal rights. ( )

03. Required Training. Each applicant must have completed: ( )

a. A minimum of six (6) hours of training, provided by a Department-approved trainer, on the role of designated examiners and the processes used in fulfilling the responsibilities of designated examiners. ( )

b. A minimum of four (4) additional hours observing a designated examiner conducting a designated examination. ( )

201. -- 299. (RESERVED).

300. MINIMUM QUALIFICATIONS AND REQUIREMENTS FOR APPOINTMENT AS A DESIGNATED DISPOSITIONER.
To be appointed as a designated dispositioner in Idaho, an applicant must meet the following minimum qualifications and requirements. ( )

01. Appointment as a Designated Examiner. Applicants for designated dispositioner must also be appointed as a designated examiner by the Director. ( )

02. Required Experience and Abilities. Each applicant must have and demonstrate specific knowledge of available treatment alternatives in Idaho, types of treatment available for appropriate placement in Idaho, and level of care requirements in Idaho. ( )

301. -- 399. (RESERVED).

400. PROCESS AND PROCEDURE FOR APPLICANTS SEEKING CONSIDERATION FOR AN INITIAL APPOINTMENT AS A DESIGNATED EXAMINER, DESIGNATED DISPOSITIONER, OR BOTH.
Each applicant seeking an initial appointment as a designated examiner or designated dispositioner, or both, must submit the following information to the Regional Behavioral Health Program Manager of the region where he intends to practice or the State Hospital Administrative Director of the hospital at which he intends to practice. ( )

01. Complete an Application. Each applicant must complete and sign an application using Department form HW-0790. ( )

02. Provide Verification of Education, Training, Experience, and Criminal Background Check. Each applicant must provide the Department with the following: ( )

a. A current resume that documents: ( )

i. The applicant's degree, the date the degree was awarded, and the school from which the degree was received; and ( )

ii. How the applicant meets the requirements under Subsection 200.02 of these rules. ( )

b. A copy of the applicant's license. If the applicant is an LMSW, he must also provide a copy of the supervision plan approved by the Board of Social Work Examiners; ( )

c. Evidence of completion of the required ten (10) hours of training within sixty (60) days prior to the date of application in accordance with Subsection 200.03 of these rules showing the date(s), place(s), number of hours of training and the qualifications of the person(s) providing the training; ( )

d. Documentation of a criminal history and background check clearance completed within ninety (90) days of the date of the application. ( )

03. Regional or Hospital Recommendation. ( )

a. To be eligible for consideration and appointment as a designated examiner or designated dispositioner, or both, each applicant must receive a favorable recommendation from the Regional Behavioral Health Program Manager of the region where he intends to practice or the State Hospital Administrative Director of the hospital at which he intends to practice. ( )

b. Within thirty (30) days of the receipt of a completed and signed application, the Regional Behavioral Health Program Manager or the State Hospital Administrative Director will review the applicant's qualifications and, if satisfied, sign the application and forward it to the

Division along with all the information provided by the applicant as required under Subsection 400.02 of this rule. ( )

04. Final Decision on Appointment. ( )

a. Upon receiving a favorable recommendation in accordance with Subsection 400.03 of these rules, the Division will review each application for completeness and compliance with these rules. The review of the application will include such factors as the availability of funding, the degree of need in the regions and the state, and other factors, including the requirements under this rule. ( )

b. Upon completion of this review, the Division will make recommendations to the Director regarding appointments as designated examiner or designated dispositioner, or both. ( )

c. In accordance with Sections 66-317(5), 66-317(f), and 54-2303(a), Idaho Code, the Director has the authority to appoint applicants for designated examiner or designated dispositioner, or both, who meet the requirements under these rules. ( )

d. The Division will notify each applicant in writing of the Department's decision within sixty (60) days of the date the application was received by the Division. Written notification of the Department's decision will also be sent to the Regional Behavioral Health Program Manager or State Hospital Administrative Director that rendered a favorable recommendation in accordance with Subsection 400.03 of these rules. ( )

401. -- 499. (RESERVED).

500. DURATION OF APPOINTMENT AS DESIGNATED EXAMINER OR DESIGNATED DISPOSITIONER, OR BOTH.

01. Initial Appointment. Initial appointment of a designated examiner or a designated dispositioner, or both, expires one (1) year from the date of appointment, unless the designated examiner or designated dispositioner applies for, and is granted, reappointment in accordance with Section 600 of these rules. ( )

02. Reappointment. Reappointment of an individual as a designated examiner or designated dispositioner, or both, expires two (2) years from the date of such appointment, unless the designated examiner or designated dispositioner applies for, and is granted, reappointment. ( )

03. Expiration of Appointment Upon Leaving Department Employment. When an individual serving as a designated examiner, designated dispositioner, or both, leaves the employ of the Department, his appointment(s) expires the date his employment ends. He may reapply as a contractor under Section 600 of these rules. ( )

501. -- 599. (RESERVED).

600. PROCESS AND PROCEDURE FOR APPLICANTS SEEKING CONSIDERATION FOR REAPPOINTMENT AS A DESIGNATED EXAMINER OR DESIGNATED DISPOSITIONER, OR BOTH.

Each applicant seeking reappointment as a designated examiner or designated dispositioner, or both, must submit the following information to the Regional Behavioral Health Program Manager of the region where he intends to practice or the State Hospital Administrative Director of the hospital at which he intends to practice. ( )

01. Complete an Application. Each applicant *for reappointment* must complete and sign an application using Department form HW-0790. ~~*(1-1-09)T( )*~~

02 Criminal History and Background Check Requirement for Individuals Appointed as a Designated Examiner or Designated Dispositioner Prior to January 1, 2009. *Each individual appointed as a designated examiner or designated dispositioner, or both, prior to January 1, 2009, must show documentation of a criminal history and background check clearance completed within ninety (90) days prior to the date of his application for reappointment.*
( )

0~~2~~3. Regional or Hospital Recommendation. ( )

a. To be eligible for consideration and *re*appointment as a designated examiner or designated dispositioner, or both, each applicant must receive a favorable recommendation from the Regional Behavioral Health Program Manager of the region where he intends to practice or the State Hospital Administrative Director of the hospital at which he intends to practice.
~~*(1-1-09)T( )*~~

b. Within thirty (30) days of the receipt of a completed and signed application, the Regional Behavioral Health Program Manager or the State Hospital Administrative Director will review the applicant's qualifications and, if satisfied, sign the application and forward it to the Division along with ~~*all the information provided by the applicant as required under Subsection 400.02 of this rule*~~ *a copy of the applicant's current license*. ~~*(1-1-09)T( )*~~

0~~3~~4. Final Decision on Reappointment. ( )

a. The request for reappointment must be received by the Division at least sixty (60) days prior to the expiration date of the previous appointment of the designated examiner or designated dispositioner. ( )

b. The Division will notify each applicant in writing of the Department's decision within sixty (60) days of the date the application for reappointment was received by the Division. Written notification of the Department's decision will also be sent to the Regional Behavioral Health Program Manager or State Hospital Administrative Director that submitted the request for reappointment. ( )

c. If a designated examiner or designated dispositioner allows his appointment to expire, the applicant must reapply in accordance with the initial appointment requirements under Section 400 of this rule. ( )

601. -- 699. (RESERVED).

700. REVOCATION OF APPOINTMENT AS DESIGNATED EXAMINER OR DESIGNATED DISPOSITIONER, OR BOTH.
The Department may deny, suspend, or revoke the appointment or reappointment of designated examiners and designated dispositioners, or both, in accordance with the following procedures:
( )

01. Emergency Denial, Suspension, Revocation of Appointment or Reappointment. The Department will deny, suspend, or revoke appointment or reappointment, without prior notice, when conditions exist as to endanger the health or safety of any client.
( )

02. Written Request for Denial, Suspension, or Revocation of Appointment or Reappointment. In the absence of an emergency, a written request from the Regional Behavioral Health Program Manager or State Hospital Administrative Director must be made to the Division. The request must state the reason(s) for the requested denial, suspension, or revocation of an appointment or reappointment. ( )

03. Grounds for Revocation of Appointment or Reappointment. The Department may deny, suspend, or revoke an appointment or reappointment for any of the following reasons:
( )

a. Failure to comply with these rules. ( )

b. Failure to furnish data, information, or records as requested by the Department.
( )

c. Revocation or suspension of the applicant's professional license. ( )

d. Refusal to participate in a quality assurance process as requested by the Department. ( )

e. Inadequate knowledge or performance as demonstrated by repeated substandard peer or quality assurance reviews. ( )

f. Misrepresentation by the applicant in his application, or in documents required by the Department, or by an appointee in which there is a criminal, civil, or administrative determination that he has misrepresented the facts or the law to the court or administrative agency.
( )

g. Conflict of interest in which an appointee exploits his position as a designated examiner or designated dispositioner for personal benefit. ( )

h. A criminal, civil, or administrative determination that an appointee has committed fraud or gross negligence in his capacity as a designated examiner or designated dispositioner.
( )

i. Substantiated disposition of a child protection referral or adult protection referral. ( )

j. Failure to correct within thirty (30) days of written notice, any unacceptable conduct, practice, or condition as determined by the Department to be detrimental to public health or safety. ( )

04. Appeal of Department Decision. Applicants may appeal a Department decision to deny, suspend, or revoke an appointment in accordance with IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ( )

05. Reapplication for Appointment. Following denial, suspension, or revocation of appointment or reappointment, the same appointee may not reapply for appointment for a period of one (1) year after the effective date of the action. ( )

701. -- 999. (RESERVED).

IDAPA 19 - STATE BOARD OF DENTISTRY

19.01.01 - RULES OF THE STATE BOARD OF DENTISTRY

DOCKET NO. 19-0101-0901

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 54-912, 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.

No changes have been made to the pending rule from the proposed rule. The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 7, 2009 Idaho Administrative Bulletin, Vol.09-10, pages 86 through 89.

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 fiscal impact to the general fund as a result of this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact: Arthur R. Sacks, 208-334-2369

Dated this 9th day of November, 2009.

Arthur R. Sacks
Executive Director
Idaho State Board of Dentistry
350 North 9th Street,
Suite M-100, Boise, ID 83702
P. O. Box 83720, Boise, ID 83720-0021
Phone: 208-334-2369
Fax: 208-334-3247

THE FOLLOWING NOTICE 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 54-912, Idaho Code.

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

THURSDAY, OCTOBER 15, 2009 - 10:00 A.M.

OFFICE OF THE IDAHO BOARD OF DENTISTRY
350 North 9th Street
Suite M-100
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:

Rule 045: The proposed rule change provides for licensure of dental specialists by making the rule more inclusive. It defines the procedures necessary for specialty examinations for licensure.

Rule 050: The proposed rule change provides that not more than eight (8) of the required continuing education credits for license renewals for dentists be from self-study.

Rule 051: The proposed rule change provides that not more than six (6) of the required continuing education credits for license renewals for dental hygienists be from self-study.

Rule 062: The proposed rule change provides that a dentist may use other anesthesia personnel in his office during dental procedures without the necessity of having an anesthesia permit, so long as the dentist's facilities meet the same requirements as a dentist who holds a permit.

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 as a result of this rulemaking: N/A

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because of the relatively simple nature of the rule change.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Arthur R. Sacks, 208-334-2369.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2009.

DATED this 26th day of August, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

045. LICENSURE OF DENTAL SPECIALISTS (RULE 45).

01. ~~***Qualifications***~~ **Requirements for Specialty Licensure**. Each applicant shall have a general license for the practice of dentistry in the state of Idaho or another state. Any applicant who desires to be licensed in one (1) of the Board recognized specialties, which include and are limited to Dental Public Health, Endodontics, Oral and Maxillofacial Pathology, Oral and Maxillofacial Radiology, Oral and Maxillofacial Surgery, Orthodontics, Pediatric Dentistry, Periodontics, and Prosthodontics, must be a graduate of and hold a certificate from both a dental school and a Graduate Training Program that are accredited by the Commission on Dental Accreditation of the American Dental Association. ~~*Any dentist licensed in Idaho who has met the educational requirements and standards approved by the Board, and who has practiced in a Board recognized specialty prior to February 1, 1992, may be granted a specialty license by the Board without undergoing examination*~~. ~~*(4-6-05)*~~( )

02. Application. Application for license to practice a recognized dental specialty must be filed in the office of the Board of Dentistry, Statehouse Mail, Boise, Idaho. The application must be attested before a notary public. (7-1-93)

03. Examination. Specialty licensure in those specialties recognized may be granted solely at the discretion of the Idaho State Board of Dentistry. An examination covering the applicant's chosen field may be required and, if so, will be given by the Idaho State Board of Dentistry or its agent. Applicants who have met the requirements for licensure as a specialist may be required to pass an examination as follows: ( )

a. Applicants who have passed a general licensure examination acceptable to the Board may be granted specialty licensure by Board approval. ( )

b. Applicants who have passed a general licensure examination not acceptable to the Board may be required to pass a specialty examination. ( )

c. ~~*Candidates*~~ Applicants who are certified by the American Board of that particular

specialty as of the date of application for speciality licensure~~, and who meet the qualifications set forth in the Board's Rules,~~ may be granted specialty licensure by Board approval.~~(3-20-04)~~( )

04. Limitation of Practice. No dentist shall announce or otherwise hold himself out to the public as a specialist unless he has first complied with the requirements established by the Idaho State Board of Dentistry for such specialty and has been issued a specialty license authorizing him to do so. Any individual granted a specialty license must limit his practice to the specialty(s) in which he is licensed. (3-20-04)

(BREAK IN CONTINUITY OF SECTIONS)

050. CONTINUING EDUCATION FOR DENTISTS (RULE 50).
Effective October 1994, renewal of any active dental license will require evidence of completion of continuing education or volunteer dental practice that meets the following requirements. (4-6-05)

01. Requirements: (3-18-99)

a. All active dentists must hold a current CPR card. (7-1-93)

b. All active dentists shall acquire thirty (30) credits of continuing education in each biennial renewal period. One (1) credit is defined as one (1) hour of instruction. (3-30-07)

c. Continuing education must be oral health/health-related for the professional development of a dentist. The thirty (30) credits shall be obtained through continuing education courses, correspondence courses, college credit courses, and viewing of videotape or listening to other media devoted to dental education. Not more than eight (8) of the required credits shall be obtained through self-study. ~~(3-30-07)~~( )

d. A dentist holding an active status license issued by the Board shall be allowed one (1) credit of continuing education for every two (2) hours of verified volunteer dental practice performed during the biennial renewal period up to a maximum of ten (10) credits. (3-30-07)

e. Any person who becomes licensed as an active dentist during any biennial renewal period shall be required at the time of the next successive license renewal to report a prorated amount of continuing education credits as specified by the Board. (3-30-07)

02. Documentation. In conjunction with license renewal, the dentist shall provide a list of continuing education credits obtained and verification of hours of volunteer dental practice performed and certify that the minimum requirements were completed in the biennial renewal period. (3-30-07)

051. CONTINUING EDUCATION FOR DENTAL HYGIENISTS (RULE 51).
Effective April 1994, renewal of any active dental hygiene license or dental hygiene license endorsement will require evidence of completion of continuing education or volunteer dental

hygiene practice that meets the following requirements. (4-6-05)

01. Requirements for Renewal of an Active Status Dental Hygiene License: (4-6-05)

a. All active dental hygienists must hold a current CPR card. (6-2-92)

b. All active dental hygienists shall acquire twenty-four (24) credits of continuing education in each biennial renewal period. One (1) credit is defined as one (1) hour of instruction. (3-30-07)

c. Continuing education must be oral health/health-related education for the professional development of a dental hygienist. The twenty-four (24) credits shall be obtained through continuing education courses, correspondence courses, college credit courses, viewing of videotape or listening to other media devoted to dental hygiene education. Not more than six (6) of the required credits shall be obtained through self-study. ~~*(3-30-07)*~~( )

d. A dental hygienist holding an active status license issued by the Board shall be allowed one (1) credit of continuing education for every two (2) hours of verified volunteer dental hygiene practice performed during the biennial renewal period up to a maximum of ten (10) credits. (3-30-07)

e. Any person who becomes licensed as an active dental hygienist during any biennial renewal period shall be required at the time of the next successive license renewal to report a prorated amount of continuing education credits as specified by the Board. (3-30-07)

02. Requirements for Renewal of an Extended Access Dental Hygiene License Endorsement. In addition to any other continuing education requirements for renewal of a dental hygiene license, a person granted an extended access dental hygiene license endorsement shall complete twelve (12) credits of continuing education in each biennial renewal period in the specific practice areas of medical emergencies, local anesthesia, oral pathology, care and treatment of geriatric, medically compromised or disabled patients and treatment of children. Any person who is issued an extended access dental hygiene license endorsement during any biennial renewal period shall be required at the time of the next successive license renewal to report a prorated amount of those continuing education credits required under this section as specified by the Board. (3-30-07)

03. Documentation. In conjunction with license and endorsement renewal, the dental hygienist shall provide a list of continuing education credits obtained and verification of hours of volunteer dental hygiene practice performed and certify that the minimum requirements were completed in the biennial renewal period. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

062. USE OF OTHER ANESTHESIA PERSONNEL (RULE 62).

A ~~D~~dentist~~s~~ who does not hold an anesthesia permit may perform~~*ing*~~ dental procedures in a dental office ~~*who utilize the services of*~~ on a patient who receives anesthesia induced by an anesthesiologist, a certified registered nurse anesthetist (CRNA), or another dentist with an anesthesia permit~~*, must possess an anesthesia permit required under these rules for the level of anesthesia being provided to the patient.*~~ as follows: ~~*(4-5-00)*~~( )

01. Personnel and Equipment Requirements. The dentist shall have the same personnel, facilities equipment, and drugs available during the procedure and during recovery as required of a dentist who has a permit for the level of anesthesia being provided. ( )

02. Patient's Condition Monitored Until Discharge. The qualified anesthesia provider who induces anesthesia shall monitor the patient's condition until the patient is discharged and record the patient's condition at discharge in the patient's dental record as required by the rules applicable to the level of anesthesia being induced. The anesthesia record shall be maintained in the patient's dental record and is the responsibility of the dentist who is performing the dental procedures. ( )

03. Use of Services of a Qualified Anesthesia Provider. A dentist who intends to use the services of a qualified anesthesia provider shall notify the Board in writing of his intent. Such notification need only be submitted once every licensing period. ( )

04. Advertising. A dentist who intends to use the services of a qualified anesthesia provider may advertise the service provided so long as each such advertisement contains a prominent disclaimer that the service "will be provided by a qualified anesthesia provider."( )

IDAPA 22 - BOARD OF MEDICINE

22.01.01 - RULES OF THE BOARD OF MEDICINE FOR THE LICENSURE TO PRACTICE MEDICINE AND SURGERY AND OSTEOPATHIC MEDICINE AND SURGERY IN IDAHO

DOCKET NO. 22-0101-0901

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 54-1806 (2) (4) and (11) and 54-1806A, 54-1812, 54-1813, 54-1814 and 54-1841, 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 purpose of the change to the pending is to update the rule and ensure public health, safety and welfare by providing the Board an opportunity to collaborate with other medical regulatory bodies by providing the Board the authority to share information with other state boards. This opportunity increases the ability to restrict incompetent practitioners moving from state to state without disclosure or discovery of previous damaging or incompetent performance.

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 5, 2009 Idaho Administrative Bulletin, Vol. 09-8, pages 123 and 124.

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 negative fiscal impact to the general fund as a result of this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Nancy M. Kerr at 208-327-7000.

DATED this October 21, 2009.

Nancy M. Kerr, Executive Director
Board of Medicine
1755 Westgate Dr. #140
PO Box 83720, Boise, ID 83720-0058
Phone 208-327-7000
Fax 208-327-7005

THE FOLLOWING NOTICE 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 54-1806 (2) (4) and (11), and 54-1806A, 54-1812, 54-1813, 54-1814 and 54-1841, 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 19, 2009.

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 change's purpose is to assure the public health, safety and welfare in Idaho by providing the Board an opportunity to collaborate with other medical regulatory bodies. This proposed language provides the Board the authority to share information with other state boards to increase the capacity to restrict the ability of incompetent practitioners to move from state to state without disclosure or discovery of previous damaging or incompetent performance.

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, Idaho Code, negotiated rulemaking was not conducted, however, the Board received input and comments regarding sharing information, otherwise exempt from disclosure from other state medical boards and the Federation of State Medical Boards, Inc.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN

COMMENTS: For assistance on technical questions concerning the proposed rule, contact Nancy M. Kerr, Idaho State Board of Medicine, (208) 327-7000.

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 26, 2009.

DATED this 1st day of July, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

003. ADMINISTRATIVE APPEAL.
All contested cases shall be governed by the provisions of IDAPA 04.11.01, "Idaho Rules of Administrative Procedures of the Attorney General," and IDAPA 22.01.07, "Rules of Practice and Procedure of the Board of Medicine," *and this chapter*. ~~*(5-3-03)*~~*( )*

004. PUBLIC RECORD ACT COMPLIANCE.
These rules have been promulgated according to the provisions of Title 67, Chapter 52, Idaho Code, and are public records. Pursuant to Section 9-340C (9), Idaho Code, the Board *may discuss, exchange and share complaints and the details of investigations with other Idaho state agencies or* with other state boards in investigation and enforcement concerning violations of the Idaho Medical Practice Act and *Board* rules and comparable *practice* acts of other states.
~~*(5-3-03)*~~*( )*

(BREAK IN CONTINUITY OF SECTIONS)

007. FILING OF DOCUMENTS - NUMBER OF COPIES.
All *original* documents in rulemaking or contested case proceedings must be filed with the office of the Board. ~~*The original and ten (10) copies of all documents must be filed with the office of the Board.*~~ ~~*(5-3-03)*~~*( )*

IDAPA 23 - IDAHO BOARD OF NURSING

23.01.01 - RULES OF THE IDAHO BOARD OF NURSING

DOCKET NO. 23-0101-0901

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 54-1404 and 54-1418, 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, therefore, it is being adopted as proposed. The complete text of the proposed rule was published in the July 1, 2009 Idaho Administrative Bulletin, Vol. 09-7, pages 101 through 104.

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. 26.

DATED this 30th day of July 2009.

Sandra Evans, M.A.Ed., R.N.
Executive Director
Board of Nursing
280 N. 8th St., Ste. 210
P. O. Box 83720, Boise, ID 83720-0061
Phone: (208) 334-3110 ext. 26
Fax: (208) 334-3262

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORAY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2009.

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 54-1404 and 54-1418, 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 15, 2009.

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:

By statute, Idaho is a party state to the Nurse Licensure Compact. Party states, through their compact administrators, are charged with promulgating uniform rules to facilitate and coordinate implementation of the compact. These temporary and proposed rules are being promulgated as uniform rules pursuant to this process. The temporary and proposed rules revise an existing definition, provide additional methods of proving an applicant's primary state of residency, and clarify circumstances and procedures for issuance of a "single state" license where appropriate.

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 temporary rulemaking is necessary to comply with deadlines in amendments to governing law.

FEE SUMMARY: Pursuant to Section 67-5226(2), Idaho Code, 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 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 of the need for temporary rulemaking, as well as the fact

that this is uniform rulemaking in compliance with controlling law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Sandra Evans, MAEd., R.N., Executive Director, (208) 334-3110 ext. 26.

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 22, 2009.

DATED this 26th day of May, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

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~~*n individual's*~~ person's declared~~, *and*~~ fixed permanent ~~*residence*~~ and principal home for legal purposes; domicile.
~~*(3-15-02)*~~( )

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) examination: (4-6-05)

a. NCLEX-RN for professional 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; ~~*or*~~ ~~*(3-15-02)*~~( )

iii. Federal income tax return declaring the primary state of residence.~~;~~ ~~*(3-15-02)*~~( )

iv. Military Form No. 2058 - state of legal residence certificate; or ( )

v. W2 from U.S. Government or any bureau, division, or agency thereof, indicating the declared state of residence. ( )

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. ( )

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. ( )

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. ( )

~~*b*~~**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 (30) days. (3-15-02)

~~*c*~~**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 (30) day period in Paragraph 077.03.b. of these rules shall be stayed until resolution of the pending investigation. (3-30-07)

~~*d*~~**g.** The former home state license is not valid upon the issuance of a new home state license. (3-15-02)

~~*e*~~**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. ( )

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

24.03.01 - RULES OF THE STATE BOARD OF CHIROPRACTIC PHYSICIANS

DOCKET NO. 24-0301-0901

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 54-707, 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 pending rule is being adopted as proposed. The complete text of the proposed rule was published in Book 2 of the October 7, 2009 Idaho Administrative Bulletin, Vol. 09-10, pages 115 through 117.

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 negative fiscal impact on the general fund as a result of this rulemaking.

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, 2009.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
1109 Main St. Ste. 220
Boise, ID 83702
(208) 334-3233 Ph. / (208) 334-3945 fax

THE FOLLOWING NOTICE 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(s) 54-707, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2009.

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 rule updates the State Board of Chiropractic Physicians' website address as it has changed. To protect the public, it adds a definition for direct personal supervision. It clarifies who qualifies as a chiropractic intern. It clarifies when a temporary permit is available.

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

No fee or charge is being imposed through this rulemaking.

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:

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because the changes were discussed in noticed open meetings.

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 October 28, 2009.

DATED this 25th day of August, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

005. ADDRESS OF IDAHO BOARD OF CHIROPRACTIC PHYSICIANS (RULE 5).
The office of the Board of Chiropractic Physicians is located within the Bureau of Occupational Licenses, Owyhee Plaza, 1109 Main Street, Suite 220, Boise, Idaho 83702-5642. The phone number of the Board is (208) 334-3233. The Board's FAX number is (208) 334-3945. The Board's e-mail address is chi@ibol.idaho.gov. The Board's official web site ~~*is*~~ can be found at http://www.ibol.idaho.gov~~*/chi.htm*~~. ~~*(4-11-06)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

010. DEFINITION (RULE 10).

0~~5~~1. **Athletic Trainer**. A person licensed by the Idaho Board of Medicine pursuant to Section 54-3909, Idaho Code. (4-11-06)

0~~1~~2. **Board**. The State Board of Chiropractic Physicians as prescribed in Section 54-703, Idaho Code. (7-1-93)

0~~2~~3. **Bureau**. The Bureau of Occupational Licenses as prescribed in Section 67-2602, Idaho Code. (3-15-02)

04. **Direct Personal Supervision**. Direct Personal Supervision means that the licensed chiropractic physician is physically present in the clinic, is monitoring the activities of the supervisee, and is available to intervene, if necessary. ( )

0~~4~~5. **Inactive Retired**. The status of a licensee who is over sixty-five (65) years of age, has paid the inactive retired fee and is permanently retired from the practice of chiropractic. The holder of an inactive retired license may not practice chiropractic in Idaho. (3-15-02)

0~~3~~6. **Inactive Status**. The status of licensure that has been made inactive by compliance with Section 54-708(2) and Subsection 300.02. The holder of an inactive license may not practice chiropractic in Idaho. (3-15-02)

(BREAK IN CONTINUITY OF SECTIONS)

551. CHIROPRACTIC INTERN (RULE 551).

01. **Definition**. A chiropractic intern is defined as any individual who is presently enrolled in a school of chiropractic and is qualified to practice as an intern as established by the approved chiropractic college that the individual attends and who will function in a dependent relationship with a supervising chiropractic physician in the performance of chiropractic practice. ~~*(3-15-02)*~~( )

02. **Chiropractic Physician Responsible and Liable**. The chiropractic physician shall be responsible and liable for: (3-15-02)

a. Direct personal supervision of the intern; (3-15-02)

b. Any acts of the intern in the performance of chiropractic practice; (3-15-02)

c. Determining that the intern possesses sufficient training and capabilities before authorization is given to perform any chiropractic practice. (3-15-02)

03. Chiropractic Intern Limitations. A chiropractic intern shall not: (3-15-02)

a. Perform any chiropractic practice independently, but must perform all such practice under the direct personal supervision of a licensed Chiropractic Physician; (3-15-02)

b. Provide diagnostic results or interpretations to the patient prior to consultation with the supervising Chiropractic Physician; (3-15-02)

c. Provide treatment advice to any patient without instructions from the supervising Chiropractic Physician. (3-15-02)

552. TEMPORARY PRACTICE PERMITS (RULE 552).
When an original application for license or internship is accepted by the board as being fully completed, in accordance with the requirements of the Idaho Chiropractic Physician Law and these Rules, a temporary permit to practice may be issued. (3-15-02)

01. Supervision Required. A permit holder may work only when under the direct personal supervision of a chiropractic physician currently licensed in Idaho. The name, address and signature of the supervising chiropractic physician shall appear on the application. (3-15-02)

02. Only One Permit May Be Issued. Only one (1) permit may be issued under any circumstances to any individual. (3-15-02)

03. Validity of Temporary Permits. Temporary permit to practice will be valid for a period not to exceed twelve (12) months and only: (3-15-02)

a. In the case of an applicant for Idaho licensure, until the results of the next scheduled examination have been released. No work permit will be issued to an applicant who has previously failed an examination for licensure in this or any other state, territory, possession, or country more than once. Failure to sit for the next scheduled examination will invalidate the work permit and no further permits will be issued. ~~*(3-15-02)*~~( )

b. In the case of an intern, until the scheduled date of graduation from an approved school of chiropractic. Upon original application for licensure in Idaho, the intern permit may be extended by the board until the results of the next scheduled examination have been released. No work permit will be issued to an applicant who has previously failed an examination for licensure in this or any other state, territory, possession, or country more than once. Failure to sit for the next scheduled examination will invalidate the work permit and no further permits will be issued. ~~*(3-15-02)*~~( )

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.10.01 - RULES OF THE STATE BOARD OF OPTOMETRY

DOCKET NO. 24-1001-0901

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 54-1509, 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 pending rule is being adopted as proposed. The complete text of the proposed rule was published in Book 2 of the October 7, 2009 Idaho Administrative Bulletin, Vol. 09-10, pages 145 through 148.

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 negative fiscal impact to the general fund as a result of this rulemaking.

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, 2009.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
1109 Main St. Ste. 220
Boise, ID 83702
(208) 334-3233 Ph.
(208) 334-3945 fax

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2009.

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 54-1509, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2009.

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 2009 Legislature passed Senate Bill 1115 which added "opticianry" to the exemptions in the law. This rule provides a definition for "opticianry." To benefit the public, it clarifies that failure to release contact lens prescriptions as required by Federal law could be gross incompetence. The rule clarifies the expiration date for prescriptions, spectacles and contact lenses for the benefit of the optometrist and the public.

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:

These temporary rules comply with federal programs and amendments in governing law and confer a public benefit.

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: 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, Idaho Code, negotiated rulemaking was not conducted because the change is due to revisions in Title 54, Chapter 15, Idaho Code.

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 October 28, 2009.

DATED this 17th day of August, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

010. DEFINITIONS (RULE 10).

01. Board. The State Board of Optometry as prescribed in Section 54-1503, Idaho Code. (7-1-93)

02. Bureau. The Bureau of Occupational Licenses as prescribed in Sections 54-1509 and 67-2602, Idaho Code. (3-15-02)

03. Low Vision. Refer to Section 54-1501(5), Idaho Code, correcting defects may include low vision but is not limited to low vision rehabilitation. (7-1-97)

04. Opticianry. The professional practice of filling prescriptions from a licensed optometrist or ophthalmologist for ophthalmic lenses, contact lenses, and any other ophthalmic device used to improve vision. Opticianry does not include prescriptive authority. ( )

045. Vision Therapy. Any person who assesses, diagnoses, treats, or prescribes treatment for conditions of the visual system or manages a patient with vision therapy, visual training, visual rehabilitation, orthoptics or eye exercises or who hold him/herself out as being able to do so for the rehabilitation and/or treatment of physical, physiological, sensorimotor, neuromuscular or perceptual anomalies of the eyes or vision system or who prescribes or utilizes lenses, prisms, filters, occlusion or other devices for the enhancement, rehabilitation and/or treatment of the visual system or prevention of visual dysfunctions, except under the supervision and management of a licensed optometrist, is engaged in the practice of optometry. (7-1-97)

(BREAK IN CONTINUITY OF SECTIONS)

425. RULES DEFINING GROSS INCOMPETENCE (RULE 425).
In order to protect the public, the Board of Optometry defines as "gross incompetence" any behavior or practice on the part of the licensed optometrist which demonstrates a lack of competence with respect to discharging professional obligations or duties which might result in

injury or damage to a patient whether such injury or damage actually occurs or not and in particular, the Board defines as "gross incompetence" any of the following: (11-6-93)

01. Failure to Meet Prevailing Standards. Failure to meet prevailing standards, or willful rendering of substandard care, either individually or as part of a third party reimbursement agreement or by other agreement. (7-1-97)

02. Failure to Meet Prevailing Standards in the Referral of Any Patient Who Is Suffering From Any Apparent or Suspected Pathological Condition. A failure to meet prevailing standards in the referral of any patient who is suffering from any apparent or suspected pathological condition to a person competent and licensed to properly treat or diagnose the condition. (7-1-93)

03. Employment of Techniques or Methods of Practice. Employment of techniques or methods of practice in treating or prescribing for a patient when he does not have proper training in the technique or methods of practice. (7-1-93)

04. Failure to Advise Patient of Possible Danger When a Lens Not Meeting Impact Resistance Standards of F.D.A. Failure to advise his patient of possible danger when a lens not meeting impact resistance standards of F.D.A. Regulation, Sec. 3.84,21 CFR., is provided for the patient. (7-1-93)

05. Failure to Provide Follow-Up Care. Failure to provide follow-up care according to prevailing standards. (11-6-93)

06. Displaying Gross Ignorance or Demonstrating Gross Inefficiency. Displaying gross ignorance or demonstrating gross inefficiency in the care of a patient. (7-1-93)

07. Failure to Verify the Specifications of All Lenses. Failure to verify the specifications of all lenses provided by him. (11-6-93)

08. Failing to Perform Tests and Record Findings. In the course of an examination of a patient, failure to perform tests and record findings in a manner consistent with prevailing standards of optometric care. (11-6-93)

09. Using Pharmaceutical Agents. Using pharmaceutical agents in the practice of optometry without having attended sufficient training programs or schools and acquiring the knowledge necessary to use the drugs in a competent manner. (11-6-93)

10. Illegal Prescription Sale, Administration, Distribution, or Use of Drugs. Prescribing, selling, administering, distributing, giving, or using drugs legally classified. Prescribing, selling, administering, distributing, giving, or using drugs legally classified as a controlled substance or as an addictive or dangerous drug for other than accepted diagnostic or therapeutic purposes. (7-1-97)

11. Disciplinary Action or Sanctions. Disciplinary action or sanctions taken by another state, jurisdiction, peer review body or a professional association or society against an optometrist for acts or conduct similar to acts or conduct which would constitute grounds for

action as defined under "Rules of the Idaho Board of Optometry." (7-1-97)

12. Sanitary Office. Has failed to maintain sanitary office conditions, equipment, and use appropriate techniques and procedures. (7-1-97)

13. Failure to Release Prescription. Failure to release either a spectacle or contact lens prescription as required by Federal law. ~~(7-1-97)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

450. CONTENTS OF PRESCRIPTION (RULE 450).
Every prescription written or issued by an optometrist practicing in Idaho shall contain at least the following information: (7-1-93)

01. Prescription for Spectacles. Prescriptions for spectacles must contain the following: (7-1-93)

a. Sphere, cylinder, axis, prism power and additional power, if applicable; and (3-30-07)

b. The standard ~~E~~expiration date of the prescription must be at least one (1) year from date the prescription was originally issued. ~~(7-1-93)~~( )

02. All Prescriptions for Rigid Contact Lenses. All prescriptions for rigid contact lenses must contain at least the following information: (7-1-93)

a. Base curve; (7-1-93)

b. Peripheral curve or curves including width; (7-1-93)

c. Overall diameter; (7-1-93)

d. Optical zone diameter; (7-1-93)

e. Power; and (3-30-07)

f. The standard ~~E~~expiration date of the prescription must be at least one (1) year from date the prescription was originally issued. A shorter prescription period may be allowed when based upon a documented medical condition. ~~(7-1-93)~~( )

03. All Prescriptions for Soft Contact Lenses. All prescriptions for soft contact lenses must contain at least the following information: (7-1-93)

a. Lens manufacturer or "brand" name; (7-1-93)

b. Series or base curve; (7-1-93)

c. Power; (7-1-93)

d. Diameter, if applicable; (7-1-93)

e. Color, if applicable; and (7-1-93)

f. The standard ~~E~~expiration date of the prescription is one (1) year from date the prescription was originally issued. A shorter prescription period may be allowed when based upon a documented medical condition. ~~(7-1-93)~~( )

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.11.01 - RULES OF THE STATE BOARD OF PODIATRY

DOCKET NO. 24-1101-0901

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 54-605, 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 pending rule is being adopted as proposed. The complete text of the proposed rule was published in Book 2 of the October 7, 2009 Idaho Administrative Bulletin, Vol. 09-10, pages 149 and 150.

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 negative fiscal impact to the general fund as a result of this rulemaking.

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, 2009.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
1109 Main St. Ste. 220
Boise, ID 83702
(208) 334-3233 Ph.
(208) 334-3945, fax

THE FOLLOWING NOTICE 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 54-605, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2009.

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 updates the contact information for the Board of Podiatry as it has changed. It updates the American Podiatric Medical Association's Code of Ethics referenced in Section 500 to reflect the current edition. It clarifies the licensure by endorsement requirements for residency programs and disciplinary action.

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

No fee or charges is being imposed through this rulemaking.

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:

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because the changes were discussed in noticed open meetings.

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 October 28, 2009.

DATED this 17th day of August, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

004. INCORPORATION BY REFERENCE (RULE 4).
The document titled American Podiatric Medical Association's Code of Ethics as published by the American Podiatric Medical Association, dated April 200~~5~~8 and referenced in Section 500, is herein incorporated by reference and is available from the Board's office and on the Board web site. ~~*(4-11-06)*~~( )

005. ADDRESS OF THE IDAHO BOARD OF PODIATRY (RULE 5).
The office of the Board of Podiatry is located within the Bureau of Occupational Licenses, Owyhee Plaza, 1109 Main Street, Suite 220, Boise, Idaho 83702-5642. The phone number of the Board is (208) 334-3233. The Board's FAX number is (208) 334-3945. The Board's e-mail address is pod@ibol.idaho.gov. The Board's official web site ~~*is*~~ can be found at http:// www.ibol.idaho.gov~~*/pod.htm*~~. ~~*(4-11-06)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

401. LICENSURE BY ENDORSEMENT (RULE 401).
Under Section 54-613, Idaho Code, applicants for licensure by endorsement may be granted a license upon the approval of the Board. Each applicant for licensure by endorsement must provide documentation for each of the following before licensure will be considered: (3-15-02)

01. Complete Application. A complete application together with the required fee. (4-11-06)

02. Certification of License. Certification of having maintained a current license or other authority to practice issued by a regulatory board of Podiatry in any state or territory. (4-11-06)

03. Credentials. Credentials as required in Subsections 200.02 through 200.0~~6~~5. ~~*(4-11-06)*~~( )

04. Examination. Successful passage of a written licensure examination covering all those subjects noted in Section 54-606, Idaho Code. Official certification of examination must be received by the board directly from: (4-11-06)

a. The applicant's state or territory of licensure; or (3-15-02)

b. The national board of podiatry examiners. (4-11-06)

05. Residency. Proof of completion of the residency requirement as set forth in Subsection 200.06 of this rule. However, if the applicant graduated from a college of podiatry prior to 1993, this requirement will be waived. ( )

0~~5~~6. Practical Experience. Having practiced podiatry under licensure for three (3) of the last five (5) years immediately prior to the date of application. (4-11-06)

0~~6~~7. Continuing Education. Obtained at least twelve (12) hours of continuing education during the twelve (12) months prior to the date of application. (4-11-06)

0~~7~~8. Disciplinary Action. Has not been the subject of any disciplinary action including pending or unresolved licensure actions within the last five (5) years immediately prior to application and has never had a license to practice podiatry revoked~~,~~ or suspended~~, or otherwise sanctioned~~ either voluntarily or involuntarily in any jurisdiction. ~~(3-15-02)~~( )

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.12.01 - RULES OF THE IDAHO STATE BOARD OF PSYCHOLOGIST EXAMINERS

DOCKET NO. 24-1201-0902

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 54-2305, 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 pending rule is being adopted as proposed. The complete text of the proposed rule was published in Book 2 of the October 7, 2009 Idaho Administrative Bulletin, Vol. 09-10, pages 157 through 160.

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 negative fiscal impact to the general fund as a result of this rulemaking.

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, 2009.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
1109 Main St. Ste. 220
Boise, ID 83702
(208) 334-3233 Ph.
(208) 334-3945 Fax

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 30, 2009.

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 54-2305, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2009.

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 2009 Legislature passed House Bill 45 which made changes to the Psychology Act. The bill clarified the experience required for a psychology license to allow credit for an internship. The proposed rules are being changed to be consistent with the new law. The rules also allow for an additional path for licensure of out of state psychologists through endorsement. The rules also establish a temporary license to allow out of state psychologists to practice in Idaho to benefit the public in an emergency or special circumstance.

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:

The temporary rule complies with deadlines in amendments to governing law and confers a benefit.

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: None.

No fee or charge is being imposed or increased through this rulemaking.

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 negative fiscal impact to the general fund as a result of this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because the change is due to update of current NCARB edition.

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 October 28, 2009.

DATED this 17th day August, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

100. CREDENTIALS TO BE FILED BY ALL APPLICANTS (RULE 100).

01. Completed Application. An application shall be completed by all applicants for licensure upon a form prescribed by the State Board of Psychologist Examiners. No application shall be accepted or considered by the Board prior to the date the required doctoral degree was conferred upon the applicant. (3-20-04)

02. Official Transcripts. All applicants shall arrange for official transcripts of all credits earned, at each approved college or university, to be transmitted by the registrars of the educational institutions directly to the Board. (7-1-93)

03. Letters of Reference. Letters of reference, regarding the character, training, and experience of the applicant shall be returned to the Board by the references before decision is rendered on the application. (7-1-93)

04. ~~*Post-Graduate*~~ Supervised Experience. One (1) of the two (2) years of ~~*post-graduate*~~ supervised experience as required by Section 2307(b), Idaho Code, ~~*(not the internship)*~~ may be pre-doctoral. The second year must be post-doctoral work under appropriate supervision and must be verified by the appropriate supervisor. ~~*(3-15-02)*~~( )

05. Official Documentation. Official documentation of meeting the requirements of Chapter 23, Title 54, Idaho Code and IDAPA 24.12.01, must be received by the Board directly from the entity or person responsible for providing such official documentation. Applicants are responsible for requesting the required documentation from the appropriate entities and persons. (3-15-02)

06. Applications on File. Applications on file with the Board for a period in excess of five (5) years from the date of receipt by the Bureau shall be terminated unless good cause is

demonstrated to the Board. (3-20-04)

07. Deadline. To be considered by the Board, a properly completed application together with all supporting documentation and required fees must be received by the Bureau at least seven (7) calendar days prior to the next scheduled meeting of the Board. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

250. ENDORSEMENT (RULE 250).

01. Eligibility for Endorsement. An applicant who is in possession of a valid statutory license or statutory certificate from another state or Canada may apply for licensing under the endorsement section of this law. (3-15-02)

02. Requirements for Endorsement. An applicant under the endorsement section shall have: (3-15-02)

a. A valid psychology license or certificate issued by the regulatory entity of another jurisdiction; and (3-15-02)

b. A current certificate of professional qualification in Psychology as defined in these rules; or (3-15-02)

c. ~~*A degree of doctor of philosophy in psychology or a doctoral degree in a field related to psychology plus two (2) years of post graduate experience acceptable to the Board and excluding internship, and document each of the following:*~~ A registration with the National Register of Health Service Providers in Psychology; or ~~*(3-15-02)*~~( )

~~*i. A passing score on the EPPP examination or other similar examination; (3-15-02)*~~

~~*ii. Two (2) years of supervised experience, one (1) of which was post-doctoral, for a minimum of three thousand (3,000) total hours acceptable to the Board; (3-15-02)*~~

d. A certification by American Board of Professional Psychology; or ( )

e. Graduated from an accredited college or university with a doctoral degree in psychology and two (2) years of supervised experience acceptable to the Board, one (1) year of which may include a pre-doctoral practicum or internship and one (1) year of which must be post-doctoral; or ( )

f. Graduated from an accredited college or university with a doctoral degree in a field related to psychology, provided experience and training are acceptable to the Board; and ( )

~~*iii*~~**g.** A record of practicing Psychology at the independent level for the five (5) years

immediately prior to application; and ~~*(3-15-02)*~~( )

~~*iv*~~**h.** A history of no disciplinary action in any jurisdiction. (3-15-02)

(BREAK IN CONTINUITY OF SECTIONS)

300. ~~*NO*~~ TEMPORARY LICENSES (RULE 300).
~~*No temporary licenses to practice psychology will be issued by the Board.*~~ Persons not licensed in this state who desire to practice psychology under the provisions of this chapter for a period not to exceed thirty (30) days within a calendar year may do so if they hold an interjurisdictional practice certificate (IPC) from the association of state and provincial psychology boards (ASPPB). As such, in order to practice temporarily under the IPC psychologists would be required to notify the Board of their intent to practice and provide documentation of their status. It is the IPC holders responsibility to contact the ASPPB to send verification of IPC status, including verification of no discipline. ~~*(7-1-93)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

550. REQUIREMENTS FOR SUPERVISED PRACTICE (RULE 550).

01. Duration and Setting of Supervised Practice. (7-1-93)

a. A year of supervised experience is defined as a minimum of one thousand (1000) hours of supervised service provision acquired during not less than a twelve (12) month and no more than a thirty-six (36) calendar month period. The first year of supervised experience shall be accredited only after acquiring the equivalent of one (1) year of full time graduate study. A second year must be obtained post-doctorally. (5-3-03)

b. A minimum qualifying supervised experience consists of two (2) years of supervised experience, ~~*neither of which is the internship, and at least*~~ one (1) of which is obtained post-doctorally. ~~*(7-1-93)*~~( )

02. Qualifications of Supervisors. Supervising psychologists shall be licensed and shall have training in the specific area of practice in which they are offering supervision. (7-1-93)

03. Amount of Supervisory Contact. One (1) hour per week of face-to-face individual contact per twenty (20) hours of applicable experience is a minimum. (7-1-93)

04. Evaluation and Accreditation of Supervised Practice. The Board shall require submission of information by the supervisor(s) which enable it to evaluate and credit the extent and quality of the candidate's supervised practice. The form requesting such information shall cover the following: (7-1-93)

a. Name of supervisee; (7-1-93)

b. Educational level of supervisee; (7-1-93)

c. Supervisor's name, address, license number, state in which granted and area of specialization; (7-1-93)

d. Name and nature of setting in which supervised practice took place; (7-1-93)

e. Date of practice covered in this report; (7-1-93)

f. Number of practice hours during this period; (7-1-93)

g. Supervisee's duties; (7-1-93)

h. Number of one-to-one supervisory hours; (7-1-93)

i. Assessment of supervisee's performance; and (7-1-93)

j. Whether or not the supervisee received monetary compensation for the supervised services they provided. (7-1-93)

05. Unacceptable Supervision. Supervised practice time during which the supervisor deems supervisee's performance to have been unacceptable shall not be credited towards the required supervised practice hours. (7-1-93)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.15.01 - RULES OF THE IDAHO LICENSING BOARD OF PROFESSIONAL COUNSELORS AND MARRIAGE AND FAMILY THERAPISTS

DOCKET NO. 24-1501-0901

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 54-3404, 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 pending rule is being adopted as proposed. The complete text of the proposed rule was published in Book 2 of the October 7, 2009 Idaho Administrative Bulletin, Vol. 09-10, pages 161 through 168.

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 negative fiscal impact to the general fund as a result of this rulemaking.

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, 2009.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
1109 Main St. Ste. 220
Boise, ID 83702
(208) 334-3233 Ph.
(208) 334-3945 Fax

THE FOLLOWING NOTICE 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 54-3404, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2009.

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 Board of Professional Counselor and Marriage and Family Therapists is proposing changes that clarify the content of the graduate program to ensure competency. It allows for supervision to be provided by a counselor education faculty member for the benefit of a student and it clarifies interns. For the benefit of out of state applicants, it provides that out of state supervised experience does not need to be provided by a registered supervisor. It deletes reference to professional counselor as it relates to administration fees for examination as fees are paid to test administrator. To ensure competency, it clarifies endorsement for applicants from a foreign country. To protect the public, it updates language for various methods of meeting the requirements which will provide a licensee more flexibility to meet the requirements. The Board is also updating the website as it has changed.

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

No fees are being imposed or increased through this rulemaking.

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:

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because the changes were discussed in noticed open meetings.

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 October 28, 2009.

DATED this 14th day of August, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

005. ADDRESS OF IDAHO LICENSING BOARD OF PROFESSIONAL COUNSELORS AND MARRIAGE AND FAMILY THERAPISTS (RULE 5).
The office of the Board of Professional Counselors and Marriage and Family Therapists is located within the Bureau of Occupational Licenses, Owyhee Plaza, 1109 Main Street, Suite 220, Boise, Idaho 83702-5642. The phone number of the Board is (208) 334-3233. The Board's FAX number is (208) 334-3945. The Board's e-mail address is cou@ibol.idaho.gov. The Board's official web site ~~*is*~~ can be found at http://www.ibol.idaho.gov~~*/cou.htm*~~. ~~*(3-30-06)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

150. QUALIFICATIONS FOR PROFESSIONAL COUNSELOR LICENSURE (RULE 150).
Licensure as a "professional counselor" shall be restricted to persons who have successfully completed the required examination and each of the following requirements: (3-30-06)

01. Graduate Program Requirement. A planned graduate program of sixty (60) semester hours which is primarily counseling in nature, six (6) semester hours of which are earned in an advanced counseling practicum, and including a graduate degree in a counseling field from an accredited university or college offering a graduate program in counseling. (7-1-93)

a. A planned graduate program in a counseling field shall be defined as completion of one (1) of the following: (7-1-93)

i. A counseling program approved by the Council for Accreditation of Counseling and Related Educational Programs; or (7-1-93)

ii. A counseling program approved by the Council on Rehabilitation Education; or (7-1-93)

iii. A counseling program approved by the Board which shows evidence of education in the following areas: Counseling Theory, Counseling Techniques and Supervised Counseling Experience (this practicum must be supervised at the ratio of at least one (1) hour of one-to-one supervision for every ten (10) hours of experience in the setting) ~~*and a minimum of one (1)*~~

~~*graduate level course in at least six (6)*~~. Applicant must show completion of one (1) graduate level course unique to each of the following eight (8) areas: ~~*(3-26-08)*~~( )

(1) Human growth and development: Includes studies that provide a broad understanding of the nature and needs of individuals at all developmental levels. Emphasis is placed on psychological, sociological, and physiological approaches. Also included are areas such as human behavior (normal and abnormal), personality theory, and learning theory. (7-1-93)

(2) Social and cultural foundations: Includes studies of change, ethnic groups, subcultures, changing roles of women, sexism, urban and rural societies, population patterns, cultural mores, use of leisure time, and differing life patterns. (7-1-93)

(3) The helping relationship: Includes philosophic bases of the helping relationship: Consultation theory and/or an emphasis on the development of counselor and client (or consultee) self-awareness and self-understanding. (7-1-93)

(4) Groups: Includes theory and types of groups, as well as descriptions of group practices, methods dynamics, and facilitative skills. It includes either a supervised practice and/or a group experience. (7-1-93)

(5) Life-style and career development: Includes areas such as vocational-choice theory, relationship between career choice and life-style, sources of occupational and educational information, approaches to career decision-making processes, and career-development exploration techniques. (7-1-93)

(6) Appraisal of the individual: Includes the development of a framework for understanding the individual, including methods of data gathering and interpretation, individual and group testing, case-study approaches and the study of individual differences. Ethnic, cultural, and sex factors are also considered. (7-1-93)

(7) Research and evaluation: Includes areas such as statistics, research design, and development of research and demonstration proposals. It also includes understanding legislation relating to the development of research, program development, and demonstration proposals, as well as the development and evaluation of program objectives. (7-1-93)

(8) Professional orientation: Includes goals and objectives of professional counseling organizations, codes of ethics, legal consideration, standards of preparation, certification, and licensing and role of identity of counselors. (7-1-93)

b. A total of at least sixty (60) graduate semester hours or ninety (90) graduate quarter hours shall be required. (7-1-93)

c. Advanced counseling practicum shall be practica taken at the graduate school level. (7-1-93)

d. A graduate degree shall be one of the following beyond the baccalaureate level: The master's degree, the educational specialist certificate or degree, or the doctor's degree. (7-1-93)

e. An accredited university or college shall be a college or university accredited by one (1) of the following: the Middle States Association of Colleges and Schools, the New England Association of Schools and Colleges, the North Central Association of Colleges and Schools, the Northwest Association of Schools and of Colleges and Universities, the Southern Association of Colleges and Schools, or the Western Association of Schools and Colleges. (3-26-08)

02. Supervised Experience Requirement. One thousand (1,000) hours of supervised experience in counseling acceptable to the Board. (7-1-93)

a. One thousand (1,000) hours is defined as one thousand (1,000) clock hours of experience working in a counseling setting, four hundred (400) hours of which shall be direct client contact. Supervised experience in practica and/or internships taken at the graduate level may be utilized. The supervised experience shall include a minimum of one (1) hour of face-to-face or one-to-one (1/1) or one-to-two (1/2) consultation with the supervisor for every twenty (20) hours of job/internship experience. Face-to-face may include a face-to-face setting provided by a live video connection between the supervisor and supervisee. As stated under Subsection 150.01.a.iv. counseling practicum experience as opposed to job or internship experience shall be supervised at a ratio of one (1) hour of supervision for every ten (10) hours in the settings. For example: (3-30-06)

i. A person in a twenty (20) hour per week job/internship who is receiving one (1) hour of individual supervision each week would accumulate one thousand (1,000) supervised hours in fifty (50) weeks to equal the twenty to one (20/1) ratio. (7-1-93)

ii. A person in a forty (40) hour per week setting with one (1) hour of supervision per week would still require fifty (50) weeks to equal the twenty to one (20/1) ratio. (7-1-93)

iii. A person in a forty (40) hour per week setting with two (2) hours of supervision per week would accumulate the one thousand (1,000) hours at the twenty to one (20/1) supervision ratio in twenty-five (25) weeks. (7-1-93)

b. Until July 1, 2004, the supervision must be provided by a Professional Counselor or a Clinical Professional Counselor licensed by the state of Idaho. Effective July 1, 20~~04~~10, ~~*postgraduate*~~ supervision must be provided by a counselor education faculty member at an accredited college or university or a Professional Counselor, a Clinical Professional Counselor or a Marriage and Family Therapist licensed by the state of Idaho and registered with the Board as a Supervisor. If the applicant's supervision was provided in another state, it must have been provided by a counseling professional licensed by that state, provided the requirements for licensure in that state are substantially equivalent to the requirements of Title 54, Chapter 34, Idaho Code. If supervision was obtained prior to July 1, 1988, or in a state that does not regulate counseling, that supervision must have been provided by a qualified counselor educator as a part of a planned graduate program or by a person who holds a graduate degree beyond the baccalaureate level who is certified and/or licensed as a counselor, social worker, psychologist, or psychiatrist. Supervision by an administrative superior who is not in a counseling related profession is not acceptable to the Board. Supervision by a professional counseling peer, however, may be acceptable to the Board if the peer/supervisory relationship includes the same controls and

procedures expected in an internship setting. (See Subsection 150.02.a.) For example, the relationship should include the staffing of cases, the critiquing of counseling tapes and this supervision must be conducted in a formal, professional, consistent manner on a regularly scheduled basis. ~~*(3-30-06)*~~( )

c. Experience in counseling is defined as assisting individuals or groups, through the counseling relationship, to develop an understanding of personal problems, to define goals, and to plan action reflecting interests, abilities, aptitudes, and needs as related to persona-social concerns, educational progress, and occupations and careers. Counseling experience may include the use of appraisal instruments, referral activities, and research findings. (7-1-93)

d. The Board shall consider the recommendation of the supervisor(s) when determining the acceptability of the applicant's supervised experience. (4-2-03)

(BREAK IN CONTINUITY OF SECTIONS)

245. REGISTERED INTERNS (RULE 245).
An individual pursuing Idaho licensure as a Professional Counselor may register with the Board as an Intern. An individual pursuing Idaho licensure as a Marriage and Family Therapist shall be licensed as an Associate Marriage and Family Therapist or Licensed Professional Counselor, or register prior to commencement of supervised experience with the Board as an Intern in compliance with Section 54-3402, Idaho Code. If the Marriage and Family Therapist applicant's supervised experience was obtained out of state, such applicant must meet the requirements of Rule 238.03, except that applicant's supervisor need not be registered with the Board.
~~*(4-9-09)*~~( )

01. Requirements for Registration. (4-2-03)

a. Possess a graduate degree in counseling, marriage and family therapy, or a closely related field from an accredited university or college. (4-2-03)

b. Be actively pursuing postgraduate supervised experience. (4-2-03)

c. Designate a supervisor who is registered as a supervisor or who is otherwise approved to provide marriage and family therapy supervision as defined in Section 54-3405C, Idaho Code, and who shall be responsible to provide supervision. (3-20-04)

02. Registration. An individual applying for registration as a Counselor Intern or Marriage and Family Therapist Intern shall fully complete the application form as established by the Board and submit the designated fee as adopted by Board rule. (4-2-03)

03. Practice. (4-2-03)

a. A Registered Intern may only practice counseling or marriage and family therapy under the direct supervision of a Counselor Supervisor or Marriage and Family Therapist Supervisor who shall be responsible to ensure that a Registered Intern is competent to practice

such counseling or marriage and family therapy as may be provided. (4-2-03)

b. Only a Registered Intern may use the title Counselor Intern or Marriage and Family Therapist Intern. (4-2-03)

c. An individual shall not practice as an intern for more than four (4) years from the original date of registration. (4-2-03)

246. -- 249. (RESERVED).

250. FEES (RULE 250).

01. Application Fee. Application fee: (7-1-97)

a. Professional Counselor -- seventy-five dollars ($75). (3-13-02)

b. Clinical Professional Counselor -- seventy-five dollars ($75). (3-13-02)

c. Marriage and Family Therapist -- seventy-five dollars ($75). (3-13-02)

d. Associate Marriage and Family Therapist -- seventy-five dollars ($75). (4-9-09)

e. Intern Registration -- twenty-five dollars ($25). (4-2-03)

02. ~~*Professional Counselor and*~~ Marriage and Family Therapist Examination or Reexamination Fee. The ~~*Professional Counselor and*~~ Marriage and Family Therapist license examination or reexamination fee shall be the fee as set by the provider of the approved examination plus an administration fee of twenty-five dollars ($25). ~~*(3-30-06)*~~(____)

03. Original License Fee. Original license fee for Professional Counselor, Clinical Professional Counselor, Associate Marriage and Family Therapist, or Marriage and Family Therapist -- seventy-five dollars ($75). (4-9-09)

04. Annual Renewal Fee. Annual license renewal fee for Professional Counselor, Clinical Professional Counselor, Associate Marriage and Family Therapist, or Marriage and Family Therapist -- one hundred dollars ($100). (4-9-09)

05. Annual Renewal Fee for Inactive License. Annual license renewal fee for inactive Professional Counselor, Clinical Professional Counselor, Associate Marriage and Family Therapist, or Marriage and Family Therapist -- fifty dollars ($50). (4-9-09)

06. Annual Renewal Fee for Senior Status. Annual license renewal fee for senior Professional Counselor, Clinical Professional Counselor, Associate Marriage and Family Therapist, or Marriage and Family Therapist -- sixty dollars ($60). (4-9-09)

07. Fees are Non-Refundable. All fees are non-refundable. (7-1-93)

251. -- 299. (RESERVED).

300. ENDORSEMENT (RULE 300).
The Board may grant a license to any person who submits a completed application on a form approved by the Board together with the required fees and who: (3-13-02)

01. **Holds a Current License**. The applicant must be the holder of a current active license, in the profession for which a license is being sought, issued by the authorized regulatory entity in another state or foreign country~~,~~. The foreign country must have substantially similar requirements for licensing as is provided for new applicants in Idaho. ~~*t*~~The certification of ~~*which*~~ licensure must be received ~~*directly*~~ by the Board from the issuing agency; and ~~*(3-13-02)*~~( )

02. Has Not Been Disciplined. The applicant must ~~*certify they*~~ have not been disciplined within the last five (5) years, had a license revoked, suspended, restricted, or otherwise sanctioned by any regulatory entity and has never voluntarily surrendered a license; and ~~*(3-13-02)*~~( )

03. Is of Good Moral Character. The applicant must ~~*certify they are*~~ be of good moral character and have not been convicted, found guilty, or received a withheld judgment or suspended sentence for any felony; and ~~*(3-13-02)*~~( )

04. Has Documented Experience. The applicant must provide a documented record of at least five (5) years actual practice under licensure immediately prior to application in the profession for which a license is being sought, or can demonstrate hardship or extenuating circumstances that prohibited practice during a portion of the five (5) year period as determined by the Board; and (3-13-02)

05. Will Abide by Laws, Rules and Code of Ethics. The applicant must certify under oath to abide by the laws and rules governing the practice of counseling and marriage and family therapy in Idaho and the applicable code of ethics as adopted; and either (3-30-07)

06. National Credential Registry. If applicant has been granted credentials by the American Association of State Counseling Boards as qualifying for Category II of the national credential registry or any such similar qualification granted by a national credentialing entity otherwise approved by the Board; or (3-30-07)

07. Provides Information. The applicant must document at least three (3) of the following during the five (5) years immediately prior to application: (3-13-02)

a. A minimum of one thousand (1,000) hours client contact; (3-13-02)

b. Service as an officer of a state or national counseling or marriage and family therapy organization, or a member of a state or national counseling or marriage and family therapy board or committee, or other leadership positions as may be approved by the Board; (3-13-02)

c. Teaching at least three (3) graduate courses for credit at an accredited college or university; (3-13-02)

d. A certificate to supervise issued by the NBCC or AAMFT; (3-13-02)

e. Providing at least twelve (12) months of supervision to each of no less than three (3) persons seeking licensure; (3-13-02)

f. Maintained professional liability insurance for the previous five (5) years with proof of no claims filed; (3-13-02)

g. Obtained a post graduate degree in a field of study related to counseling or marriage and family therapy that is in addition to the minimum licensure requirements; (3-13-02)

h. Current certification by a national credentialing entity as approved by the Board in the discipline for which licensure is sought; (3-13-02)

i. A total of one hundred (100) hours of continuing education completed in the five (5) years immediately prior to application. (3-26-08)

(BREAK IN CONTINUITY OF SECTIONS)

425. CONTINUING EDUCATION (RULE 425).
Every person holding an Idaho license as a Professional Counselor, Clinical Professional Counselor, Associate Marriage and Family Therapist, or a Marriage and Family Therapist must ~~*annually*~~ complete in each twelve-month period preceding the renewal of a license, twenty (20) contact hours of continuing education ~~*prior to license renewal*~~. A contact hour is one (1) hour of actual participation in a continuing education activity, exclusive of breaks. ~~*(4-9-09)*~~( )

01. Contact Hours. The contact hours of continuing education must be obtained in areas of study germane to the practice for which the license is issued as approved by the Board. No less than three (3) contact hours for each renewal period must be in ethics, which must be specific to legal issues, law, or ethics. Therapeutic workshops, retreats and other self-help activities are not considered continuing education training unless specific parts of the experience are applicable to counseling or therapy practice. ~~*(3-30-06)*~~( )

02. Documentation of Attendance. It shall be necessary for the ~~*applicant*~~ licensee to ~~*provide*~~ maintain documentation verifying attendance by securing authorized signatures or other documentation from the course instructors, providers, or sponsoring institution substantiating any hours attended by the ~~*applicant*~~ licensee. This documentation must be ~~*maintained by the applicant and*~~ provided to the Board upon request by the Board or its agent. ~~*(4-2-03)*~~( )

03. Approved Contact Hours, Limitations, and Required Documents. ( )

a. College or University Courses for Credit or Audit. There is no limit to the contact hours that a licensee may obtain in this category during each reporting period. However, all courses are subject to Board approval. For college or university courses, one (1) semester credit equals fifteen (15) contact hours; one (1) quarter credit equals ten (10) contact hours. The licensee must provide the Board with a copy of the licensee's transcript substantiating any hours attended

by the licensee. ( )

b. Seminars, Workshops, Conferences. There is no limit to the contact hours that a licensee may obtain in this category during each reporting period. Teleconferences must feature an interactive format in order to qualify for contact hour credit. Interactive conferences are those that provide the opportunity for participants to communicate directly with the instructor. The licensee must provide the Board with a copy of the certificate, or letter signed by course instructors, providers, or sponsoring institution substantiating any hours attended by the licensee. ( )

c. Publications. A maximum of four (4) contact hours may be counted in this category during each reporting period. Publication activities are limited to articles in journals, a chapter in an edited book, or a published book or professional publication. The licensee must provide the Board with a copy of the cover page or the article or book in which the licensee has been published. For a chapter in an edited book the licensee must submit a copy of the table of contents. ( )

d. Presentations. A maximum of four (4) contact hours may be counted in this category during each reporting period. Presentations may be used for contact hour credit if the topic is germane to the field. A particular presentation will qualify for contact hour credit one (1) time in a five (5) year period. Only actual presentation time may be counted; preparation time does not qualify for contact hour credit. The licensee must provide the Board with a copy of the conference program or a letter from the sponsor, host organization, or professional colleague. ( )

e. Clinical Supervision and Case Consultation. A maximum of five (5) contact hours of received supervision/consultation may be counted in this category during each reporting period. In order to qualify for contact hour credit, supervision/consultation must be received on a regular basis with a set agenda. No credit will be given for the licensee's supervision of others. The licensee must provide the Board with a letter from the supervisor or consultant listing periods of supervision, where the supervision occurred, and the name of the supervisor. ( )

f. Dissertation. A maximum of five (5) contact hours may be counted in this category during each reporting period. The licensee must provide the Board with a copy of the licensee's transcript and the title of the dissertation. ( )

g. Leadership. A maximum of four (4) contact hours may be counted in this category during each reporting period. The licensee must provide the Board with a letter from a professional colleague listing the position of leadership, periods of leadership, and the name of the organization under which the leadership took place. The following leadership positions qualify for continuing education credits: ( )

i. Officer of a state or national counseling or therapy organization; ( )

ii. Editor of a professional counseling or therapy journal; ( )

iii. Member of a national ethics disciplinary review committee rendering licenses, certification, or professional membership; ( )

iv. Active member of a counseling or therapy working committee producing a substantial written product; ( )

v. Chair of a major counseling or therapy conference or convention; or ( )

vi. Other leadership positions with justifiable professional learning experiences. ( )

h. Home Study and On-line Education. A maximum of ten (10) contact hours may be counted through self-study during each reporting period. In order for a home study or on-line course to qualify for contact hours, the course must be provided by a Board-approved continuing education provider or a course pre-approved by the Board. Ethics contact hours cannot be earned through self-study or on-line education. ( )

i. Copy of Certification Required. A licensee applying for home study or on-line credit must provide the Board a copy of the certification that is verified by the authorized signatures from the course instructors, providers, or sponsoring institution and substantiates any hours completed by the licensee. A licensee seeking contact credit for reading a publication must submit results from a test on the information contained within the publication and administered by an independent third-party. ( )

j. Continuing Education Credit. Continuing education credit may be granted for a maximum of two (2) hours each renewal period for time spent attending one (1) Board meeting. Members of the Board are not entitled to continuing education credit for Board service. ( )

03~~3~~4. Excess Hours. Continuing education hours accumulated during the twelve (12) months immediately preceding the license expiration date may be applied toward meeting the continuing education requirement for the next license renewal. No more than five (5) hours in excess of the required twenty (20) hours shall be carried forward. Excess hours may be used only during the next renewal period and may not be carried forward more than one (1) time. (4-2-03)

04~~3~~5. Compliance Audit. The Board may conduct random continuing education audits of those persons required to obtain continuing education in order to renew a license and require that proof acceptable to the Board of meeting the continuing education requirement be submitted to the Bureau. Failure to provide proof of meeting the continuing education upon request of the Board shall be grounds for disciplinary action in accordance with section 54-3407, Idaho Code. (4-2-03)

05~~5~~6. Special Exemption. The Board shall have authority to make exceptions for reasons of individual hardship, including health (certified by a medical doctor) or other good cause. The licensee must request such exemption prior to renewal and provide any information requested by the Board to assist in substantiating hardship cases. This exemption is granted at the sole discretion of the Board. There is no continuing education required of those holding a current inactive license. ~~*(3-26-08)*~~( )

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.16.01 - RULES OF THE STATE BOARD OF DENTURITRY

DOCKET NO. 24-1601-0901

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 54-3309, 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 pending rule is being adopted as proposed. The complete text of the proposed rule was published in Book 2 of the October 7, 2009 Idaho Administrative Bulletin, Vol. 09-10, pages 169 through 171.

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 negative fiscal impact to the general fund as a result of this rulemaking.

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, 2009.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
1109 Main St. Ste. 220
Boise, ID 83702
(208) 334-3233 Ph.
(208) 334-3945 Fax

THE FOLLOWING NOTICE 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 54-3309, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2009.

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:

Updates the Board of Denturitry contact information, as it has changed. To protect the public, it clarifies that the supervising denturist or dentist must be present and directly observe any intern interaction with a patient.

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

No fees or charges are being imposed or increased through this rulemaking.

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:

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because the changes were discussed in noticed open meetings.

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 October 28, 2009.

DATED this 3rd day of August, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

005. ADDRESS OF IDAHO BOARD OF DENTURITRY (RULE 5).
The office of the Board of Denturitry is located within the Bureau of Occupational Licenses, Owyhee Plaza, 1109 Main Street, Suite 220, Boise, Idaho 83702-5642. The phone number of the Board is (208) 334-3233. The Board's FAX number is (208) 334-3945. The Board's e-mail address is ~~*ibol*~~den@ibol.idaho.gov. The Board's official web site ~~*is*~~ can be found at http://www.ibol.idaho.gov~~*/den.htm*~~. ~~*(3-24-05)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

300. INTERNSHIP (RULE 300).

01. Requirements and Conditions for Internship. (3-10-00)

a. To be eligible for internship the applicant must have completed: (3-10-00)

i. The educational requirements set forth in Section 54-3310(b), Idaho Code; or (3-10-00)

ii. Have denturitry experience of three (3) years within the five (5) years immediately preceding application. (3-10-00)

b. Where an internship is established based on experience, the internship is valid only while the intern is actively pursuing completion of Idaho licensure requirements. (3-10-00)

c. Application shall be made on forms provided by the Bureau of Occupational Licenses and shall: (3-10-00)

i. Document the location of practice; (3-10-00)

ii. Include the name and address of the supervising denturist or dentist; (3-10-00)

iii. Include a sworn or affirmed statement by the supervising denturist or dentist; (3-10-00)

iv. Include a sworn or affirmed statement by the supervisor accepting supervision of the intern; (3-10-00)

v. Include a sworn statement by applicant that he is knowledgeable of law and rules and will abide by all requirements of such law and rules; and (3-10-00)

vi. Include such other information necessary to establish applicant's qualifications for

licensure as a denturist and establish compliance with pre-intern requirements. (3-10-00)

d. The supervising denturist or dentist must be present and directly observe any intern interaction with a patient. ( )

~~**d**~~**e.** Two (2) years of internship under the supervision of a licensed denturist shall be completed in not less than twenty-four (24) months and shall not exceed thirty (30) months except as approved by the board. (4-2-08)

02. Internship Equivalency. A person shall be considered to have the equivalent of two (2) years internship under a licensed denturist who has met and verifies one (1) of the following within the five (5) years immediately preceding application: (3-10-00)

a. Two (2) years internship as a denture lab technician under a licensed dentist; or (3-10-00)

b. Two (2) years in the military as a denture lab technician; or (3-10-00)

c. Three (3) years experience as a denturist under licensure in another state or Canada. (3-10-00)

03. Internship Not to Exceed One Year. Internship not to exceed one (1) year acquired through a formal training program in an acceptable school will be accepted toward the two (2) year required internship for licensure. (7-1-93)

04. Training Requirements. Each year of required internship shall consist of two thousand (2,000) clock hours of training and performance of the following minimum procedures for licensure. (7-1-93)

a. Procedures shall include all steps required in constructing a finished denture but are not limited to the following: (7-1-93)

i. Patient charting -- thirty-six (36) minimum. (7-1-93)

ii. Operatory sanitation -- thirty-six (36) minimum. (7-1-93)

iii. Oral examination -- thirty-six (36) minimum. (7-1-93)

iv. Impressions, preliminary and final (pour models, custom trays) -- thirty-six (36) minimum. (7-1-93)

v. Bite registrations -- twelve (12) minimum. (7-1-93)

vi. Articulations -- twelve (12) minimum. (7-1-93)

vii. Set ups -- twelve (12) minimum. (7-1-93)

viii. Try ins -- twelve (12) minimum. (7-1-93)

ix. Processing (wax up, flask-boil out, packing, grind-polish) -- thirty-six (36) minimum. (7-1-93)

x. Delivery-post adjustment -- thirty-six (36) minimum. (7-1-93)

b. Processed relines (one (1) plate = one (1) unit) -- twenty-four (24) units. (7-1-93)

c. Tooth repairs -- forty-eight (48) minimum. (7-1-93)

d. Broken or fractured plates or partials -- forty-eight (48) minimum. (7-1-93)

05. Reporting Requirements. Interns must file reports, attested to by the supervisor, with the board on forms provided by the Bureau of Occupational Licenses on a monthly basis and recapped at termination or completion of the training. (7-1-93)

06. Denture Clinic Requirements. Denture clinic requirements for approved internship training: (7-1-93)

a. There shall be not more than one (1) internee per licensed denturist or dentist who is practicing at the clinic on a full time basis. (7-1-93)

b. There shall be a separate work station in the laboratory area for each intern with standard equipment, i.e. lathe, torch and storage space. The intern shall provide necessary hand tools to perform the duties of the denture profession. Use of the operatory facilities and other equipment will be shared with the intern. (7-1-93)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.19.01 - RULES OF THE BOARD OF EXAMINERS OF RESIDENTIAL CARE FACILITY ADMINISTRATORS

DOCKET NO. 24-1901-0901

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 54-4205, 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 pending rule is being adopted as proposed. The complete text of the proposed rule was published in Book 2 of the October 7, 2009 Idaho Administrative Bulletin, Vol. 09-10, 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:

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

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, 2009.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
1109 Main St. Ste. 220
Boise, ID 83702
(208) 334-3233 Ph.
(208) 334-3945 Fax

THE FOLLOWING NOTICE 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 54-4205, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2009.

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 updates the contact information for the Board of Examiners of Residential Care Facility Administrators as it has changed. It allows for termination of inactive applications upon notification to the applicant in an effort to ensure files are current. It clarifies the qualifications for applicants licensed as nursing home administrators to ensure they are competent to run a residential care facility. It adds a special exemption from continuing education requirements to allow the Board to consider a hardship.

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

No fee or charge is being imposed through this rulemaking.

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:

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because the changes were discussed in noticed open meetings.

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 October 28, 2009.

DATED this 18th day of August, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

005. ADDRESS OF IDAHO BOARD OF EXAMINERS OF RESIDENTIAL CARE FACILITY ADMINISTRATORS (RULE 5).
The office of the Board of Examiners of Residential Care Facility Administrators is located within the Bureau of Occupational Licenses, Owyhee Plaza, 1109 Main Street, Suite 220, Boise, Idaho 83702-5642. The phone number of the Board is (208) 334-3233. The Board's FAX number is (208) 334-3945. The Board's e-mail address is rca@ibol.idaho.gov. The Board's official web site ~~*is*~~ can be found at http://www.ibol.idaho.gov~~*/rca.htm*~~. ~~*(3-30-06)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

100. APPLICATIONS (RULE 100).
Applications will be on forms approved by the Board. No application will be considered for any action unless accompanied by the appropriate fees and until the required supporting documentation is received by the Bureau. If an applicant fails to respond to a Board request or an application has lacked activity for twelve (12) consecutive months, the application on file with the Board will be deemed denied and will be terminated upon thirty (30) days written notice, unless good cause is established to the Board. ~~*(3-15-02)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

150. QUALIFICATIONS FOR ADMINISTRATOR LICENSE (RULE 150).

01. Qualifications. Each applicant for an administrator's license and each licensed administrator, as requested by the Board, shall submit proof, along with their application, that said individual meets the following qualifications for the issuance of a license or permit, or the retention or renewal of a license: (4-6-05)

0~~1~~2. Good Moral Character. The applicant shall cause to be submitted a criminal background check by an entity approved by the Board establishing that the applicant has not been convicted, pled guilty or nolo contendere or received a withheld judgment for a felony or any crime involving dishonesty or the health or safety of a person. (3-30-06)

151. -- 1~~9~~59. (RESERVED).

160. NURSING HOME ADMINISTRATOR QUALIFICATIONS FOR LICENSE (RULE 160).
Any applicant who holds a valid Idaho nursing home administrator license must meet the

requirements provided in Section 54-4211(2), Idaho Code, and must take and pass the Board-approved residential care administrator examination. This requirement may be waived if the applicant submits evidence satisfactory to the Board that he has at least one (1) year of leadership or management experience working in a residential care facility within the five (5) years preceding the application. ( )

161. -- 199. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

401. CONTINUING EDUCATION (RULE 401).

01. Minimum Hours Required. Applicants for annual renewal shall be required to complete a minimum of twelve (12) hours of continuing education courses within the preceding twelve (12) month period. Basic First Aid, Cardio-Pulmonary Resuscitation, medication assistance, or fire safety courses shall not be considered for continuing education credit.(3-30-06)

02. Course Approval. Courses of study relevant to residential care facility administration and sponsored or provided by the following entities or organizations shall be approved for continuing education credits: (3-30-06)

a. Accredited colleges or universities. (3-30-06)

b. Federal, state or local government entities. (3-30-06)

c. National or state associations. (3-30-06)

d. Otherwise approved by the Board based upon documentation submitted by the licensee or course provider reviewing the nature and subject of the course and its relevancy to residential care administration, name of instructor(s) and their qualifications, date, time and location of the course and procedures for verification of attendance. (3-30-06)

03. Credit. Continuing education credit will only be given for actual time in attendance or for the time spent participating in the educational activity. One (1) hour of continuing education is equal to sixty (60) minutes. Courses taken by correspondence or by computer on-line may be approved for continuing education if the courses require an exam or other proof of successful completion. Each licensee shall maintain proof of attendance or successful completion documentation of all continuing education courses for a period of three (3) years. (3-30-06)

04. Special Exemption. The Board shall have authority to make exceptions for reasons of individual hardship, including health, when certified by a medical doctor, or other good cause. The licensee must provide any information requested by the Board to assist in substantiating hardship cases. This exemption is granted at the sole discretion of the Board.( )

IDAPA 27 - BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-0901

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 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 pending rule is being adopted as proposed. The complete text of the proposed rule was published in Book 2 of the October 7, 2009 Idaho Administrative Bulletin, Vol. 09-10, pages 231 and 232.

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 negative fiscal impact to the general fund as a result of this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the proposed rule, contact Mark Johnston, R.Ph., Executive Director, (208) 334-2356.

DATED this 4th day of November, 2009.

Mark Johnston, R.Ph.
Executive Director
Board of Pharmacy
3380 Americana Terrace, Ste. 320
P. O. Box 83720
Boise, ID 83720-0067
Phone: (208) 334-2356
Fax: (208) 334-3536

THE FOLLOWING NOTICE 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 21, 2009.

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:

Current licensee contact information is essential to a successful regulatory process. The current Board of Pharmacy rules do not require licensees to provide updates on a timely basis. The proposed rules will amend the standards of conduct to require licensees to provide the Board with notice of any changes to the licensee's name, address, or telephone number within ten (10) business days from the date of any such change.

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

No fees or charges are being imposed or increased through this rulemaking.

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:

There is no negative impact to the general fund as a result of this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because of the simple nature of the rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Mark Johnston, R.Ph., Executive Director, (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 28, 2009.

DATED this 28th day of August 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

142. ~~*STANDARDS OF CONDUCT*~~ PROFESSIONAL RESPONSIBILITIES.
A failure to fulfill any of the following duties may constitute a violation of Section 54-1726(a), Idaho Code. ( )

01. Duty to Cooperate in Investigation. It is the duty of every licensee and registrant to cooperate with a disciplinary investigation, and any failure or refusal to do so is grounds for disciplinary action. ~~*(4-6-05)*~~( )

02. Duty to Report Theft, Loss, or Adulteration. It is the duty of every pharmacist-in-charge or pharmacy director to report any theft or loss of controlled substances and any adulteration of any prescription drug to the Board, even if the theft, loss, or adulteration has been accounted for and the employee disciplined internally. The report of theft or loss, required hereunder, shall contain all of the information reported to the Drug Enforcement Administration (DEA), as required under 21 CFR 1301.74(c), and shall be reported to the Board at the same time it is reported to the DEA. (3-30-07)

03. Duty to Provide Current Contact Information. It is the duty of every licensee and registrant to provide the Board with notice of any change to the licensee's or registrant's name, address, or telephone number within ten (10) business days from the change. ( )

IDAPA 27 - BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-0903

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 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:

In response to the public comment that was received, the Board has determined to adopt the pending rule which includes a change in text from the proposed rule. The change in text is necessary to change the timeframe for notice provided to the Board regarding the change of pharmacy hours of operation and to clarify that no notice to the Board is required for a change in hours of operation for a state recognized holiday.

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 Book 2 of the October 7, 2009 Idaho Administrative Bulletin, Vol. 09-10, pages 244 through 246.

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, R.Ph., Executive Director, (208) 334-2356.

DATED this 4th day of November, 2009.

Mark Johnston, R.Ph.
Executive Director
Board of Pharmacy
3380 Americana Terrace, Ste. 320
P. O. Box 83720
Boise, ID 83720-0067
Phone: (208) 334-2356
Fax: (208) 334-3536

THE FOLLOWING NOTICE 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 21, 2009.

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 rulemaking is necessary to alleviate any public safety issues that may be created by pharmacies not being open during their established hours of operation. The proposed rules will require pharmacies to notify the Board of Pharmacy in writing of their hours of operation and to notify the Board of any change in those hours at least thirty (30) days prior to commencing new hours of operation. The rules will require pharmacies to remain open during their stated hours of operation and to maintain sufficient staffing to ensure pharmacies are open during their stated business hours.

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

No fees or charges are being imposed or increased through this rulemaking.

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:

There is no negative impact to the general fund as a result of this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because of the simple nature of the rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Mark Johnston, R.Ph., Executive Director, (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 28, 2009.

DATED this 28th day of August, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

180. DIFFERENTIAL HOURS.

01. Security at Pharmacy. A pharmacy must provide adequate security for its drug supplies, equipment, and records and in the absence of a pharmacist, the pharmacy must be closed. If a pharmacy is located within a larger business establishment that is open to the public for business at times when a pharmacist is not present, the pharmacy must be totally enclosed by a partition, such as a glass or metal mesh screen or a security fence, that is sufficient to provide adequate security for the pharmacy, as approved by the Board or its representatives. In the absence of a pharmacist, the pharmacy must be locked. Employees of the business establishment may not be authorized to enter the closed pharmacy during those hours that the business establishment is open to the public for business. (7-1-93)

02. Equipment, Records, Drugs, and Other Items. All equipment and records referred to in these rules and all drugs, devices, poisons, and other items or products that are restricted to sale either by or under the personal supervision of a pharmacist must be kept in the pharmacy area. (7-1-93)

03. Prescription Orders and Refill Requests. Written prescription orders and refill requests can be delivered to a pharmacy at any time. If no pharmacist is present, the prescription orders must be deposited by the patient, or his agent delivering the prescription order or refill request, into a "mail slot" or "drop box" that deposits the prescription order into the pharmacy area. The times that the pharmacy is open for business must be displayed in a manner that is prominently visible to the person depositing the prescription order. (7-1-93)

04. Storage of Prescriptions. Prescriptions shall be stored in the pharmacy and cannot be removed from the pharmacy unless the pharmacist is present and the removal is for the immediate delivery to the patient, person picking up the prescription for the patient, or person delivering the prescription to the patient at his residence or similar place. (7-1-93)

05. Sale Restrictions. No drugs, devices, poisons, or other items or products that are restricted to sale either by or under the personal supervision of a pharmacist may be sold or delivered without a pharmacist being present in the pharmacy. (7-1-93)

06. Separate Telephone. Any pharmacy having hours differing from the remainder of a business shall have a separate and distinct telephone number from that of the business. The telephone shall not be answerable in the remainder of the establishment unless all telephone conversations during a pharmacist's absence are recorded and played back by the pharmacist. (7-1-93)

07. Oral Prescriptions. An oral prescription may not be accepted if the pharmacist is

not present unless the prescription is taken on a recording that must inform the caller of the times the pharmacy is open. (7-1-93)

08. Hours Open for Business. A pharmacy must notify the Board, on a form prescribed by the Board, of the hours that the pharmacy is open for business. Any pharmacy desiring to change the hours that it is open for business, must notify the Board, on a form prescribed by the Board, at least *seven (7)* days prior to commencing such hours. *A pharmacy desiring to change its hours for a holiday as set forth in Section 73-108, Idaho Code, does not need to provide notice of the changes to the Board, but must provide at least seven (7) days notice to the public.* A pharmacy must prominently display in a permanent manner on or adjacent to its entrance the hours it is open for business. A pharmacy must remain open for business the hours for which the Board has received such notification and that are prominently displayed. A pharmacy must maintain sufficient staffing by pharmacists in order to ensure that the pharmacy will be open during the hours of operation for which the pharmacy provided notice to the Board. If a pharmacy is located within a larger business establishment that has hours of operation different from the pharmacy, the hours the pharmacy is open for business shall be prominently displayed, in a permanent manner, at the pharmacy area and on, or adjacent to, the entrance to the mercantile establishment. *~~(7-1-93)~~( )*

09. Advertising. Any advertising by the business establishment that references the pharmacy or products sold only in the pharmacy, and that includes the hours that the business establishment is open to the public for business, must also indicate the hours that the pharmacy is open to the public for business. (7-1-93)

10. Notification to the Board of Differential Hours. Any person desiring to operate a pharmacy within an establishment having hours of business differing from the pharmacy, must notify the Board at least thirty (30) days prior to commencing such differential hours. To constitute notification, the applicant must complete and file the form provided by the Board with the required information. Board inspection and approval shall be completed prior to commencing differential hours. The inspection and approval or disapproval shall be completed within ten (10) days of receiving notification that the premises are ready for inspection. Approval or disapproval shall be predicated upon compliance with this rule and the pharmacy minimum standards set forth in Section 151 of these rules. (7-1-93)

IDAPA 27 - BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-0905

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 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 pending rule is being adopted as proposed. The complete text of the proposed rule was published in Book 2 of the October 7, 2009 Idaho Administrative Bulletin, Vol. 09-10, pages 251 and 252.

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 negative fiscal impact to the general fund as a result of this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the proposed rule, contact Mark Johnston, R.Ph., Executive Director, (208) 334-2356.

DATED this 4th day of November, 2009.

Mark Johnston, R.Ph.
Executive Director
Board of Pharmacy
3380 Americana Terrace, Ste. 320
P. O. Box 83720
Boise, ID 83720-0067
Phone: (208) 334-2356
Fax: (208) 334-3536

THE FOLLOWING NOTICE 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 21, 2009.

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 rulemaking is necessary to allow pharmacists to provide up to a three (3)-month supply of legend drugs that are not controlled substances, when a prescription is written for a smaller supply but includes refills sufficient to equal the larger supply. The proposed rulemaking amends an existing rule to clarify that a pharmacist, filling a drug order for a legend drug that is not a controlled substance, may provide up to a three (3)-month supply when the practitioner has written a prescription for a smaller supply with refills in sufficient numbers to fill the larger supply.

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, Idaho Code, negotiated rulemaking was not conducted because of the simple nature of the rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Mark Johnston, R.Ph., Executive Director, (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 28, 2009.

DATED this 28th day of August, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

184. UNPROFESSIONAL CONDUCT.
The following acts or practices by a licensed pharmacist or a pharmacy owner declared to be specifically, but not by way of limitation, unprofessional conduct and conduct contrary to the public interest: (7-1-93)

01. General. Manufacturing, compounding, selling, or dispensing or permitting to be manufactured, compounded, sold, or dispensed substandard drugs or preparations. (7-1-93)

02. Secret Formulas. Using secret formulas. (7-1-93)

03. Prescriber Incentives. Allowing a commission or rebate to be paid to a person writing, making, or otherwise ordering a prescription, or providing consultant services at no charge to receive prescription business. (7-1-93)

04. Prescription Order Noncompliance. Failing to strictly follow the instructions of the person writing, making, or ordering a prescription as to refills, contents, or label, or giving a copy of a prescription to any person without marking said prescription across the face: "Copy for Information Only. Not to Be Filled," except that a pharmacist, utilizing his best professional judgment, may provide up to a three-month supply of a legend drug that is not a controlled substance when the practitioner has written a drug order to be filled with a smaller supply but which includes refills in sufficient numbers to fill a three-month supply. ~~(7-1-93)~~( )

05. Errors or Omissions. Failing to confer with the person writing, making or ordering a prescription, if there is an error or omission therein which should be questioned. (7-1-93)

06. False or Deceptive Advertising. Advertising in a manner that is false, misleading or deceptive, which includes making material claims of professional superiority that cannot be substantiated. (7-1-93)

07. Addiction. Being addicted or habituated to the use of alcohol or controlled substances. (7-1-93)

08. Diversion of Drug Products and Devices. Supplying or diverting drugs, biologicals, and other medicines, substances, or devices, legally sold in pharmacies, that allows unqualified persons to circumvent laws pertaining to the legal sale of such articles. (7-1-93)

09. Fraudulent Practice. Performing, or in any way being a party to, any fraudulent or deceitful practice or transaction. (7-1-93)

10. Incompetency and Negligence. Performing duties as a pharmacist or pharmacy owner in an incompetent, unskilled, or negligent manner. (7-1-93)

11. Unprofessional Conduct. Exhibiting unprofessional conduct toward customers,

employees, colleagues, inspectors or others. (7-1-93)

12. Insubordination. Failure to follow an order of the Board. (2-23-94)

13. Inappropriate Conduct. Any activity by a pharmacist that is inappropriate to the conduct of the profession of pharmacy. (2-23-94)

14. Disciplinary Actions in Other States. Conduct that results in a suspension, revocation or other disciplinary proceeding or action with respect to a pharmacy or pharmacist license that the Idaho licensee holds in another state. (7-1-98)

15. Reporting Theft, Loss, or Adulteration. Failure of any pharmacist-in-charge or pharmacy director to report any theft or loss of controlled substances or any adulteration of a prescription drug to the Board, even if the theft, loss, or adulteration was accounted for and the employee was disciplined by the employer. (4-6-05)

16. Cooperating in an Investigation. Failure of any licensee to cooperate with a disciplinary investigation. (4-6-05)

IDAPA 27 - BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-0906

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 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 pending rule is being adopted as proposed. The complete text of the proposed rule was published in Book 2 of the October 7, 2009 Idaho Administrative Bulletin, Vol. 09-10, pages 253 through 257.

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, R.Ph., Executive Director, (208) 334-2356.

DATED this 4th day of November, 2009.

Mark Johnston, R.Ph., Executive Director
Board of Pharmacy
3380 Americana Terrace, Ste. 320
P. O. Box 83720, Boise, ID 83720-0067
Phone: (208) 334-2356 / Fax: (208) 334-3536

THE FOLLOWING NOTICE 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 21, 2009.

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 rulemaking is necessary to allow pharmacists to provide pharmaceutical care outside of a licensed pharmacy under certain conditions. The proposed rules set forth the conditions under which a licensed pharmacist may practice outside a licensed pharmacy. These conditions address access to records and information, provide for security and documentation, and mandate the maintenance of records to provide accountability and an audit trail.

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

No fees or charges are being imposed or increased through this rulemaking.

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:

There is no negative impact to the general fund as a result of this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because of the simple nature of the rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Mark Johnston, R.Ph., Executive Director, (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 28, 2009.

DATED this 28th day of August, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

165. PHARMACEUTICAL CARE.

A licensed pharmacist's scope of pharmacy practice may include, but is not limited to, the provision of those acts or services necessary to provide pharmaceutical care as defined in these rules. (5-8-09)

01. Definitions. (7-1-99)

a. Collaborative pharmacy practice. Means that practice of pharmacy whereby one (1) or more pharmacists have jointly agreed to work in conjunction with one (1) or more practitioners under protocol whereby the pharmacist may perform certain patient care functions authorized by the practitioner under certain specified conditions or limitations. (5-8-09)

b. Collaborative pharmacy practice agreement. Means a written and signed agreement between one (1) or more pharmacists and one (1) or more practitioners that provides for collaborative pharmacy practice for the purpose of conducting drug therapy management services, as defined in these rules. (5-8-09)

c. Drug therapy management. Means a distinct service or group of services that optimize therapeutic outcomes for individual patients. Drug therapy management services are independent of, but can occur in conjunction with, the provision of a drug or a device. Drug therapy management encompasses a broad range of professional activities and responsibilities within the licensed pharmacist's scope of practice. These services may include, but are not limited to, the following, according to the individual needs of the patient: (5-8-09)

i. Performing or obtaining necessary assessments of the patient's health status; (5-8-09)

ii. Formulating a drug treatment plan; (5-8-09)

iii. Selecting, initiating, modifying, or administering drug therapy; (5-8-09)

iv. Monitoring and evaluating the patient's response to therapy, including safety and effectiveness; (5-8-09)

v. Performing a comprehensive drug review to identify, resolve, and prevent drug-related problems, including adverse drug events; (5-8-09)

vi. Documenting the care delivered and communicating essential information to the patient's other primary care providers; (5-8-09)

vii. Providing information, support services and resources designed to enhance patient adherence with his therapeutic regimens; (5-8-09)

viii. Coordinating and integrating drug therapy management services within the broader health care-management services being provided to the patient; and (5-8-09)

ix. Such other drug therapy management services as may be allowed by law. (5-8-09)

d. Health information. Means any information, whether oral or recorded in any form

or medium, that: (5-8-09)

i. Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (5-8-09)

ii. 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 healthcare to an individual. (5-8-09)

e. HIPAA. Means the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) and any amendments thereof. (5-8-09)

f. Individually identifiable health information. Means information that is a subset of health information, including demographic information collected from an individual and that: (5-8-09)

i. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (5-8-09)

ii. 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: (5-8-09)

(1) Identifies the individual; or (5-8-09)

(2) With respect to which there is a reasonable basis to believe the information can be used to identify the individual. (5-8-09)

g. Other pharmaceutical patient care services. Means services that may include, but are not limited to, the following: (5-8-09)

i. Collaborative pharmacy practice. (5-8-09)

ii. Such other pharmaceutical patient care services as may be allowed by law. (5-8-09)

h. Pharmaceutical care. Means the provision by a pharmacist of drug therapy management services and other pharmaceutical patient care services intended to achieve outcomes related to the cure or prevention of a disease, elimination or reduction of a patient's symptoms, or arresting or slowing of a disease process as defined in these rules. (5-8-09)

i. Pharmacist's scope of practice pursuant to the collaborative practice agreement. Means those duties and limitations of duties placed upon one (1) or more pharmacists by the collaborative practitioner or practitioners, the Board, and applicable law and includes the limitations implied by the scope of practice of the collaborating practitioner or practitioners. (5-8-09)

j. Practitioner. Means, for purposes of Section 165, an individual currently licensed,

registered, or otherwise authorized in Idaho to prescribe and administer drugs in the course of professional practice. (5-8-09)

k. Protected health information. Means individually identifiable health information that, except as provided in Subparagraph 165.01.k.iv. of these rules, is: (5-8-09)

i. Transmitted by electronic media; (5-8-09)

ii. Maintained in any medium described in the definition of electronic media at 45 CFR 162.103 (HIPAA privacy rules); and (5-8-09)

iii. Transmitted or maintained in any other form or medium. (5-8-09)

iv. Protected health information excludes individually identifiable health information in: (5-8-09)

(1) Education records covered by the Family Education Right and Privacy Act, as amended (20 U.S.C. Section 1231(g)); (5-8-09)

(2) Records described at 20 U.S.C. Section 1231 (g)(4)(B)(iv); and (5-8-09)

(3) Employment records held by a licensee in its role as an employer. (5-8-09)

02. Collaborative Pharmacy Practice. Collaborative pharmacy practice is subject to the following requirements: (5-8-09)

a. Collaborative pharmacy practice agreement. A pharmacist planning to engage in collaborative pharmacy practice shall have on file at his place of practice the written collaborative pharmacy practice agreement. The initial existence and subsequent termination of any such agreement and any additional information the Board may require concerning the collaborative pharmacy practice agreement including the agreement itself, shall be made available to the Board for review upon request. The agreement may allow the pharmacist, within the pharmacist's scope of practice pursuant to the collaborative pharmacy practice agreement, to conduct drug therapy management services approved by the practitioner and as defined by these rules. The collaboration that the practitioner agrees to conduct with the pharmacist must be within the scope of the practitioner's current practice. Patients or caregivers shall be advised of such agreement. (5-8-09)

b. Contents. The collaborative pharmacy practice agreement shall include: (5-8-09)

i. Identification of the practitioner and pharmacist who are parties to the agreement; (5-8-09)

ii. The types of drug therapy management decisions that the pharmacist is allowed to make; (5-8-09)

iii. A method for the practitioner to monitor compliance with the agreement and clinical outcomes and to intercede where necessary; (5-8-09)

iv. A provision that allows the practitioner to override a collaborative practice decision made by the pharmacist whenever he deems it necessary or appropriate; (5-8-09)

v. A provision that allows either party to cancel the agreement by written notification; (5-8-09)

vi. An effective date; and (5-8-09)

vii. Signatures of each collaborating pharmacist and practitioner who are parties to the agreement as well as dates of signing. Amendments to a collaborative pharmacy practice agreement must be documented, signed, and dated. (5-8-09)

c. Initiation of the collaborative pharmacy practice agreement. The collaborative pharmacy practice agreement must be coupled with a medical order from the practitioner to initiate allowed activities for any particular patient. (5-8-09)

d. Documentation of pharmacist activities. Documentation of allowed activities must be kept as part of the patient's permanent record and must be readily available to other health care professionals providing care to that patient and who are authorized to receive it. Documentation of allowed activities shall be considered protected health information. (5-8-09)

e. Review. At a minimum, the written agreement shall be reviewed and renewed and, if necessary, revised every year. (5-8-09)

03. Independent Practice. A licensed pharmacist may provide pharmaceutical care outside of a licensed pharmacy if all of the following conditions are met: ( )

a. The pharmacist has access to prescription records, patient profiles, or other relevant medical information for purposes of pharmaceutical care and appropriately reviews such information before performing any such functions; ( )

b. Access to the information described in Paragraph 165.03.a. of these rules is secure from unauthorized access and use, and all access by pharmacists is documented; and ( )

c. A pharmacist providing pharmaceutical care outside of the premises of a licensed pharmacy shall maintain the records or other patient-specific information used in such activities in a readily retrievable form in a system that is secured and managed by the pharmacy with whom the pharmacist is providing such services or, if acting independent of a pharmacy, a secure system maintained by the pharmacist. Such records or information shall: ( )

i. Provide accountability and an audit trail; ( )

ii. Be provided to the Board upon request; and ( )

iii. Be preserved for a period of at least two (2) years from the date relied upon or consulted for the purposes of performing any such function. ( )

IDAPA 27 - BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-0907

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 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 pending rule is being adopted as proposed. The complete text of the proposed rule was published in Book 2 of the October 7, 2009 Idaho Administrative Bulletin, Vol. 09-10, pages 258 through 261.

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 negative fiscal impact to the general fund as a result of this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the proposed rule, contact Mark Johnston, R.Ph., Executive Director, (208) 334-2356.

DATED this 4th day of November, 2009.

Mark Johnston, R.Ph.
Executive Director
Board of Pharmacy
3380 Americana Terrace, Ste. 320
P. O. Box 83720
Boise, ID 83720-0067
Phone: (208) 334-2356
Fax: (208) 334-3536

THE FOLLOWING NOTICE 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 21, 2009.

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 rulemaking is necessary to reflect changes made by the 2009 Idaho Legislature to the Wholesale Drug Distribution Act. The proposed rule adds repackagers who are authorized distributors of record for FDA registered manufacturers to the definition of normal distribution channel.

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

No fees or charges are being imposed or increased through this rulemaking.

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:

There is no negative impact to the general fund as a result of this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because of the simple nature of the rulemaking and the need to reflect changes made in current law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Mark Johnston, R.Ph., Executive Director, (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 28, 2009.

DATED this 28th day of August, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

321. DEFINITIONS.

01. Authentication. To affirmatively verify before any wholesale distribution of a prescription drug occurs that each transaction listed on the pedigree has occurred. (4-2-08)

02. Authorized Distributor of Record. A wholesale distributor with whom a manufacturer has established an ongoing relationship to distribute the manufacturer's prescription drug. An ongoing relationship is deemed to exist between such wholesale distributor and a manufacturer when the wholesale distributor, including any affiliated group of the wholesale distributor, as defined in Section 1504 of the Internal Revenue Code, complies with the following: (4-2-08)

a. The wholesale distributor has a written agreement currently in effect with the manufacturer evidencing such ongoing relationship; and (4-2-08)

b. The wholesale distributor is listed on the manufacturer's current list of authorized distributors of record, which is updated by the manufacturer on no less than a monthly basis. (4-2-08)

03. Chain Pharmacy Warehouse. A physical location for prescription drugs that acts as a central warehouse and performs intra-company sales or transfers of such drugs to a group of chain pharmacies that have the same common ownership and control. (4-2-08)

04. Co-Licensed Partner or Product. An instance where two (2) or more parties have the right to engage in the manufacturing or marketing, or both, of a prescription drug consistent with the federal Food and Drug Administration's implementation of the Prescription Drug Marketing Act. (4-2-08)

05. Components. Articles intended for use as a component of any articles specified in Subsections 321.01, 321.02, or 321.03 of these rules. (4-2-08)

06. Drop Shipment. The sale of a prescription drug to a wholesale distributor or chain pharmacy warehouse by the manufacturer of the prescription drug, that manufacturer's co-licensed product partner, that manufacturer's third party logistics provider, or that manufacturer's exclusive distributor, whereby the wholesale distributor or chain pharmacy warehouse takes title but not physical possession of such prescription drug. The wholesale distributor invoices the pharmacy, chain pharmacy warehouse, or other person authorized by law to dispense or administer such drug to a patient, and the pharmacy or chain pharmacy warehouse or other authorized person receives delivery of the prescription drug directly from the manufacturer, that manufacturer's third party logistics provider, or that manufacturer's exclusive distributor.(4-2-08)

07. Drug. Articles recognized as drugs in the official United States Pharmacopoeia, official National Formulary, official Homeopathic Pharmacopoeia, other drug compendia or their supplement. (7-1-93)

08. Facility. Facility of a wholesale distributor where prescription drugs are stored, handled, repackaged, or offered for sale. (4-2-08)

09. Manufacturer. A person licensed or approved by the federal Food and Drug Administration to engage in the manufacture of drugs or devices consistent with the federal Food and Drug Administration definition of "manufacturer" under its regulations and guidance implementing the Prescription Drug Marketing Act. (4-2-08)

10. Manufacturer's Exclusive Distributor. A person who contracts with a manufacturer to provide or coordinate warehousing, distribution, or other services on behalf of a manufacturer and who takes title to that manufacturer's prescription drug, but who does not have general responsibility to direct the sale or disposition of the manufacturer's prescription drug. Such manufacturer's exclusive distributor must be licensed as a wholesale distributor, pursuant to Section 54-1753, Idaho Code, and must also be an authorized distributor of record to be considered part of the normal distribution channel. (4-2-08)

11. Normal Distribution Channel. A chain of custody for a prescription drug that goes from a manufacturer of the prescription drug, from that manufacturer to that manufacturer's co-licensed partner, from that manufacturer to that manufacturer's third party logistics provider, or from that manufacturer to that manufacturer's exclusive distributor, or from that manufacturer directly or through its co-licensed partner, third party logistics provider or manufacturer's exclusive distributor to a repackager who is an authorized distributor of record for the manufacturer, whose facility is registered with the United States Food and Drug Administration and who engages in the practice of repackaging the original dosage form of a prescription drug in accordance with applicable regulations and guidelines of the United States Food and Drug Administration, either directly or by drop shipment to: ~~*(4-2-08)*~~( )

a. A pharmacy to a patient; (4-2-08)

b. A designated person authorized by law to dispense or administer such drug to a patient; (4-2-08)

c. A wholesale distributor to a pharmacy to a patient or other designated persons authorized by law to dispense or administer such drug to a patient; (4-2-08)

d. A wholesale distributor to a chain pharmacy warehouse to that chain pharmacy warehouse's intra-company pharmacy to a patient or other designated persons authorized by law to dispense or administer such drug to a patient; or (4-2-08)

e. A chain pharmacy warehouse to the chain pharmacy warehouse's intra-company pharmacy to a patient or other designated persons authorized by law to dispense or administer such drug to a patient. (4-2-08)

12. Pedigree. A document or electronic file containing information that records each

wholesale distribution of a prescription drug. (4-2-08)

13. Prescription Drug. Any drug, including any biological product, except for blood and blood components intended for transfusion or biological products that are also medical devices, required by federal law or federal regulation to be dispensed only by prescription, including finished dosage forms and bulk substances, subject to Section 503(b) of the federal Food, Drug and Cosmetic Act. (4-2-08)

14. Repackage. Repackaging or otherwise changing the container, wrapper, or labeling to further the distribution of a prescription drug, excluding any repackaging completed by the pharmacist responsible for the purpose of dispensing the drug to the patient. (4-2-08)

15. Repackager. A person who repackages. (4-2-08)

16. Sample. A unit of a drug that is not intended to be sold and is intended to promote the sale of the drug. (4-2-08)

17. Third Party Logistics Provider. A person who contracts with a prescription drug manufacturer to provide or coordinate warehousing, distribution, or other services on behalf of the manufacturer, but who does not take title to the prescription drug or have general responsibility to direct the prescription drug's sale or disposition. A third party logistics provider must be licensed as a wholesale distributor, pursuant to Section 54-1753, Idaho Code, and must also be an authorized distributor of record to be considered part of the normal distribution channel. (4-2-08)

18. Wholesale Distribution. Distribution of prescription drugs to persons other than a consumer or patient, but excluding the following: (4-2-08)

a. Intracompany sales of prescription drugs, meaning any transaction or transfer between any division, subsidiary, parent or affiliated or related company under common ownership and control of a corporate entity or any transaction or transfer between co-licensees of a co-licensed product. (4-2-08)

b. The sale, purchase, distribution, trade, or transfer of a prescription drug or the offer to sell, purchase, distribute, trade, or transfer a prescription drug for emergency medical reasons. (4-2-08)

c. The distribution of prescription drug samples by manufacturers' representatives. (4-2-08)

d. Drug returns when conducted by a hospital, health care entity, or charitable institution in accordance with 21 CFR 203.23. (4-2-08)

e. The sale of minimal quantities of prescription drugs by retail pharmacies to licensed practitioners for office use. (4-2-08)

f. The sale, purchase, or trade of a drug; an offer to sell, purchase, or trade a drug; or the dispensing of a drug pursuant to a prescription. (4-2-08)

g. The sale, transfer, merger, or consolidation of all or part of the business of a pharmacy from or with another pharmacy, whether accomplished as a purchase and sale of stock or business assets. (4-2-08)

h. The sale, purchase, distribution, trade, or transfer of a prescription drug from one (1) authorized distributor of record to one (1) additional authorized distributor of record when the manufacturer has stated in writing to the receiving authorized distributor of record that the manufacturer is unable to supply such prescription drug and the supplying authorized distributor of record states in writing that the prescription drug being supplied had, to date, been exclusively in the normal distribution channel. (4-2-08)

i. The delivery of, or the offer to deliver, a prescription drug by a common carrier solely in the common carrier's usual course of business of transporting prescription drugs if the common carrier does not store, warehouse, or take legal ownership of the prescription drug. (4-2-08)

j. The sale or transfer from a retail pharmacy or chain pharmacy warehouse of expired, damaged, returned, or recalled prescription drugs to the original manufacturer or third party returns processor, including a reverse distributor. (4-2-08)

19. Wholesale Distributor. A person engaged in wholesale distribution of drugs including, but not limited to: manufacturers; repackagers; own-label distributors; private-label distributors; jobbers; brokers; warehouses, including manufacturer's and distributor's warehouses; manufacturer's exclusive distributors; authorized distributors of record; drug wholesalers or distributors; independent wholesale drug traders; specialty wholesale distributors; third party logistics providers; retail pharmacies that conduct wholesale distribution; and chain pharmacy warehouses that conduct wholesale distribution. To be considered part of the normal distribution channel, a wholesale distributor, except for a chain pharmacy warehouse not engaged in wholesale distribution, must also be an authorized distributor of record. (4-2-08)

IDAPA 27 - BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-0908

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2010 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 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:

In response to the public comment that was received, the Board has determined to adopt the pending rule which includes a change in text from the proposed rule. The change in text is necessary to clarify that all prescriptions, including those for controlled substances, are within the scope of the rule. This change is also necessary to make Idaho's rules regarding prescription transfer in conformity with those of the Drug Enforcement Administration.

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 Book 2 of the October 7, 2009 Idaho Administrative Bulletin, Vol. 09-10, pages 262 through 264.

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 negative fiscal impact to the general fund as a result of this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the proposed rule, contact Mark Johnston, R.Ph., Executive Director, (208) 334-2356.

DATED this 4th day of November, 2009.

Mark Johnston, R.Ph.
Executive Director
Board of Pharmacy

3380 Americana Terrace, Ste. 320
P. O. Box 83720
Boise, ID 83720-0067
Phone: (208) 334-2356
Fax: (208) 334-3536

THE FOLLOWING NOTICE 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 21, 2009.

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 rulemaking is necessary to clarify that a pharmacy may transfer a prescription to another pharmacy without first having to fill it. The proposed rule will permit a pharmacist to transfer a prescription to another pharmacy to be filled or refilled. The rule will also clarify the recordkeeping responsibility of the receiving pharmacy.

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

No fees or charges are being imposed or increased through this rulemaking.

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:

There is no negative impact to the general fund as a result of this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because of the simple nature of the rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Mark Johnston, R.Ph., Executive Director, (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 28, 2009.

DATED this 28th day of August, 2009.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

160. PRESCRIPTION TRANSFER.

A pharmacist may transfer prescription order information for the purpose of filling or refilling a prescription only if the information is communicated orally directly from pharmacist to pharmacist. Such oral information can be communicated by a student pharmacist, under the direct supervision of a pharmacist, to another pharmacist as long as one (1) of the parties involved in the communication is a pharmacist. In the alternative, the transferring pharmacist may transfer the prescription order information by facsimile transmission to the receiving pharmacist. In the case of a facsimile transmission, the transmission shall be signed by the transferring pharmacist.
~~*(5-8-09)*~~( )

01. Transferring Prescriptions for Controlled Substances. A prescription for a controlled substance may be transferred only from the pharmacy where it was originally filled and never from the pharmacy that received the transfer. (7-1-93)

a. In addition to the information required in Subsection 160.02 the pharmacist transferring the prescription shall record on the back of the original order the DEA number and address of the pharmacy to which the transfer was made. (7-1-93)

b. The receiving pharmacist must record the DEA number and address of the pharmacy transferring the order. (7-1-93)

02. Documenting the Transfer of a Prescription. The pharmacist who transfers the prescription shall: (5-8-09)

a. Invalidate the original prescription by writing the word "void" across the face of the form; and (7-1-93)

b. On the back of the form, record the following information: his name; name of the receiving individual; name of the receiving pharmacy; date of the transfer, and the number of authorized refills available. (7-1-93)

03. Documenting the Receipt of a Transferred Prescription. The pharmacist who receives the transferred prescription shall: (5-8-09)

a. Reduce the transferred information to writing including all information required by law or rule and a notation that the prescription is a "transfer"; and (7-1-93)

b. On ~~*the back of*~~ the form, record the following information: his name; the name of the transferring individual; the name of the transferring pharmacy; the date of the original dispensing and transfer, the number of refills authorized, the number of valid refills remaining, the date of the last refill, and the serial number of the prescription transferred. ~~*(7-1-93)*~~( )

04. Documenting Prescription Transfers by Computer. Transferring pharmacies that utilize a computer prescription database that contains all of the prescription information required by law or rule may enter the information required under Section 160 of these rules into the pharmacy's prescription database (including de-activation of the transferred prescription in the database of the transferring pharmacy) in lieu of entry of the required information on the original written prescription. ~~*The receiving pharmacy must generate a hard copy to be treated as a new prescription, and the hard copy shall also contain all of the information required under Section 160 of these rules.*~~ ~~*(3-30-01)*~~( )

05. Documenting Receipt of Prescription Transfers by Computer. A receiving pharmacy that utilizes a computer prescription database that contains all of the prescription information required by law or rule must generate a hard copy to be treated as a new prescription; however, the receiving pharmacy may enter the information required under Section 160 of these rules into the pharmacy's prescription database in lieu of writing the information on the hard copy of the new prescription. ( )

0~~5~~6. Transferring Prescription Refills. Prescriptions for non-controlled drugs may be transferred more than one (1) time as long as there are refills remaining and all of the provisions of these rules are followed. (7-1-93)

0~~6~~7. Transferring Prescription Between Pharmacies Using Common Electronic Prescription Files. (7-1-98)

a. ~~*For prescriptions written for drugs other than controlled substances t*~~Two (2) or more pharmacies may establish and use a common electronic prescription file to maintain required dispensing information. Pharmacies using the common file are not required to transfer prescriptions or information for dispensing purposes between or among other pharmacies using in the same common electronic prescription file. ~~*(7-1-98)*~~( )

~~***b.*** *For controlled substances pharmacies using a common electronic prescription must satisfy all documentation requirements of a manual prescription transfer.* *(7-1-98)*~~

~~***c****b***.** All common electronic prescription files must contain complete and accurate records of each prescription and refill dispensed. Hard copies must be generated and treated as new prescriptions by the receiving pharmacies. (7-1-98)

IDAPA 41 - PUBLIC HEALTH DISTRICTS

41.04.02 - RULES FOR COMMUNITY SUBSURFACE SEWAGE DISPOSAL SYSTEMS

DOCKET NO. 41-0402-0901 (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 2010 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 39-416(1), 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 pending rule is being adopted as proposed. The complete text of the proposed rule was published in the September 2, 2009, Idaho Administrative Bulletin, Vol. 09-9, page 325.

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 negative fiscal impact to the general fund as a result of this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Russell A. Duke at 327-8501.

DATED this 4th day of October, 2009.

Russell A. Duke, Director
Central District Health Department
707 N. Armstrong Pl.
Boise, Idaho 83704-0825
Ph: 327-8501, Fax: 327-8500

THE FOLLOWING NOTICE 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 39-416(1), 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 16, 2009.

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 rule was made effective on July 1, 1993 and applied only to Public Health District 4. On October 17, 2007, all seven public health districts were delegated certain responsibilities for regulation of subsurface sewage disposal by the Idaho Department of Environmental Quality, pursuant to IDAPA 58.01.03, "Individual/Subsurface Sewage Disposal Rules." This request is to repeal IDAPA 41.04.02 because the standards provided in IDAPA 58.01.03 promote more consistent and effective statewide regulation of subsurface sewage disposal.

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, negotiated rulemaking was not conducted because the nature of the rulemaking is to repeal the chapter.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Russell A. Duke at 327-8501.

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 23, 2009.

DATED this 21st day of July, 2009.

IDAPA 41.04.02 IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 41 - PUBLIC HEALTH DISTRICTS

41.04.03 - RULES FOR ON-SITE SEWAGE TREATMENT SYSTEMS

DOCKET NO. 41-0403-0901 (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 2010 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 39-416(1), 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 pending rule is being adopted as proposed. The complete text of the proposed rule was published in the September 2, 2009, Idaho Administrative Bulletin, Vol. 09-9, page 326.

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 negative fiscal impact to the general fund as a result of this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Russell A. Duke at 327-8501.

DATED this 4th day of October, 2009.

Russell A. Duke, Director
Central District Health Department
707 N. Armstrong Pl.
Boise, Idaho 83704-0825
Ph: 327-8501, Fax: 327-8500

THE FOLLOWING NOTICE 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 39-416(1), 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 16, 2009.

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 rule was made effective on May 6, 1990 and applied only to Public Health District 4. On October 17, 2007, all seven public health districts were delegated certain responsibilities for regulation of subsurface sewage disposal by the Idaho Department of Environmental Quality, pursuant to IDAPA 58.01.03 Individual/Subsurface Sewage Disposal Rules. This request is to repeal IDAPA 41.04.03 because the standards provided in IDAPA 58.01.03 promote more consistent and effective statewide regulation of subsurface sewage disposal.

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, Idaho Code, negotiated rulemaking was not conducted because the nature of the rulemaking is to repeal the chapter.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Russell A. Duke at 327-8501.

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 23, 2009.

DATED this 21st day of July, 2009.

IDAPA 41.04.03 IS BEING REPEALED IN ITS ENTIRETY.