# *HEALTH & WELFARE COMMITTEE*

## *ADMINISTRATIVE RULES REVIEW*

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## *2011 Legislative Session*

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# IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

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

## DOCKET NO. 16-0202-1001

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 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 56-1013A and 56-1023, Idaho Code.

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

**To best protect the public's health and safety, the EMS Physician Commission is revising its Standards Manual that is incorporated by reference in this chapter of rules. This revision to rule will ensure that the most recent edition of the manual has the force and effect of law.**

**The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the** July 7, 2010, Idaho Administrative Bulletin, Vol. 10-7, pages 16 and 17**.**

**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 Dia Gainor at (208) 334-4000.

DATED this 27th day of September, 2010.

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

***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 56-1013A and 56-1023, Idaho Code.

**PUBLIC HEARING SCHEDULE:** Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than July 21, 2010.

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

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

**To best protect the public's health and safety, the EMS Physician Commission is revising its Standards Manual that is incorporated by reference in this chapter of rules. This revision to rule will ensure that the most recent edition of the manual has the force and effect of law.**

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

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

There is no anticipated fiscal impact to the state general fund related to this rulemaking.

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because the content of the proposed updates to the EMS Physician Commission Standards Manual already represents extensive input from stakeholders gathered during 2009 and early 2010.

**INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, edition 2011-1, is being incorporated by reference into these rules to give it the force and effect of law. The document is not being reprinted in this chapter of rules due to its length and format and because of the cost for republication.**

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

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 28, 2010.

DATED this 4th day of June, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0202-1001***

**004. INCORPORATION BY REFERENCE.**
The Idaho Emergency Medical Services (EMS) Physician Commission has adopted the Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, edition 201~~*0*~~1-1, 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. ~~*(3-29-10)*~~(    )

# IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

## 16.02.06 - RULES GOVERNING QUALITY ASSURANCE FOR IDAHO CLINICAL LABORATORIES

## DOCKET NO. 16-0206-1001 (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 2011 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 56-1003, 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** August 4, 2010, Idaho Administrative Bulletin, Vol. 10-8, page 61**.**

**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. The functions administered under these rules are 100% federally funded under the CLIA (Clinical Laboratory Improvement Amendments of 1988) grant.**

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning this pending rule, contact David Eisentrager at (208) 334-2235 x245.

DATED this 4th day of November, 2010.

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 56-1003, Idaho Code.

**PUBLIC HEARING SCHEDULE:** Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 18, 2010.

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 the last major update of these rules in 1987, there have been significant technological changes that render much of the language in this chapter obsolete and outdated. Further, the rules do not reflect more recent changes in federal regulations, in the organizational structure of the Department's Bureau of Laboratories, and in the Bureau's current practices.**

**As a result, this chapter of rules is being repealed under this docket and rewritten in this Bulletin under companion Docket No. 16-0206-1002.**

**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 related to this rulemaking. The functions administered under these rules are 100% federally-funded under the CLIA (Clinical Laboratory Improvement Amendments of 1988) grant.**

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted.

**The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the** May 5, 2010, Idaho Administrative Bulletin, Volume 10-5, page 25**.**

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

this rule: N/A

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the proposed rule, contact David Eisentrager at (208) 334-2235 x245.

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 25, 2010.

DATED this 9th day of July, 2010.

**IDAPA 16.02.06 IS BEING REPEALED IN ITS ENTIRETY**

# IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

## 16.02.06 - QUALITY ASSURANCE FOR IDAHO CLINICAL LABORATORIES

## DOCKET NO. 16-0206-1002 (CHAPTER REWRITE)

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 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 56-1003, 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** August 4, 2010, Idaho Administrative Bulletin, Vol. 10-8, pages 62 through 68**.**

**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. The functions administered under these rules are 100% federally funded under the CLIA (Clinical Laboratory Improvement Amendments of 1988) grant.**

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning this pending rule, contact David Eisentrager at (208) 334-2235 x245.

DATED this 4th day of November, 2010.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
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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 Section 56-1003, Idaho Code.

**PUBLIC HEARING SCHEDULE:** Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 18, 2010.

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 the last major update of these rules in 1987, there have been significant technological changes that render much of the language in this chapter obsolete and outdated. Further, the rules do not reflect more recent changes in federal regulations, in the organizational structure of the Department's Bureau of Laboratories, and in the Bureau's current practices.**

**As a result, this chapter of rules is being completely rewritten in order to simplify, clarify, update, and modernize the content, and to revise the chapter to reflect current practice of the Department's Bureau of Laboratories. The current chapter is being repealed in this Bulletin under companion Docket No. 16-0206-1001.**

**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 related to this rulemaking. The functions administered under these rules are 100% federally-funded under the CLIA (Clinical Laboratory Improvement Amendments of 1988) grant.**

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted.

**The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the** May 5, 2010, Idaho Administrative Bulletin, Volume 10-5, page 25**.**

**INCORPORATION BY REFERENCE:** Pursuant to Section 67-5229(2)(a), Idaho Code, the

following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the proposed rule, contact David Eisentrager at (208) 334-2235 x245.

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 25, 2010.

DATED this 9th day of July, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0206-1002***

## IDAPA 16, TITLE 02, CHAPTER 06

## 16.02.06 - QUALITY ASSURANCE FOR IDAHO CLINICAL LABORATORIES

### 000. LEGAL AUTHORITY.

Under Section 56-1003, Idaho Code, the Idaho Legislature has delegated to the Board of Health and Welfare the authority to set standards for laboratories in the state of Idaho. ( )

### 001. TITLE AND SCOPE.

**01. Title**. The title of these rules is IDAPA 16.02.06, "Quality Assurance for Idaho Clinical Laboratories." ( )

**02. Scope**. These rules protect the public and individual health by requiring that all Idaho clinical laboratories develop satisfactory quality assurance programs that meet minimal standards approved by the Board. ( )

### 002. WRITTEN INTERPRETATIONS.

There are no written interpretations of 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.

No documents have been incorporated by reference into this chapter of rules. ( )

**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**. ( )

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

**b.** The Idaho Bureau of Laboratories is located at 2220 Old Penitentiary Road, Boise, Idaho, 83712-8299. ( )

**04. Telephone**. ( )

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

**b.** The telephone number for the Idaho Bureau of Laboratories is (208) 334-2235. ( )

**05. Internet Website**. ( )

**a.** The Department's internet website is found at http://www.healthandwelfare.idaho.gov. ( )

**b.** The webpage for the Department's Idaho Bureau of Laboratories (IBL) is found at http://www.statelab.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. -- 009. (RESERVED).**

**010. DEFINITIONS.**
For the purposes of these rules, the following terms apply: ( )

**01. Board**. The Idaho Board of Health and Welfare. ( )

**02. Department**. The Idaho Department of Health and Welfare. ( )

**03. Director**. The Director of the Idaho Department of Health and Welfare, or his designee. ( )

**04. Laboratory or Clinical Laboratory**. A facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examinations of material derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease, or the impairment or assessment of human health. ( )

**05. Laboratory Director**. The person under whose supervision the laboratory is operating. ( )

**06. Pathologist**. A physician who is: ( )

**a.** Licensed by the Idaho State Board of Medicine in accordance with 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"; and ( )

**b.** Board certified by the American Board of Anatomic and Clinical Pathology. ( )

**07. Proficiency Testing**. Evaluation of a laboratory's ability to perform laboratory procedures within acceptable limits of accuracy through analysis of unknown specimens distributed at periodic intervals. ( )

**08. Quality Control**. A day-to-day analysis of reference materials to ensure reproducibility and accuracy of laboratory results, and also includes an acceptable system to assure proper functioning of instruments, equipment and reagents. ( )

**09. Reviewer**. An employee or other designated representative of the Department's Idaho Bureau of Laboratories, who is knowledgeable and experienced in clinical laboratory methods and procedures. ( )

**011. -- 099. (RESERVED).**

**100. REGISTRATION REQUIREMENTS FOR CLINICAL LABORATORIES.**

**01. Registration Timeframes**. ( )

**a.** Every person responsible for the operation of a laboratory that performs tests on material derived from the human body must register such facility with the Department within

thirty (30) days after first accepting specimens for testing. ( )

**b.** Existing laboratories must submit a completed laboratory registration form every two (2) years and indicate any changes in laboratory operations. ( )

**02. Registration Form**. Each laboratory must submit its registration information on the Department-approved form. These forms are available upon request from the Department. Each completed registration form must include the following information: ( )

**a.** Name and location of the laboratory; ( )

**b.** Name of the laboratory director; ( )

**c.** Types of laboratory tests performed in the laboratory; and ( )

**d.** Other information requested by the Department that it deems necessary to evaluate the performance of the laboratory. ( )

**101. -- 109. (RESERVED).**

**110. EXCLUSIONS.**

**01. Other Certifying Agencies**. Laboratories will be excluded from compliance with these rules (except Sections 100 and 200) upon submission of evidence of certification from one (1) of the following agencies: ( )

**a.** Centers for Medicare and Medicaid Services (CMS), Clinical Laboratory Improvement Amendment (CLIA) certification program (http://www.cms.gov/CLIA/01_Overview.asp); ( )

**b.** College of American Pathologists; ( )

**c.** Agencies approved by CMS as accreditation organizations. To review the current list of CMS-approved accreditation organizations, go to: http://www.cms.gov/CLIA/downloads/AO.List.pdf; ( )

**d.** Laboratories located in hospitals approved by the Joint Commission (http://www.jointcommission.org/AccreditationPrograms/LaboratoryServices/lab_facts.htm); and ( )

**e.** Other certification programs approved by the Department. ( )

**03. Facilities and Laboratories**. The following laboratories and facilities are also excluded from compliance with this chapter: ( )

**a.** Laboratories operated for teaching or research purposes only, provided tests results are not used for diagnosis or treatment; ( )

**b.** Prosthetic dental laboratories; and ( )

**c.** Facilities performing skin testing solely for detection of allergies and sensitivities. ( )

**111. -- 119. (RESERVED).**

**120. DEPARTMENT INSPECTIONS OF CLINICAL LABORATORIES.**
A qualified representative of the Department is authorized to inspect the premises and operations of all approved laboratories for the purpose of determining the adequacy of the quality control program and supervision of each laboratory. ( )

**121. -- 129. (RESERVED).**

**130. GENERAL REQUIREMENTS FOR CLINICAL LABORATORIES.**

**01. Laboratory Facilities**. Each laboratory must have adequate space, equipment, and supplies to perform the services offered, with accuracy, precision, and safety. ( )

**02. Records**. ( )

**a.** Laboratory records must identify the person responsible for performing the procedure. ( )

**b.** Each laboratory must maintain a suitable record of each test result for a period of at least two (2) years. Reports of tests must be filed in a manner that permits ready identification and accessibility. ( )

**c.** Laboratory records and reports must identify specimens referred to other laboratories and must identify the reference laboratory testing such referred specimens. ( )

**131. -- 149. (RESERVED).**

**150. PERSONNEL REQUIREMENTS FOR CLINICAL LABORATORIES.**
The laboratory director must ensure that the staff of the laboratory: ( )

**01. Appropriate Education, Experience, and Training**. Have appropriate education, experience, and training to perform and report laboratory tests promptly and proficiently; ( )

**02. Sufficient in Number for the Scope and Complexity**. Are sufficient in number for the scope and complexity of the services provided; ( )

**03. In-service Training**. Receive in-service training appropriate to the type and complexity of the laboratory services offered; and ( )

**04. Procedures and Tests that are Outside the Scope of Training**. Do not perform procedures and tests that are outside the scope of training of the laboratory personnel. ( )

**151. -- 199. (RESERVED).**

**200. PROFICIENCY TESTING OF CLINICAL LABORATORIES.**

**01. Scope**. All laboratories must subscribe to, and satisfactorily participate in, a proficiency testing program that has been approved by the Department. ( )

**02. Results to the Bureau of Laboratories**. The laboratory director must furnish the Laboratory Improvement Section with copies of all proficiency testing results within thirty (30) days of receipt or make provisions for a duplicate of the results to be sent by the testing service directly to the Department. ( )

**201. -- 209. (RESERVED).**

**210. QUALITY CONTROL PROGRAM REQUIREMENTS FOR CLINICAL LABORATORIES.**

**01. Establishment of Quality Control Program**. To ensure reliability of day-to-day results, each laboratory must establish a quality control program compatible with regional and statewide practices. ( )

**02. Program Scope**. An acceptable quality control program must include the following: ( )

**a.** An effective preventive maintenance program that ensures proper functioning of all instruments and equipment; ( )

**b.** Routine testing of quality control materials along with patient specimens; ( )

**c.** Quality control checks on reagents and media utilized in the performance of tests; ( )

**d.** Maintenance of quality control records that will enable determination of reliability of all procedures performed. ( )

**211. -- 219. (RESERVED).**

**220. DEPARTMENT APPROVAL OF CLINICAL LABORATORIES.**
The Department will approve clinical laboratories for performance of tests on material from the human body if the laboratory meets the minimum standards specified in these regulations. ( )

**221. -- 229. (RESERVED).**

**230. DEPARTMENT REVOCATION OF APPROVAL.**
The Department may revoke approval, either in total or in part, for the following reasons: ( )

**01. Failure to Participate in Proficiency Testing**. The approved laboratory fails to participate in a proficiency testing program as outlined in Section 200. ( )

**02. Failure to Participate in Quality Control**. The approved laboratory fails to implement a quality control program as outlined in Section 210. ( )

**03. Failure to Obtain Satisfactory Results**. The Department, through the quality review process, determines that the approved laboratory has failed to obtain satisfactory results on two (2) consecutive or on two (2) out of three (3) consecutive sets of proficiency test program specimens in one (1) or more testing categories. ( )

**04. Failure to Submit Documentation**. Failure to submit documentation of corrective action as indicated in Subsection 240.02. ( )

**231. -- 239. (RESERVED).**

**240. REVOCATION PROCEDURE.**

**01. Unacceptable Results**. Laboratories that fail to obtain passing results on two (2) consecutive proficiency testing events, or two (2) out of three (3) events, will be required to submit documentation of corrective action within fifteen (15) working days after receipt of the notification of the failures. Evaluation of proficiency testing results may overlap from one year to the next. ( )

**02. Corrective Action**. Upon receipt of documentation of corrective action, a reviewer will determine the adequacy of the action taken. If, in the opinion of the reviewer, the corrective action is not adequate, the laboratory will be required to submit to an on-site inspection that may include on-site testing of unknown samples. ( )

**03. On-Site Inspection**. If the results of the on-site inspection indicate that the laboratory's performance is unacceptable in one or more testing categories, the approval to perform the test(s) in question will be revoked. ( )

**04. Satisfactory Performance**. The laboratory will continue to be approved for performance of all test procedures for which it has demonstrated satisfactory performance. ( )

**05. Other Deficiencies**. Failure to comply with other provisions of these rules may invoke revocation procedures. ( )

**241. -- 249. (RESERVED).**

**250. RENEWAL OF APPROVAL OF TEST OR TESTS WHICH HAVE BEEN DISAPPROVED.**

**01. Renewal Granted**. ( )

**a.** A laboratory that has lost approval to perform certain tests for reasons outlined in Section 240 may gain reapproval by documenting corrective action taken, and by requesting the Department review the unacceptable performance and the corrective action taken. ( )

**b.** Within ten (10) days after completion of this review, the reviewer will submit his

report to the Chief of the Bureau of Laboratories. ( )

**c.** Upon determination that corrections leading to satisfactory and acceptable performance have been made, the Chief of the Bureau of Laboratories may reinstate approval. ( )

**02. Renewal Denied**. If the Chief of the Bureau of Laboratories does not grant reapproval of the laboratory, he will provide the laboratory supervisor with written notice of actions to be taken to correct deficiencies. The laboratory supervisor may request a new review at any time after thirty (30) days from the date of last review. The laboratory supervisor may also file a written appeal in accordance with IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings," Section 400. ( )

**251. -- 269. (RESERVED).**

**270. LIST OF APPROVED LABORATORIES.**

The Department will maintain a list of laboratories approved in accordance with this chapter. This list must include the name and address of each approved laboratory, and the name of the person directing the laboratory. ( )

**271. -- 299. (RESERVED).**

**300. PENALTY FOR FAILURE TO REGISTER OR OPERATION OF A NONAPPROVED CLINICAL LABORATORY.**

Failure to register a clinical laboratory, operation of a nonapproved clinical laboratory, or performance of unapproved testing constitutes a violation of these rules. Any violation of these rules constitutes a misdemeanor under Section 56-1008, Idaho Code. ( )

**301. -- 999. (RESERVED).**

# IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

## 16.02.11 - IMMUNIZATION REQUIREMENTS FOR CHILDREN ATTENDING LICENSED DAYCARE FACILITIES

## DOCKET NO. 16-0211-1001

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 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 39-1118, 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 to allow the Regulatory Authority, in the case of a vaccine shortage or an emergency situation, to temporarily suspend an immunization requirement for the length of time needed to remedy the vaccine shortage or emergency situation. Also, the exclusion criteria is being clarified for noncompliance.**

**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 1, 2010, Idaho Administrative Bulletin, Vol. 10-09, pages 141 through 146**.**

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

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning the pending rule, contact Carmela Kerns-Gupta at (208) 334-6994.

DATED this 4th day of November, 2010.

Tamara Prisock
DHW - Administrative Procedures Section
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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 Section 39-1118, Idaho Code.

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

| Thursday, September 9, 2010<br>6:00 p.m. MDT | Tuesday, September 14, 2010<br>6 p.m. MDT | Thursday, September 16, 2010<br>6:00 p.m. PDT |
|---|---|---|
| Central District Health Dept.<br>707 N Armstrong Place<br>Immunization Lobby<br>Boise, ID | Eastern ID Public Health Dept.<br>1250 Hollipark Dr.<br>North Conf. Rm<br>Idaho Falls, ID | Red Lion Hotel<br>621 21st Street<br>Port One - Conf. Rm.<br>Lewiston, 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:

**In an effort to increase the number of children who are fully protected from preventable diseases, the Department is amending these rules to increase the number of vaccines required for children attending licensed daycare facilities. The changes to these rules will help protect children from additional vaccine-preventable diseases, provide a conditional attendance clause for children who are in the process of receiving required vaccines, provide clarification on exclusion of children from attendance, and update existing language to match current practices. Parents who choose not to immunize their children will still be able to sign an exemption form for medical, religious, or other reasons.**

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

**FISCAL IMPACT:** The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: This rulemaking has no anticipated fiscal impact to state general funds.

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(2), Idaho Code, informal negotiated rulemaking was conducted with the following:

**Idaho Public Health Districts, Idaho Medical Association (IMA), American Academy of Pediatrics - Idaho chapter, American Academy of Family Physicians - Idaho chapter, IdahoSTARS, Idaho Child Care Program staff (ICCP), and the Idaho Immunization**

**Coalition.**

**INCORPORATION BY REFERENCE:** Pursuant to Section 67-5229(2)(a), Idaho Code.

**The "Recommended Immunization Schedules for Persons Aged 0 through 18 Years -- United States, 2010," is being incorporated by reference into these rules because it contains the national standard for immunization schedules and is regularly updated to reflect best practices and to give it the force and effect of law. The document is not being republished in this chapter of rules due to its length and format and because of the cost of republication.**

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the proposed rule, contact Rebecca Coyle at (208) 334-5942.

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 22, 2010.

DATED this 29th day of July, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0211-1001***

**004. INCORPORATION BY REFERENCE.**

~~*No documents have been incorporated by reference in this chapter of rules.*~~ The "Recommended Immunization Schedules for Persons Aged 0 Through 18 Years -- United States, 2010," are incorporated by reference for this chapter of rules. Published in the Morbidity and Mortality Weekly Report, January 8, 2010, Vol. 58 (51 and 52), by the Centers for Disease Control and Prevention as recommended by the Advisory Committee on Immunization Practices (ACIP). This document is referred to in this chapter of rules as "ACIP Recommended Schedule." These schedules may be obtained from the Department or viewed online at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5851a6.htm. ~~*(4-6-05)*~~(     )

***(BREAK IN CONTINUITY OF SECTIONS)***

**010. DEFINITIONS.**

**01. ACIP**. The Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. ~~*(4-6-05)*~~(     )

**02. Board**. The Idaho State Board of Health and Welfare. (12-31-91)

**03. Board of Medicine**. The Idaho State Board of Medicine. (5-24-91)

**04. Child**. A person less than ~~*twelve*~~ thirteen (1~~2~~3) years of age, as defined in Section 39-1102, Idaho Code. ~~*(5-24-91)*~~(    )

**05. Department**. The Idaho Department of Health and Welfare. (5-24-91)

**06. Director**. The Director of the Idaho Department of Health and Welfare, or designated individual. (12-31-91)

~~***07. Immunization Document***~~~~*. A medical or other written record initiated and retained by a licensed daycare facility which gives the month, day and year of each immunization a child has received.*~~ ~~*(5-24-91)*~~

**0~~8~~7. Immunization Record**. An electronic medical health record, an immunization registry document, or a written ~~*document signed*~~ immunization certificate confirmed by a ~~*physician*~~ licensed health care professional or a physician's representative which states the month, day, and year of each immunization a person has received. ~~*(5-24-91)*~~(    )

**0~~9~~8. Initial Attendance**. The first admission of a child to any licensed daycare facility in Idaho. (5-24-91)

**~~1~~09. Laboratory Proof**. A certificate from a licensed medical laboratory stating the type of test performed, the date of each test and the results, accompanied by a physician's statement indicating the child is immune. Tests performed must meet the requirements ~~*of*~~ in IDAPA 16.02.06, "Rules Governing Quality Assurance for Idaho Clinical Laboratories." ~~*(4-6-05)*~~(    )

**1~~1~~0. Licensed Daycare Facility**. Any Idaho daycare facility maintained by an individual, organization or corporation and licensed by an authorized governmental entity to provide care to children. (5-24-91)

**1~~2~~1. Licensed Daycare Facility Operator**. Any person who owns and operates or is designated by an individual, organization or corporation to manage the day-to-day operation of a licensed daycare facility described in Subsection 010.10 of these rules. (4-6-05)

**12. Licensed Health Care Professional**. A practitioner, licensed in the State of Idaho by the Board overseeing the practitioner's license, or by a similar body in another state or jurisdiction within the United States. The practitioner's scope of practice for licensure must allow for the ordering of immunizations and writing of prescriptions, or the practitioner must be under the direction of a licensed physician. Licensed health care professionals who may provide for immunization requirements include: medical doctors, osteopaths, nurse practitioners, physicians' assistants, licensed professional nurses, registered nurses, and pharmacists. Other persons authorized by law to practice any of the healing arts, shall not be considered licensed health care professionals for the purposes of this chapter. (    )

**13. Parent, Custodian, or Guardian**. The legal parent, custodian, or guardian of a child or those with limited power of attorney for the temporary care or custody of a minor child. (5-24-91)

~~***14.*** ***Pertussis**. An infectious agent, Bordetella pertussis, that causes the disease commonly known as whooping cough.* (4-6-05)~~

**1~~*5*~~4.** **Physician**. A medical doctor or osteopath licensed by the Idaho State Board of Medicine, or by a similar body in another state or jurisdiction within the United States, to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine. ~~*(4-6-05)*~~(    )

**1~~*6*~~5.** **Physician's Representative**. Any person appointed by or vested with the authority to act on behalf of a physician in matters concerning health. (5-24-91)

**1~~*7*~~6.** **Regulatory Authority**. The Director of the Idaho Department of Health and Welfare or the Director's designee. (5-24-91)

**011. -- 099. (RESERVED).**

**100. IMMUNIZATION ~~*PROGRAM*~~ REQUIREMENTS.**

All immunizations listed in Subsections 100.01 through 100.0~~*5*~~9 of these rules, are required of children who ~~*are to*~~ attend licensed daycare facilities. These immunizations must be administered age appropriately according to the "~~*General*~~ ACIP Recommend~~*ations*~~ed ~~*on Immunizations*~~ Schedule," ~~*established by the ACIP*~~ incorporated by reference in Section 004 of these rules, unless fewer doses are medically recommended by a physician. These recommendations are available from the Department. ~~*(4-6-05)*~~(    )

**01.** **Diphtheria, Tetanus and A-Cellular Pertussis (DTaP) Vaccine**. ~~*Five (5) doses of DTaP (Diphtheria, Tetanus and a-cellular Pertussis) vaccine are required and must be administered to the child unless fewer doses are medically recommended.*~~ ~~*(4-6-05)*~~(    )

**02.** **Polio Vaccine**. ~~*Three (3) doses of polio vaccine are required and must be administered to the child unless fewer doses are medically recommended. See Section 110 of these rules.*~~ ~~*(4-6-05)*~~(    )

**03.** **Measles, ~~*Rubella and*~~ Mumps, and Rubella (MMR) Vaccine**. ~~*Two (2) doses of measles, rubella and mumps vaccine are required and must be administered to the child according to ACIP recommendations.*~~ ~~*(4-6-05)*~~(    )

**04.** **Haemophilus Influenza Type B (HIB) Vaccine**. ~~*Haemophilus influenza type b (HIB) vaccine is required and must be administered to the child according to ACIP recommendations.*~~ ~~*(4-6-05)*~~(    )

**05.** **Hepatitis B Vaccine**. ~~*Three (3) doses of hepatitis B vaccine administered to children born after November 22, 1991, unless fewer doses are medically recommended. See Section 110 of these rules.*~~ ~~*(4-6-05)*~~(    )

**06.** **Varicella Vaccine**. (    )

**07.** **Pneumococcal Vaccine**. (    )

**08.** **Rotavirus Vaccine**. (    )

**09. Hepatitis A Vaccine.** ( )

**101. *TIME PERIOD FOR* COMPLIANCE.**

The *legal* parent, custodian, or guardian of a child must comply with the provisions contained in this chapter within fourteen (14) days of initial attendance to any licensed daycare facility in Idaho. *(4-6-05)*( )

**102. EVIDENCE OF IMMUNIZATION STATUS.**

**01. Immunization *Certification Statement* Record**. Within the deadlines established in Section 101 of these rules, a *legal* parent, custodian, or guardian of each child must present to the licensed daycare facility operator an immunization record *or certification statement signed by a physician or a physician's representative stating the type, number and dates of immunizations received*. *(4-6-05)*( )

**02. Schedule of Intended Immunizations Form**. A child who has received at least one (1) dose of each required vaccine and is currently on schedule for subsequent immunizations may conditionally attend daycare when a schedule of intended immunizations form is provided. The licensed daycare facility operator, *within fourteen (14) days of initial attendance,* must have a *statement* schedule of intended immunizations form completed by a *legal* parent, custodian, or guardian *of* for any child who is not immunized, excepted, or exempted, and who is in the process of receiving, or has been scheduled to receive, the required immunizations. *This statement* A form provided by the Department, or one similar, must include the following information: *(4-6-05)*( )

**a.** Name and *age* date of birth of child; *(4-6-05)*( )

**b.** Type, number and dates of scheduled immunizations to be administered; *(4-6-05)*( )

**c.** Signature of the *legal* parent, custodian, or guardian *providing the information*; and *(4-6-05)*( )

**d.** Signature of a *physician or physician's representative* licensed health care professional providing care to the child. *(5-24-91)*( )

**103. -- 104. (RESERVED).**

**105. EXCEPTIONS TO IMMUNIZATION REQUIREMENT *FOR THE APPLICABLE DISEASE*.**

A child who meets one (1) or *both* *more* of the following conditions, when supporting documentation is in the possession of the licensed daycare facility operator, will not be required to *undergo* receive the required immunizations*:* in order to attend the licensed daycare facility. *(4-6-05)*( )

**01. Laboratory Proof**. A child who has laboratory proof of immunity to any of the *nine (9)* childhood diseases listed in Section 100 of these rules, will not be required to *undergo*

receive the required immunizations for which the child is immune. ~~(4-6-05)~~(        )

**02. Disease Diagnosis**. A child who has a statement signed by a licensed ~~*physician*~~ health care professional stating the child has had ~~*measles (rubeola) or mumps*~~ varicella (chickenpox) disease ~~*and*~~ diagnosed by ~~*the physician*~~ a licensed health care professional upon personal examination will not be required to ~~*undergo*~~ receive the required immunizations for the diagnosed disease. ~~(4-6-05)~~(        )

***03. Suspension of Requirement**. The Regulatory Authority may temporarily suspend one or more of the immunization requirements listed in Section 100 of these rules, if the Regulatory Authority determines that suspension of the requirement is necessary to address a vaccine shortage or other emergency situation in the state. The Regulatory Authority will suspend a requirement for the length of time needed to remedy the vaccine shortage or emergency situation.* (        )

**106. -- 109. (RESERVED).**

**110. EXEMPTIONS TO IMMUNIZATION REQUIREMENT.**

When supporting documentation is in the possession of the licensed daycare facility operator, a child who meets one (1) or both of the ~~*following*~~ conditions in Subsections 110.01 and 110.02 of this rule, will be exempt from the required immunizations. ~~(4-6-05)~~(        )

**01. Life or Health Endangering Circumstances**. A signed statement of a licensed physician that the child's life or health would be endangered if any or all of the required immunizations are administered~~;~~. ~~*or*~~ ~~(4-6-05)~~(        )

**02. Religious or Other Objections**. A signed statement of the ~~*legal*~~ parent, custodian, or guardian on a form provided by the Department ~~*or one containing similar information*~~, ~~*and*~~ that includes the following: ~~(4-6-05)~~(        )

**a.** Name of child, date of birth; and ~~(5-24-91)~~(        )

**b.** A statement of objection on religious or other grounds. (5-24-91)

**111. -- 1~~9~~49. (RESERVED).**

**150. EXCLUSION CRITERIA.**

**01. Noncompliance**. A child meeting any one (1) of the following conditions must be excluded by the licensed daycare facility operator: (        )

**a.** Has received fewer than the required number of doses of immunizations described in Section 100 of these rules*, and does not have the remaining required vaccine doses scheduled*; (        )

**b.** Has failed to continue to receive immunizations as provided on the schedule of intended immunizations form described in Subsection 102.02 of these rules; (        )

**c.** Has received one or more doses at less than the minimum interval or less than the minimum age as recommended by the ACIP under Section 004; ( )

**d.** Has not received any doses of the required immunization and does not have a valid exception or exemption described in Sections 105 and 110 of these rules; or ( )

**e.** Has no immunization record on file at the daycare facility. ( )

**02. Exempted Children**. A child exempted under Section 110 of these rules, may be excluded by the regulatory authority in the event of a disease outbreak under IDAPA 16.02.10, "Idaho Reportable Diseases." ( )

**151. -- 199. (RESERVED).**

**200. DOCUMENTATION AND RETENTION OF IMMUNIZATIONS ~~*DATA*~~ RECORD BY LICENSED DAYCARE FACILITY OPERATORS.**

**01. Provision of Information**. The licensed daycare facility operator will provide to the ~~*legal*~~ parent, custodian, or guardian, information on immunization requirements and the ACIP recommended immunization schedule. ~~*(4-6-05)*~~( )

~~***02. Immunization Document**. The licensed daycare facility operator will copy the immunization data from the child's immunization record to a daycare immunization document or have on file a true and correct copy of the child's immunization record. This immunization document must include the month, day and year of each immunization the child has received.*~~ ~~*(4-6-05)*~~

**0~~*3*~~2. Immunization ~~*Document*~~ Record Retention**. The immunization documentation described in S~~*ubs*~~ection ~~*200.*~~102 of these rules, must be retained by the licensed daycare facility ~~*on all children*~~ for each child as long as the child attends the licensed daycare facility plus one (1) year after last attendance. ~~*(4-6-05)*~~( )

**201. -- 299. (RESERVED).**

**300. INSPECTIONS ~~*BY PUBLIC DISTRICT HEALTH DEPARTMENTS*~~.**

**01. Compliance Inspection**. The regulatory authority will verify that the immunization ~~*document*~~ record described in S~~*ubs*~~ection ~~*200.02*~~ 010 of these rules, is ~~*initiated and*~~ retained in the licensed daycare facility. ~~*(4-6-05)*~~( )

**02. Recording of Violation**. Following an inspection which reveals a violation of this chapter by a licensed daycare facility, the regulatory authority will record the violations in writing and provide a copy to the licensed daycare facility operator. (4-6-05)

**03. Response to Violation**. The licensed daycare facility operator will submit a written report to the regulatory authority within thirty (30) days following the inspection stating that the specified violations have been corrected. (4-6-05)

**04. Failure to Respond**. The regulatory authority will report in writing to the licensing authority any violations recorded in Subsection 300.02 of ~~*these*~~ this rule~~*s*~~, to which a licensed daycare facility operator has not responded as required by Subsection 300.03 of ~~*these*~~ this rule~~*s*~~. ~~*(4-6-05)*~~(        )

**301. -- 309. (RESERVED).**

**310. ENFORCEMENT OF IMMUNIZATION REQUIREMENT.**

**01.** ~~***Noncompliance**. Licensed daycare facility operators in Idaho must exclude any child who is not in compliance with this chapter within fourteen (14) days of initial attendance in their daycare facility.*~~ **Enforcement** The regulatory authority may exclude any child who does not meet the requirements in this chapter and who has not been excluded from the licensed daycare facility as required in Section 150 of these rules. ~~*(4-6-05)*~~(        )

**02. Length of Exclusion**. Any child excluded from a licensed daycare facility in Idaho as required in Subsection 310.01 of ~~*these*~~ this rule~~*s*~~, may not be readmitted to the facility until the~~*y are*~~ child is in compliance with the requirements of this chapter. ~~*(4-6-05)*~~(        )

**311. -- 399. (RESERVED).**

**400. TECHNICAL ASSISTANCE.**

**01. Random Evaluations**. A representative of the Department will randomly select and visit licensed daycare facilities in Idaho to evaluate the facility files for the following: (4-6-05)

**a.** Immunization ~~*documents*~~ record described in S~~*ubs*~~ection ~~200.02~~ 010 of these rules; ~~*(4-6-05)*~~(        )

**b.** Exceptions documentation described in Section 105 of these rules; and (4-6-05)

**c.** Exemption statements described in Section 110 of these rules. (4-6-05)

**02. Notice of Intent to Review**. A representative of the Department will inform licensed daycare facilities selected in Subsection 400.01 of ~~*these*~~ this rule~~*s*~~, at least thirty (30) days prior to an intent to review the licensed daycare facilities' documents. ~~*(4-6-05)*~~(        )

**03. Evaluation Results**. Information will be provided to the licensed daycare facility about the results of the immunization evaluation described in Subsection 400.01 of ~~*these*~~ this rule~~*s*~~, and the recommendations for correcting deficiencies and increasing immunity levels. ~~*(4-6-05)*~~(        )

# IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

## 16.02.15 - IMMUNIZATION REQUIREMENTS FOR IDAHO SCHOOL CHILDREN

## DOCKET NO. 16-0215-1001

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 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 39-4801, 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 to allow the Regulatory Authority, in the case of a vaccine shortage or an emergency situation, to temporarily suspend an immunization requirement for the length of time needed to remedy the vaccine shortage or emergency situation.**

**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 1, 2010, Idaho Administrative Bulletin, Vol. 10-09, pages 160 through 167**.**

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

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning the pending rule, contact Carmela Kerns-Gupta at (208) 334-6994.

DATED this 4th day of November, 2010.

Tamara Priscock
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 39-1118, Idaho Code.

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

| Thursday, September 9, 2010<br>6:00 p.m. MDT | Tuesday, September 14, 2010<br>6:00 p.m. MDT | Thursday, September 16, 2010<br>6:00 p.m. PDT |
|---|---|---|
| Central District Health Dept.<br>707 N Armstrong Place<br>Immunization Lobby<br>Boise, ID | Eastern Idaho Public Health Dept.<br>1250 Hollipark Dr.<br>North Conf. Rm.<br>Idaho Falls, ID | Red Lion Hotel<br>621 21st Street<br>Port One - Conf. Rm.<br>Lewiston, 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:

**In an effort to increase the number of children who are fully protected from preventable diseases, the Department is amending these rules to increase the number of vaccines required for children attending schools in Idaho. The changes to these rules will help protect children from additional vaccine-preventable diseases, provide a conditional admission clause for children who are in the process of receiving required vaccines, provide clarification on exclusion of children from attendance, and update existing language to match current practices. Parents who choose not to immunize their children will still be able to sign an exemption form for medical, religious, or other reasons.**

**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:

This rulemaking has no anticipated fiscal impact to state general funds.

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(2), Idaho Code:

**Informal negotiated rulemaking was conducted with the following: Idaho Public Health Districts, Idaho Medical Association (IMA), American Academy of Pediatrics - Idaho**

**chapter, American Academy of Family Physicians - Idaho chapter, State Board of Education, Idaho School Boards Association, Idaho State Department of Education, School Nurses Association of Idaho (SNOI), Head Start - Friends of Family and Children, Meridian Joint District No. 2 - Nursing Services, and the Idaho Immunization Coalition.**

**INCORPORATION BY REFERENCE:** Pursuant to Section 67-5229(2)(a), Idaho Code:

**The "Recommended Immunization Schedules for Persons Aged 0 through 18 Years -- United States, 2010," is being incorporated by reference into these rules because it contains the national standard for immunization schedules and is regularly updated to reflect best practices and to give it the force and effect of law. The document is not being republished in this chapter of rules due to its length and format and because of the cost of republication.**

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the proposed rule, contact Rebecca Coyle at (208) 334-5942.

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 22, 2010.

DATED this 29th day of July, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0215-1001***

**001. TITLE AND SCOPE.**

**01. Title**. The title of this chapter is, IDAPA 16.02.15, "Immunization Requirements for Idaho School Children." (4-6-05)

**02. Scope**. These rules contain the legal requirements for the administration of an immunization program for children enrolled in grades preschool, kindergarten through twelve (12) of any Idaho public, private, or parochial school. ~~*(3-30-07)*~~(____)

***(BREAK IN CONTINUITY OF SECTIONS)***

**004. INCORPORATION BY REFERENCE.**
~~*No documents have been incorporated by reference in this chapter of rules.*~~ The "Recommended Immunization Schedules for Persons Aged 0 Through 18 Years -- United States, 2010," are incorporated by reference for this chapter of rules. Published in the Morbidity and Mortality Weekly Report, January 8, 2010, Vol. 58 (51 and 52), by the Centers for Disease Control and

Prevention as recommended by the Advisory Committee on Immunization Practices (ACIP). This document is referred to in this chapter of rules as "ACIP Recommended Schedule." These schedules may be obtained from the Department or viewed online at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5851a6.htm. ~~(4-6-05)~~( )

***(BREAK IN CONTINUITY OF SECTIONS)***

**010. DEFINITIONS.**

**01. ACIP**. The Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. ~~(4-6-05)~~( )

**02. Admission**. Admission to a public, private or parochial school is: (4-2-08)

**a.** Registration of a child before attendance; or (4-2-08)

**b.** Re-entry of a child after withdrawing from previous enrollment. (4-2-08)

**c.** Transfer of a child from one (1) Idaho school to another or from schools outside Idaho. ( )

**03. Child**. A minor who is enrolled in preschool, kindergarten through grade twelve (12) in any Idaho public, private, or parochial school. ~~(3-30-07)~~( )

**04. Department**. Idaho Department of Health and Welfare. (10-13-92)

**05 Immunization Record**. An electronic medical health record, an immunization registry document, or a written immunization certificate confirmed by a licensed health care professional or a physician's representative which states the month, day, and year of each immunization a person has received. ( )

**0~~5~~6. Laboratory Proof**. A certificate from a licensed medical laboratory stating the type of test performed, the date of each test, and the results, accompanied by a physician's statement indicating the child is immune. Tests performed must meet the requirements of IDAPA 16.02.06, "Rules Governing Quality Assurance for Idaho Clinical Laboratories." ~~(4-6-05)~~( )

**07. Licensed Health Care Professional**. A practitioner, licensed in the State of Idaho by the Board overseeing the practitioner's license, or by a similar body in another state or jurisdiction within the United States. The practitioner's scope of practice for licensure must allow for the ordering of immunizations and writing of prescriptions, or the practitioner must be under the direction of a licensed physician. Licensed health care professionals who may provide for immunization requirements include: medical doctors, osteopaths, nurse practitioners, physicians' assistants, licensed professional nurses, registered nurses, and pharmacists. Other persons authorized by law to practice any of the healing arts, shall not be considered licensed health care professionals for the purposes of this chapter. ( )

**0~~6~~8. Parent, Custodian, or Guardian**. The legal parent, custodian, or guardian of a child or those with limited power of attorney for the temporary care or custody of a minor child. (4-6-05)

~~***07. Pertussis**. An infectious agent, Bordetella pertussis, that causes the disease commonly known as whooping cough.* (4-6-05)~~

**0~~8~~9. Physician**. A medical doctor or osteopath licensed by the Idaho State Board of Medicine, or by a similar body in another state or jurisdiction within the United States, to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine. ~~*(4-6-05)*~~( )

**~~09~~10. Physician's Representative**. Any person appointed by, or vested with the authority to act on behalf of a physician in matters concerning health. (8-15-79)

**11. Preschool**. The provision of education for children before the commencement of statutory and obligatory education, differing from traditional daycare in that the emphasis is learning and development rather than enabling parents to work or pursue other activities. Preschools may include, but are not limited to, federally-funded Head Start centers, state-funded preschools, government-funded special education programs, public school preschool programs, and for-profit and not-for profit preschool programs. ( )

**1~~0~~2. Private or Parochial School**. Any Idaho school maintained by an individual, organization or corporation, not at public expense, and open only to children selected and admitted by the individual, organization or corporation, or to children of a certain class or possessing certain qualifications, which may or may not charge tuition fees. (1-25-79)

**1~~1~~3. Public School**. Any Idaho school maintained at the public expense and open to all children within a given district, including those responsible for the education and training of exceptional children or those schools specially chartered. (1-25-79)

**14. Regulatory Authority**. The Director of the Idaho Department of Health and Welfare or the Director's designee. ( )

**1~~2~~5. School Authority**. An authorized representative designated by the Board of Trustees of a public school or a person or body designated to act on behalf of the governing body of a private or parochial school. (8-15-79)

**011. -- 099. (RESERVED).**

**100. IMMUNIZATION ~~*PROGRAM*~~ REQUIREMENTS.**

All ~~*I*~~immunizations listed in Subsections 100.01 through 100.04 of this rule, are required of children upon admission to kindergarten through grade twelve (12) of any Idaho public, private, or parochial school. Upon admission to preschool, children must be age appropriately immunized with all immunizations listed in Subsections 100.01 through 100.03 of this rule. Immunizations must be administered according to the "~~*General*~~ ACIP Recommend~~*ations*~~ed ~~*on Immunizations*~~ Schedule," ~~*established by the ACIP or their equivalent*~~ incorporated by reference in Section 004 of these rules, unless fewer doses are medically recommended by a physician. These

recommendations are available from the Department ~~as provided in Section 004 of these rules~~. Exemptions from these immunization requirements are provided in Section 110 of these rules. ~~(4-2-08)~~(        )

**01.** ~~**Measles, Mumps and Rubella (MMR)**~~ **Child Born on or Before September 1, 1999**. ~~(4-2-08)~~

~~**a.** A child born after September 1, 1999, is required to have any combination of two (2) doses of the vaccines listed in Subsections 100.01.c. and 100.01.d. of this rule. (4-2-08)~~

~~**b.**~~ A child born on or before September 1, 1999, ~~is required to have one (1) dose of either of the vaccines listed in Subsections 100.01.c. and 100.01.d. of this rule.~~ must meet the following minimum immunization requirements prior to admission for these vaccines: one (1) dose of ~~(4-2-08)~~

~~**c.**~~ Measles, Mumps, and Rubella (MMR)~~; or~~ ~~(4-2-08)~~

~~**d.** Measles, Mumps, Rubella and Varicella (MMRV).~~, four (4) doses of Diphtheria, Tetanus, Pertussis (DTaP), three (3) doses of Polio, and three (3) doses of Hepatitis B. ~~(4-2-08)~~(        )

**02.** ~~**Diphtheria and Tetanus**~~ **Child Born After September 1, 1999 Through September 1, 2005**. ~~(4-2-08)~~

~~**a.**~~ A child born after September 1, 1999~~, is required to have any combination of five (5) doses of the following vaccines listed in Subsections 100.02.c. through 100.02.g. of this rule. If the fourth dose was administered on or after the child's fourth birthday, the fifth dose is not needed.~~ ~~(4-2-08)~~

~~**b.** A child born on or before September 1, 1999, is required to have any combination of four (4) doses, of the vaccines listed in Subsections 100.02.c. through 100.02.g. of this rule.~~ through September 1, 2005, must meet the following minimum immunization requirements prior to admission for these vaccines: two (2) doses of Measles, Mumps, and Rubella (MMR), five (5) doses of ~~(4-2-08)~~

~~**c.**~~ Diphtheria, Tetanus, and ~~acellular~~ Pertussis (DTaP~~ - Pediatric~~)~~;~~ ~~(3-30-07)~~

~~**d.** Diphtheria, Tetanus and Pertussis (DTP); (3-30-07)~~

~~**e.** Tetanus, Diphtheria and acellular Pertussis (Tdap - Adolescent); (3-30-07)~~

~~**f.** Diphtheria, Tetanus (DT - Pediatric); or (4-2-08)~~

~~**g.** Tetanus, Diphtheria (Td - Adolescent)~~, three (3) doses of Polio, and three (3) doses of Hepatitis B. ~~(3-30-07)~~(        )

**03.** ~~**Pertussis**~~ **Child Born After September 1, 2005**. ~~(4-2-08)~~

~~a.~~ A child born after September 1, ~~1999, is required to have any combination of five (5) doses of the vaccines listed in Subsections 100.03.c. through 100.03.e. of this rule. If the fourth dose was administered on or after the child's fourth birthday, the fifth dose is not needed.(4-2-08)~~

~~b. A child born on or before September 1, 1999, is required to have any combination of four (4) doses of the vaccines listed in Subsection 100.03.c. through 100.03.e. of this rule.~~ 2005, must meet the following minimum immunization requirements prior to admission for the following vaccines: two (2) doses of Measles, Mumps, and Rubella (MMR), five (5) doses of ~~(4-2-08)~~

~~c.~~ Diphtheria, Tetanus, and ~~acellular~~ Pertussis (DTaP~~- Pediatric~~)~~;~~ ~~(4-2-08)~~

~~d. Diphtheria, Tetanus and Pertussis (DTP); or (4-2-08)~~

~~e. Tetanus, Diphtheria and acellular Pertussis (Tdap - Adolescent)~~, four (4) doses of Polio, three (3) doses of Hepatitis B, two (2) doses of Hepatitis A, and two (2) doses of Varicella. ~~(4-2-08)~~(    )

**04.** ~~**Polio**. A child is required to have three (3) doses of Polio vaccine.~~ **Seventh Grade Immunization Requirements**. Effective with the 2011-2012 school year, and each year thereafter, in addition to the required immunizations listed in Section 100.01 through 100.03 of this rule, a child must meet the following minimum immunization requirements prior to admission into the seventh (7th) grade for these vaccines: one (1) dose of Tetanus, Diphtheria, Pertussis Booster (Tdap), and one (1) dose of Meningococcal. This requirement will be extended to: 7th - 8th grade students in 2012, 7th - 9th grade students in 2013, 7th - 10th grade students in 2014, 7th - 11th grade students in 2015, and 7th - 12th grade students in 2016. ~~(4-2-08)~~(    )

~~**05.** **Hepatitis B**. A child born after November 22, 1991, is required to have three (3) doses of Hepatitis B vaccine. (4-2-08)~~

**0~~6~~5. Summary of Immunization Requirements**. (    )

a. Immunization requirements.

**TABLE 100.0~~6~~5.a. SUMMARY OF IMMUNIZATION REQUIREMENTS**

| Immunization Requirement* | Child born ~~after~~ on or before September 1, 1999 | Child born ~~on or before~~ after September 1, 1999, through September 1, 2005 | Child born after September 1, 2005 |
|---|---|---|---|
| Measles, Mumps, and Rubella (MMR) | ~~2~~1 dose~~s~~ | ~~1~~2 doses | 2 doses |
| Diphtheria, Tetanus, Pertussis | ~~5~~4 doses | ~~4~~5 doses | 5 doses |
| ~~Pertussis~~ | ~~5 doses~~ | ~~4 doses~~ | |
| Polio | 3 doses | 3 doses | 4 doses |
| Hepatitis B | 3 doses | 3 doses** | 3 doses |

| TABLE 100.0~~6~~5.a. SUMMARY OF IMMUNIZATION REQUIREMENTS | | | |
|---|---|---|---|
| **Immunization Requirement*** | **Child born ~~after~~ on or before September 1, 1999** | **Child born ~~on or before~~ after September 1, 1999, through September 1, 2005** | **Child born after September 1, 2005** |
| Hepatitis A | 0 doses | 0 doses | 2 doses |
| Varicella | 0 doses | 0 doses | 2 doses |
| * Exemptions for immunization requirements are found in Section 110 of these rules.<br>~~** Hepatitis B - Three (3) doses unless child was born on or before November 22, 1991.~~ | | | |

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

**b.** Seventh grade immunization requirements.

| TABLE 100.05.b SUMMARY OF SEVENTH GRADE IMMUNIZATION REQUIREMENTS | | |
|---|---|---|
| **Immunization Requirement*** | **Child admitted to 7th grade prior to 2011-2012 school year** | **Child admitted to 7th grade during 2011-2012 school year and each year thereafter** |
| Tetanus, Diphtheria, Pertussis (Tdap) | 0 doses | 1 dose |
| Meningococcal | 0 doses | 1 dose |
| * Exemptions for immunization requirements are found in Section 110 of these rules. | | |

(        )

**101. ~~DEADLINE FOR~~ COMPLIANCE.**
The ~~legal~~ parent, custodian, or guardian of any child who is to attend any public, private, or parochial school in Idaho must comply with the provisions contained in this chapter at the time of admission and before attendance. ~~(4-6-05)~~(        )

**102. EVIDENCE OF IMMUNIZATION STATUS.**

**01. Immunization ~~Certification Statement~~ Record**. Within the deadlines established in Section 101 of these rules, a ~~legal~~ parent, custodian, or guardian of each child must present to school authorities an immunization ~~certification statement signed by a physician or a physician's representative stating the type, number and dates of immunizations received~~ record. ~~(4-6-05)~~(        )

**02. Schedule of Intended Immunizations Form**. A child who has received at least one (1) dose of each required vaccine and is currently on schedule for subsequent immunizations may be conditionally admitted. School authorities, at the time of admission and before attendance, must have a ~~statement~~ schedule of intended immunizations form completed by a ~~legal~~ parent, custodian, or guardian ~~of~~ for any child who is not immunized, excepted, or exempted, and who is in the process of receiving, or has been scheduled to receive, the required immunizations. A form

~~*is*~~ provided by the Department, or one similar, must include the following information: ~~*(4-6-05)*~~( )

**a.** Name and ~~*age*~~ date of birth of child; ~~*(4-6-05)*~~( )

**b.** School and grade child is enrolled in and attending; (4-6-05)

**c.** Types, numbers, and dates of scheduled immunizations to be administered; ~~*(4-6-05)*~~( )

**d.** Signature of the ~~*legal*~~ parent, custodian, or guardian~~*providing the information*~~; and ~~*(10-13-92)*~~( )

**e.** Signature of a ~~*physician or physician's representative*~~ licensed health care professional providing care to the child. ~~*(7-9-90)*~~( )

**03. Children Admitted to School and Failing to Continue the Schedule of Intended Immunizations**. A child, who does not receive the required immunizations as scheduled in Subsection 102.02 of ~~*these*~~ this rule~~*s*~~, will be excluded by school authorities until documentation of the administration of the required immunizations is provided to school authorities by the child's ~~*legal*~~ parent, custodian, or guardian. ~~*(4-6-05)*~~( )

**103. -- 104. (RESERVED).**

**105. EXCEPTIONS TO IMMUNIZATION REQUIREMENT.**

When supporting documentation is in the possession of school authorities at the time of admission and before attendance, a child who meets one (1) or ~~*more*~~ both of the following conditions, will not be required to ~~*undergo*~~ receive the required immunizations in order to attend school~~:~~. ~~*(4-6-05)*~~( )

**01. Laboratory Proof**. Laboratory proof of immunity to any of the ~~*eight (8)*~~ childhood diseases listed in Section 100 of these rules, will not be required to receive the immunization for that disease~~*; or*~~ for which the child is immune. ~~*(4-6-05)*~~( )

**02. Disease Diagnosis**. A child who has a statement signed ~~*statement of*~~ by a licensed ~~*physician*~~ health care professional stating that the child has had ~~*measles or mumps*~~ varicella (chickenpox) disease diagnosed by ~~*the physician*~~ a licensed health care professional upon personal examination, will not be required to receive the immunization for the diagnosed disease. ~~*(4-6-05)*~~( )

***03. Suspension of Requirement****. The Regulatory Authority may temporarily suspend one (1) or more of the immunization requirements listed in Section 100 of these rules, if the Regulatory Authority determines that suspension of the requirement is necessary to address a vaccine shortage or other emergency situation in the state. The Regulatory Authority will suspend a requirement for the length of time needed to remedy the vaccine shortage or emergency situation.* *( )*

**106. -- 109. (RESERVED).**

**110. EXEMPTIONS TO IMMUNIZATION REQUIREMENT.**
When supporting documentation is in the possession of school authorities, at the time of admission and before attendance, a child who meets one (1) or both of the following conditions in Subsections 110.01 and 110.02 of this rule, will not be required to ~~undergo~~ receive the required immunizations. ~~(4-6-05)~~(    )

**01. Life or Health Endangering Circumstances**. A signed statement of a licensed physician that the child's life or health would be endangered if any or all of the required immunizations are administered~~; or~~. ~~(4-6-05)~~(    )

**02. Religious or Other Objections**. A signed statement of the ~~legal~~ parent, custodian, or guardian on a form provided by the Department~~ or one containing similar information~~, ~~and~~ that includes the following: ~~(4-6-05)~~(    )

**a.** Name of child, date of birth; and ~~(1-25-79)~~(    )

**b.** A statement of objection on religious or other grounds. (1-25-79)

**111. -- 149. (RESERVED).**

**150. ENFORCEMENT OF IMMUNIZATION REQUIREMENT.**

**01. Noncompliance**. Any child not in compliance with this chapter upon admission to any Idaho public, private, or parochial school, will be denied attendance by school authorities, unless the child is excepted or exempted from these immunization requirements as provided in Sections 105 and 110 of these rules. The regulatory authority may exclude any child who does not meet the requirements in this chapter and who has not been excluded from school. ~~(4-2-08)~~(    )

**02. Length of Exclusion**. Any child denied attendance in accordance with Subsection 150.01 of this rule, will not be allowed to attend any Idaho public, private or parochial school until the child is in compliance with the requirements of this chapter. (4-2-08)

**03. Exempted Children**. A child exempted under Section 110 of these rules, may be excluded by the regulatory authority in the event of a disease outbreak under IDAPA 16.02.10, "Idaho Reportable Diseases." (    )

**151. -- 199. (RESERVED).**

**200. REPORTS BY SCHOOL AUTHORITIES.**

**01. Responsibility and Timeliness**. School authorities must submit a report of each school's immunization status, by grade, to the Department on or before the first day of November each year. (4-6-05)

**02. Form and Content of Report**. Each school report must include ~~T~~the following information ~~will~~ and be ~~provided~~ submitted on a Department form or electronically~~ by school~~: ~~(4-6-05)~~(    )

**a.** Inclusive dates of reporting period; (10-13-92)

**b.** Name and address of school, school district and county; (4-6-05)

**c.** Grade being reported and total number of children enrolled in the grade; (4-6-05)

**d.** The name and title of the person completing the report form. (4-6-05)

**e.** Number of children who meet all of the required immunizations listed in Section 100 of these rules; (4-6-05)

**f.** Number of children who do not meet all of the required number of immunizations listed by specific immunization type; (4-6-05)

**g.** Number of children who do not meet the immunization requirement, but are in the process of receiving the required immunizations; and (4-6-05)

**h.** Number of children who claimed exemption to the required immunizations as allowed in Section 110 of these rules. (4-6-05)

# IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

## 16.03.09 - MEDICAID BASIC PLAN BENEFITS

## DOCKET NO. 16-0309-1001

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** The effective date of the amendment to the temporary rule is **July 1, 2010**. This pending rule has been adopted by the agency and is now pending review by the 2011 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 55-819 and 56-225, Idaho Code, adopted by the 2010 Legislature under Senate Bill 1321.

**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 Department is making changes to the proposed rule and amending the temporary rule in this docket concerning the request for notice of transfer or encumbrance.**

**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 that differ from the proposed text are printed in this bulletin. The original text of the proposed rule was published in the** August 4, 2010, Idaho Administrative Bulletin, Vol. 10-8, pages 70 through 77**.**

**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 rule change will have no negative fiscal impact to the state general funds. This change should have a positive fiscal effect by preventing improper asset transfers and increase recovery of assets that otherwise would be missed.**

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning the pending rule and the amendment to temporary rule, contact Larry Tisdale at (208) 287-1141.

DATED this 4th day of November, 2010.

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

**_THIS NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE_**

**EFFECTIVE DATE:** The effective date of these temporary rules is **July 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 55-819 and 56-225, Idaho Code, adopted by the 2010 Legislature under Senate Bill 1321.

**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 18, 2010.

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:

**Statute changes effective on July 1, 2010, required the Department to provide a model form for notice of transfer or encumbrance to be used by a Medicaid recipient or his representative when notifying the Department of transferring real property. This requirement for a request of notice form is being added into Section 900, Liens and Estate Recovery. Because this section is long and cumbersome, the Department decided to reformat the rule into more user friendly sections at this time. Other minor changes have been made for clarity and understanding of these rules.**

**TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is necessary for compliance with deadlines in amendments to governing law.**

**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 rule change will have no negative fiscal impact to the state general funds. This change should have a positive fiscal effect by preventing improper asset transfers and increase recovery of assets that otherwise would be missed.**

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because this rulemaking is being done to meet statutory changes adopted by the 2010 Legislature under Senate Bill 1321.

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

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the temporary and proposed rule, contact Larry Tisdale at (208) 287-1141.

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 25, 2010.

DATED this 30th day of June, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1001***

***SUB AREA: LIENS AND ESTATE RECOVERY***
***(Section 900 - 909)***

**900. LIENS AND ESTATE RECOVERY.**
In accordance with Sections 55-819, 56-218, ~~*and*~~ 56-218A, and 56-225, Idaho Code, this Section of rule sets forth the provisions for recovery of medical assistance, the filing of liens against the property of deceased persons, ~~*and*~~ the filing of liens against the property of permanently institutionalized participants, and the recording of requests for notice. ~~*(3-30-07)*~~(____)

**01. Medical Assistance Incorrectly Paid**. The Department may, pursuant to a judgment of a court, file a lien against the property of a living or deceased person of any age to recover the costs of medical assistance incorrectly paid. (3-30-07)

**02. Administrative Appeals**. Permanent institutionalization determination, ~~and~~ undue hardship waiver, and request for notice hearings are governed by the fair hearing provisions of IDAPA 16~~, Title~~.05~~, Chapter~~.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ~~(3-30-07)~~(        )

**~~03~~901. LIENS AND ESTATE RECOVERY - DEFINITIONS.**
The following terms are applicable to Sections 900 through 909 of this chapter of rules: ~~(3-30-07)~~(        )

**~~a~~01. Authorized Representative**. The person appointed by the court as the personal representative in a probate proceeding or, if none, the person identified by the participant to receive notice and make decisions on estate matters. (3-30-07)

**~~b~~02. Discharge From a Medical Institution**. A medical decision made by a competent medical professional that the Medicaid participant no longer needs nursing home care because the participant's condition has improved, or the discharge is not medically contraindicated. (3-30-07)

**~~c~~03. Equity Interest in a Home**. Any equity interest in real property recognized under Idaho law. (3-30-07)

**~~d~~04. Estate**. All real and personal property and other assets including those in which the participant had any legal or beneficial title or interest at the time of death, to the extent of such interest, including such assets conveyed to a survivor, heir, or assignee of the deceased participant through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement. (3-30-07)

**~~e~~05. Home**. The dwelling in which the participant has an ownership interest, and which the participant occupied as his primary dwelling prior to, or subsequent to, his admission to a medical institution. (3-30-07)

**~~f~~06. Institutionalized Participant**. An inpatient in a nursing facility (NF), intermediate care facility for people with intellectual disabilities (ICF/ID), or other medical institution, who is a Medicaid participant subject to post-eligibility treatment of income in IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." (3-30-07)

**~~g~~07. Lawfully Residing**. Residing in a manner not contrary to or forbidden by law, and with the participant's knowledge and consent. (3-30-07)

**~~h~~08. Permanently Institutionalized**. An institutionalized participant of any age who the Department has determined cannot reasonably be expected to be discharged from the institution and return home. Discharge refers to a medical decision made by a competent medical professional that the participant is physically able to leave the institution and return to live at home. (3-30-07)

**~~i~~09. Personal Property**. Any property not real property, including cash, jewelry, household goods, tools, life insurance policies, boats and wheeled vehicles. (3-30-07)

~~*j*~~10. **Real Property**. Any land, including buildings or immovable objects attached permanently to the land. (3-30-07)

~~*k*~~11. **Residing in the Home on a Continuous Basis**. Occupying the home as the primary dwelling and continuing to occupy such dwelling as the primary residence. (3-30-07)

~~*l*~~12. **Termination of a Lien**. The release or dissolution of a lien from property. (3-30-07)

~~*m*~~13. **Undue Hardship**. Conditions that justify waiver of all or a part of the Department's claim against an estate, described in Subsections ~~*900.25*~~ 905.06 through ~~*900.29*~~ 905.10 of ~~*this*~~ these rules. ~~*(3-30-07)*~~(      )

~~*n*~~14. **Undue Hardship Waiver**. A decision made by the Department to relinquish, limit, or defer its claim to any or all estate assets of a deceased participant based on good cause. (3-30-07)

**~~*04*~~902. LIENS AND ESTATE RECOVERY - NOTIFICATION TO DEPARTMENT.**
All notification regarding liens, ~~*and*~~ estate claims, and requests for notice must be directed to the Department of Health and Welfare, Estate Recovery Unit, 3276 Elder, Suite B, P.O. Box 83720, Boise, Idaho, 83720-0036. ~~*(3-30-07)*~~(      )

**903. LIENS AND ESTATE RECOVERY - LIEN DURING LIFETIME OF PARTICIPANT.**

0~~*5*~~1. **Lien Imposed During Lifetime of Participant**. During the lifetime of the permanently institutionalized participant, and subject to the restrictions set forth in Subsection ~~*900.08*~~ 903.04 of this rule, the Department may impose a lien against the real property of the participant for medical assistance correctly paid on his behalf. The lien must be filed within ninety (90) days of the Department's final determination, after notice and opportunity for a hearing, that the participant is permanently institutionalized. The lien is effective from the beginning of the most recent continuous period of the participant's institutionalization, but not before July 1, 1995. Any lien imposed will dissolve upon the participant's discharge from the medical institution and return home. ~~*(3-30-07)*~~(      )

0~~*6*~~2. **Determination of Permanent Institutionalization**. The Department must determine that the participant is permanently institutionalized prior to the lien being imposed. An expectation or plan that the participant will return home with the support of Home and Community Based Services does not, in and of itself, justify a decision that he is reasonably expected to be discharged to return home. The following factors must be considered when making the determination of permanent institutionalization: (3-30-07)

**a.** The participant must meet the criteria for nursing facility or ICF/ID level of care and services as set forth in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 220 through 299, and 580 through 649; (3-30-07)

**b.** The medical records must be reviewed to determine if the participant's condition is expected to improve to the extent that he will not require nursing facility or ICF/D level of care;

and (3-30-07)

**c.** Where the prognosis indicated in the medical records is uncertain or inconclusive, the Department may request additional medical information, or may delay the determination until the next utilization control review or annual Inspection of Care review, as appropriate. (3-30-07)

**0~~7~~3. Notice of Determination of Permanent Institutionalization and Hearing Rights**. The Department must notify the participant or his authorized representative, in writing, of its intention to make a determination that the participant is permanently institutionalized, and that he has the right to a fair hearing in accordance with Subsection 900.02 of ~~*this*~~ these rules. This notice must ~~*include*~~ inform the participant of the following information, at a minimum: ~~*(3-30-07)*~~( )

**a.** The ~~*notice must inform the participant that the*~~ Department's decision that he cannot reasonably be expected to be discharged from the medical institution to return home is based upon a review of the medical records and plan of care, but that this does not preclude him from returning home with services necessary to support nursing facility or ICF/ID level of care; and ~~*(3-30-07)*~~( )

**b.** ~~*The notice must inform the participant that h*~~He or his authorized representative may request a fair hearing prior to the Department's final determination that he is permanently institutionalized. The notice must include information that a pre-hearing conference may be scheduled prior to a fair hearing. The notice must include the time limits and instructions for requesting a fair hearing. ~~*(3-30-07)*~~( )

**c.** ~~*The notice must inform the participant that i*~~If he or his authorized representative does not request a fair hearing within the time limits specified, his real property, including his home, may be subject to a lien, contingent upon the restrictions in Subsection ~~*900.08*~~ 903.04 of this rule. . ~~*(3-30-07)*~~( )

**0~~8~~4. Restrictions on Imposing Lien During Lifetime of Participant**. A lien may be imposed on the participant's real property; however, no lien may be imposed on the participant's home if any of the following is lawfully residing in such home: (3-30-07)

**a.** The spouse of the participant; (3-30-07)

**b.** The participant's child who is under age twenty-one (21), or who is blind or disabled as defined in 42 U.S.C. 1382c as amended; or (3-30-07)

**c.** A sibling of the participant who has an equity interest in the participant's home and who was residing in such home for a period of at least one (1) year immediately before the date of the participant's admission to the medical institution, and who has been residing in the home on a continuous basis. (3-30-07)

**0~~9~~5. Restrictions on Recovery on Lien Imposed During Lifetime of Participant**. Recovery will be made on the lien from the participant's estate, or at any time upon the sale of the property subject to the lien, but only after the death of the participant's surviving spouse, if any, and only at a time when: (3-30-07)

**a.** The participant has no surviving child who is under age twenty-one (21); (3-30-07)

**b.** The participant has no surviving child of any age who is blind or disabled as defined in 42 U.S.C. 1382c as amended; and (3-30-07)

**c.** In the case of a lien on a participant's home, when none of the following is lawfully residing in such home who has lawfully resided in the home on a continuous basis since the date of the participant's admission to the medical institution: (3-30-07)

i. A sibling of the participant, who was residing in the participant's home for a period of at least one (1) year immediately before the date of the participant's admission to the medical institution; or (3-30-07)

ii. A son or daughter of the participant, who was residing in the participant's home for a period of at least two (2) years immediately before the date of the participant's admission to the medical institution, and who establishes by a preponderance of the evidence that he provided necessary care to the participant, and the care he provided allowed the participant to remain at home rather than in a medical institution. (3-30-07)

**~~*1*~~06. Recovery Upon Sale of Property Subject to Lien Imposed During Lifetime of Participant**. Should the property upon which a lien is imposed be sold prior to the participant's death, the Department will seek recovery of all medical assistance paid on behalf of the participant, subject to the restrictions in Subsection ~~*900.09*~~ 903.05 of ~~*these*~~ this rule~~*s*~~. Recovery of the medical assistance paid on behalf of the participant from the proceeds from the sale of the property does not preclude the Department from recovering additional medical assistance paid from the participant's estate as described in Subsection ~~*900.14*~~ 904.01 of ~~*this*~~ these rules. ~~*(3-30-07)*~~(     )

**~~*11*~~07. Filing of Lien During Lifetime of Participant**. When appropriate, the Department will file, in the office of the Recorder of the county in which the real property of the participant is located, a verified statement, in writing, setting forth the following: (3-30-07)

**a.** The name and last known address of the participant; and (3-30-07)

**b.** The name and address of the official or agent of the Department filing the lien; and (3-30-07)

**c.** A brief description of the medical assistance received by the participant; and (3-30-07)

**d.** The amount paid by the Department, as of a given date, and, if applicable, a statement that the amount of the lien will increase as long as medical assistance benefits are paid on behalf of the participant. (3-30-07)

**~~*12*~~08. Renewal of Lien Imposed During Lifetime of Participant**. The lien, or any extension thereof, must be renewed every five (5) years by filing a new verified statement as

required in Subsection ~~*900.11*~~ 903.07 of this rule, or as required by Idaho law. ~~*(3-30-07)*~~(____)

~~*13*~~**09. Termination of Lien Imposed During Lifetime of Participant**. The lien will be released as provided by Idaho Code, upon satisfaction of the Department's claim. The lien will dissolve in the event of the participant's discharge from the medical institution and return home. Such dissolution of the lien does not discharge the underlying debt and the estate remains subject to recovery under estate recovery provisions in S~~*ubs*~~ections ~~*900.14 through 900.30*~~ 904 and 905 of ~~*this*~~ these rules. ~~*(3-30-07)*~~(____)

**~~*14*~~904. LIENS AND ESTATE RECOVERY - REQUIREMENTS FOR ESTATE RECOVERY.**

**01. Estate Recovery Requirements**. In accordance Sections 56-218 and 56-218A, Idaho Code, the Department is required to recover the following: ~~*(3-30-07)*~~(____)

**a.** The costs of all medical assistance correctly paid on or after July 1, 1995, on behalf of a participant who was permanently institutionalized; (3-30-07)

**b.** The costs of medical assistance correctly paid on behalf of a participant who received medical assistance at age fifty-five (55) or older on or after July 1, 1994; and (3-30-07)

**c.** The costs of medical assistance correctly paid on behalf of a participant who received medical assistance at age sixty-five (65) or older on or after July 1, 1988. (3-30-07)

~~*15*~~**02. Recovery From Estate of Spouse**. Recovery from the estate of the spouse of a Medicaid participant may be made as permitted in Sections 56-218 and 56-218A, Idaho Code. (3-30-07)

~~*16*~~**03. Lien Imposed Against Estate of Deceased Participant**. Liens may be imposed against the estates of deceased Medicaid participants and their spouses as permitted by Section 56-218, Idaho Code. (3-30-07)

~~*17*~~**04. Notice of Estate Claim**. The Department will notify the authorized representative of the amount of the estate claim after the death of the participant, or after the death of the surviving spouse. The notice must include instructions for applying for an undue hardship waiver. (3-30-07)

~~*18*~~**05. Assets in Estate Subject to Claims**. The authorized representative will be notified of the Department's claim against the assets of a deceased participant. Assets in the estate from which the claim can be satisfied must include all real or personal property that the deceased participant owned or in which he had an ownership interest, including the following: (3-30-07)

**a.** Payments to the participant under an installment contract will be included among the assets of the deceased participant. This includes an installment contract on any real or personal property to which the deceased participant had a property right. The value of a promissory note, loan or property agreement is its outstanding principal balance at the date of death of the participant. When a promissory note, loan, or property agreement is secured by a Deed of Trust, the Department may request evidence of a reasonable and just underlying debt. (3-30-07)

**b.** The deceased participant's ownership interest in an estate, probated or not probated, is an asset of his estate when: (3-30-07)

i. Documents show the deceased participant is an eligible devisee or donee of property of another deceased person; or (3-30-07)

ii. The deceased participant received income from property of another person; or (3-30-07)

iii. State intestacy laws award the deceased participant a share in the distribution of the property of another estate. (3-30-07)

**c.** Any trust instrument which is designed to hold or to distribute funds or property, real or personal, in which the deceased participant had a beneficial interest is an asset of the estate. (3-30-07)

**d.** Life insurance is considered an asset when it has reverted to the estate. (3-30-07)

**e.** Burial insurance is considered an asset when a funeral home is the primary beneficiary or when there are unspent funds in the burial contract. Any funds remaining after payment to the funeral home will be considered assets of the estate. (3-30-07)

**f.** Checking and savings accounts which hold and accumulate funds designated for the deceased participant, are assets of the estate, including joint accounts which accumulate funds for the benefit of the participant. (3-30-07)

**g.** In a conservatorship situation, if a court order under state law specifically requires funds be made available for the care and maintenance of a participant prior to his death, absent evidence to the contrary, such funds are an asset of the deceased participant's estate, even if a court has to approve release of the funds. (3-30-07)

**h.** Shares of stocks, bonds and mutual funds to the benefit of the deceased participant are assets of the estate. The current market value of all stocks, bonds and mutual funds must be proved as of the month preceding settlement of the estate claim. (3-30-07)

**~~19~~06. Value of Estate Assets**. The Department will use fair market value as the value of the estate assets. (3-30-07)

## 905. LIENS AND ESTATE RECOVERY - LIMITATIONS AND EXCLUSIONS.

**~~2~~01. Limitations on Estate Claims**. Limits on the Department's claim against the assets of a deceased participant or spouse are subject to Sections 56-218 and 56-218A, Idaho Code. A claim against the estate of a spouse of a participant is limited to the value of the assets of the estate that had been, at any time after October 1, 1993, community property, or the deceased participant's share of the separate property, and jointly owned property. Recovery will not be made until the deceased participant no longer is survived by a spouse, a child who is under age twenty-one (21), or a blind or disabled child, as defined in 42 U.S.C. 1382c as amended and,

when applicable, as provided in Subsection ~~900.09~~ 903.05 of ~~this~~ these rules. No recovery will be made if the participant received medical assistance as the result of a crime committed against the participant. ~~(3-30-07)~~( )

~~21~~02. **Expenses Deducted From Estate**. The following expenses may be deducted from the available assets to determine the amount available to satisfy the Department's claim:(3-30-07)

**a.** Burial expenses, which include only those reasonably necessary for embalming, transportation of the body, cremation, flowers, clothing, and services of the funeral director and staff may be deducted. (3-30-07)

**b.** Other legally enforceable and necessary debts with priority may be deducted. The Department's claim is classified and paid as a debt with preference as defined in Section 15-03-805, Idaho Code. Debts of the deceased participant that may be deducted from the estate prior to satisfaction of the Department's claim must be legally enforceable debts given preference over the Department's claim under Section 15-03-805, Idaho Code. (3-30-07)

~~22~~03. **Interest on Claim**. The Department's claim does not bear interest except as otherwise provided by statute or agreement. (3-30-07)

~~23~~04. **Excluded Land**. Restricted allotted land, owned by a deceased participant who was an enrolled member of a federally recognized American Indian tribe, or eligible for tribal membership, which cannot be sold or transferred without permission from the Indian tribe or an agency of the Federal Government, will not be subject to estate recovery. (3-30-07)

~~24~~05. **Marriage Settlement Agreement or Other Such Agreement**. A marriage settlement agreement or other such agreement which separates assets for a married couple does not eliminate the debt against the estate of the deceased participant or the spouse. Transfers under a marriage settlement agreement or other such agreement may be voided if not for adequate consideration. (3-30-07)

~~25~~06. **Release of Estate Claims**. The Department will release a claim when the Department's claim has been fully satisfied and may release its claim under the following conditions: (3-30-07)

**a.** When an undue hardship waiver as defined in Subsection ~~900.26~~ 905.07 of this rule has been granted; or ~~(3-30-07)~~( )

**b.** When a written agreement with the authorized representative to pay the Department's claim in thirty-six (36) monthly payments or less has been achieved. (3-30-07)

~~26~~07. **Purpose of the Undue Hardship Exception**. The undue hardship exception is intended to avoid the impoverishment of the deceased participant's family due to the Department exercising its estate recovery right. The fact that family members anticipate or expect an inheritance, or will be inconvenienced economically by the lack of an inheritance, is not cause for the Department to declare an undue hardship. (3-30-07)

~~27~~08. **Application for Undue Hardship Waiver**. An applicant for an undue hardship

waiver must have a beneficial interest in the estate and must apply for the waiver within ninety (90) days of the death of the participant or within thirty (30) days of receiving notice of the Department's claim, whichever is later. The filing of a claim by the Department in a probate proceeding constitutes notice to all heirs. (3-30-07)

~~28~~09. **Basis for Undue Hardship Waiver**. Undue hardship waivers will be considered in the following circumstances: (3-30-07)

**a.** The estate subject to recovery is income-producing property that provides the primary source of support for other family members; or (3-30-07)

**b.** Payment of the Department's claim would cause heirs of the deceased participant to be eligible for public assistance; or (3-30-07)

**c**. The Department's claim is less than five hundred dollars ($500) or the total assets of the entire estate are less than five hundred dollars ($500), excluding trust accounts or other bank accounts. (3-30-07)

**d.** The participant received medical assistance as the result of a crime committed against the participant. (3-30-07)

~~29~~10. **Limitations on Undue Hardship Waiver**. Any beneficiary of the estate of a deceased participant may apply for waiver of the estate recovery claim based on undue hardship. Any claim may be waived by the Department, partially or fully, because of undue hardship. An undue hardship does not exist if action taken by the participant prior to his death, or by his legal representative, divested or diverted assets from the estate. The Department grants undue hardship waivers on a case by case basis upon review of all facts and circumstances, including any action taken to diminish assets available for estate recovery or to circumvent estate recovery. (3-30-07)

~~30~~11. **Set Aside of Transfers**. Transfers of real or personal property of the participant without adequate consideration are voidable and may be set aside by the district court whether or not the asset transfer resulted, or could have resulted, in a period of ineligibility. (3-30-07)

**906. LIENS AND ESTATE RECOVERY - REQUEST FOR NOTICE.**

**01. Request for Notice - Notice - Hearing**. The Department must notify the participant or his authorized representative, in writing, of its intention to record a request for notice, and that he has the right to a fair hearing in accordance with Subsection 900.02 of these rules. The notice must inform the participant of the following information, at a minimum: ( )

**a.** The Department's determination that he is the record titleholder or purchaser under a land sale contract of real property subject to a request for notice; ( )

**b.** He or his authorized representative may request a fair hearing prior to the Department's recording a request for notice. The notice must include the time limits and instructions for requesting a fair hearing; and ( )

**c.** If he or his authorized representative does not request a fair hearing within the time

limits specified, a request for notice applying to his real property, including his home, may be recorded. ( )

**02. Request for Notice - Forms - *Content***. The notices must include, at a minimum, the following information: ( )

**a.** The name of the public assistance recipient and the spouse of such public assistance recipient, if any; ( )

**b.** The Medicaid number for the public assistance recipient and spouse, if any; ( )

**c.** The legal description of the real property affected or to be affected; ( )

**d.** The mailing address at which the Department is to receive notice as provided in Section 902 of these rules; ( )

**e.** If the document is a Notice of Transfer or Encumbrance, the name and address of the transferee or lien holder; and ( )

**f.** A fully executed acknowledgement as required for recording under Section 55-805, Idaho Code. ( )

***03. Webpages for Forms***. *The forms may be found at:* ( )

***a.*** *Notice of Transfer or Encumbrance:* http://healthandwelfare.idaho.gov/LinkClick.aspx?fileticket=sDegNIDVB2w%3d&tabid=123&mid=6527. ( )

***b.*** *Request for Notice:* http://healthandwelfare.idaho.gov/LinkClick.aspx?fileticket=HyIdxO7wyw8%3d&tabid=123&mid=6527. ( )

***c.*** *Termination of Request for Notice:* http://healthandwelfare.idaho.gov/LinkClick.aspx?fileticket=m5xQcFrELTQ%3d&tabid=123&mid=6527. ( )

**9017. -- 909. (RESERVED).**

# IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

## 16.03.09 - MEDICAID BASIC PLAN BENEFITS

## DOCKET NO. 16-0309-1002

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 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(b), Idaho Code, and 2010 Legislation under House Bill 701, the Medicaid appropriations budget.

**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 of Health and Welfare implemented a selective contract system for the federally mandated non-emergency medical transportation services for Medicaid participants. The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the** August 4, 2010, Idaho Administrative Bulletin, Vol. 10-8, pages 78 through 85.

**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 estimated cost avoidance for the remaining 10 months for state fiscal year 2011 using a non-emergency medical transportation brokerage contractor is $434,417. Of this amount, $99,138 would be state general funds, and $335,279 would be federal funds using the current federal match rate.**

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning this pending rule, contact Sara Stith at (208) 287-1173.

DATED this 27th day of October, 2010.

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

***THIS NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE***

**EFFECTIVE DATE:** The effective date of these temporary rules are **September 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 56-202(b), Idaho Code, and 2010 Legislation under House Bill 701, the Medicaid appropriations budget.

**PUBLIC HEARING SCHEDULE:** A public hearing concerning this rulemaking will be held as follows:

**SPECIAL NOTE:** Department staff will be available at the hearing site for a question and answer session about the Non-Emergency Medical Transportation rule changes beginning at 2:00 p.m. The Public Hearing will begin promptly at 2:30 p.m.

| Friday, August 13, 2010 at 2:00 p.m. |
|---|
| **Region IV Health & Welfare Office**<br>**1720 Westgate Drive**<br>**Suite A, Room 131**<br>**Boise, ID** |

The hearing site 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 of Health and Welfare is implementing a selective contract system for the federally mandated non-emergency medical transportation services based on legislative intent for controlling costs, while improving quality and sustaining access. These rules provide the non-emergency medical transportation requirements for a transportation brokerage system for Medicaid participants who have no other means to receive Medicaid-covered services.**

**TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is necessary for compliance with deadlines in amendments to governing law.**

**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 estimated cost avoidance for the remaining 10 months for state fiscal year 2011 using a non-emergency medical transportation brokerage contractor is $940,775. Of this amount, $188,155 would be state general funds, and $752,620 would be federal funds using the current federal match rate.**

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because this rulemaking is being done to meet Medicaid's appropriations budget adopted by the 2010 Legislature under House Bill 701.

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

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the temporary and proposed rule, contact Sara Stith at (208) 287-1173.

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 25, 2010.

DATED this 16th day of July, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1002***

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

**01. Compliance With Department Criminal History Check**. Criminal history checks are required for certain types of providers under these rules. Providers who are required to have a criminal history check must comply with IDAPA 16.05.06, "Criminal History and Background Checks." (3-30-07)

**02. Availability to Work or Provide Service**. (3-30-07)

**a.** The employer, at its discretion, may allow an individual to provide care or services on a provisional basis once the application for a criminal history and background check is completed and notarized, and the employer has reviewed the application for any disqualifying crimes or relevant records. The employer determines whether the individual could pose a health

and safety risk to the vulnerable participants it serves. The individual is not allowed to provide care or services when the employer determines the individual has disclosed a disqualifying crime or relevant records. (3-30-07)

**b.** Those individuals licensed or certified by the Department are not available to provide services or receive licensure or certification until the criminal history and background check is completed and a clearance issued by the Department. (3-30-07)

**03. Additional Criminal Convictions**. Once an individual has received a criminal history clearance, any additional criminal convictions must be reported by the agency to the Department when the agency learns of the conviction. (3-30-07)

**04. Providers Subject to Criminal History Check Requirements**. The following providers must receive a criminal history clearance: (3-30-07)

**a.** Mental Health Clinics. The criminal history check requirements applicable to mental health clinic staff are found in Subsection 714.05 of these rules. (3-30-07)

**b.** ~~*Commercial*~~ Contracted Non-Emergency Medical Transportation Providers. ~~*The criminal history check requirements applicable to commercial non-emergency*~~ All staff of transportation providers ~~*are found in*~~ having contact with participants must comply with IDAPA 16.05.06, "Criminal History and Background Checks," with the exception of individual contracted transportation providers defined in Subsection 87~~4~~0.05 of these rules. ~~*(3-30-07)*~~( )

**c.** Substance Abuse Treatment Providers. The criminal history check requirements applicable to substance abuse treatment providers are found in Section 694 of these rules. (5-8-09)

***(BREAK IN CONTINUITY OF SECTIONS)***

**870. NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES -- DEFINITIONS.**

For the purposes of Sections 870 through 879 of these rules, the following definitions apply. ( )

**01.** ~~***Commercial***~~ **Contracted Transportation Provider**. ~~*A commercial transportation provider is an entity in the business of transportation that is organized to provide, that publicly holds itself out to provide, and that actually provides personal transportation services to the general public. By "holding itself out" to the general public, the provider vigorously and diligently solicits riders from the general populace, as opposed to primarily serving riders from one (1) or more congregate living facilities. By "actually providing" services to the general public, the provider's riders include substantial numbers of persons whose travel is funded by a source other than Medicaid.*~~ A non-emergency medical transportation provider who is under contract with the transportation broker to provide non-emergency medical transportation for Medicaid participants. ~~*(3-30-07)*~~( )

**02. Individual Contracted Transportation Provider**. An individual who is under contract with the transportation broker to provide non-emergency medical transportation for a Medicaid participant in the provider's personal vehicle. ( )

**0~~2~~3. Non-~~*Commercial*~~ Emergency Medical Transportation ~~*Provider*~~**. ~~*Any*~~ Non-emergency medical transportation ~~*provider that does not meet the definition of a commercial transportation provider*~~ is ~~*a non-commercial*~~ transportation ~~*provider*~~ that is: ~~*(3-30-07)*~~( )

**a.** Not of an emergency nature; and ( )

**b.** Required for a Medicaid participant to access medically necessary services covered by Medicaid when the participant's own transportation resources, family transportation resources, or community transportation resources do not allow the participant to reach those services. ( )

**0~~3~~4.** ~~***Agency Transporters***~~. ~~*Agency transporters are entities that provide transportation as well as at least one other service to one or more Medicaid participants. Individual transporters are non-commercial providers who transport a family member, acquaintance or other person in a personal vehicle.*~~ **Transportation Broker**. An entity under contract with the Department to administer, coordinate, and manage a statewide network of non-emergency medical transportation providers. ~~*(3-30-07)*~~( )

**05. Travel-Related Services**. Travel-related services are meals, lodging, and attendant care required for non-emergency medical transportation to be completed for a Medicaid participant. ( )

**871. ~~*(RESERVED)*~~ NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES - - DUTIES OF THE TRANSPORTATION BROKER.**

The transportation broker under contract with the Department is required to: ( )

**01. Coordinate and Manage**. Coordinate and manage all non-emergency medical transportation services for Medicaid participants statewide. ( )

**02. Contract With Transportation Providers**. Contract with transportation providers throughout the state to provide non-emergency medical transportation services for Medicaid participants. ( )

**03. Call Center**. Operate a call center to receive and review non-emergency medical transportation for Medicaid participants meeting the requirements in Section 872 of these rules. ( )

**04. Authorize Non-emergency Medical Transportation Services**. Authorize non-emergency medical transportation services for Medicaid participants requesting transportation and who meet the requirements in Section 872 of these rules. ( )

**05. Reimburse Contracted Transportation Providers**. Reimburse contracted transportation providers for non-emergency medical transportation services meeting the

requirements in Section 872 of these rules. ( )

**06. Safe and Professional Transportation**. Assure that contracted transportation providers deliver non-emergency medical transportations services in a safe and professional manner. ( )

## 872. NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES -- COVERAGE AND LIMITATIONS.

**01.** ~~***General Coverage for***~~ **Non-Emergency Medical Transportation Services**. ~~*Non-emergency transportation is all transportation that is not of an emergency nature, including non-medical transportation under waiver programs. An emergency is a condition described in Section 861 of these rules. Medicaid*~~ The transportation broker will reimburse contracted transportation providers for non-emergency medical transportation ~~*by commercial or non-commercial transportation providers*~~ services under the following ~~*circumstances and limitations*~~ conditions: ~~*(3-30-07)*~~( )

**a.** The travel is essential to get to or from a medically necessary Medicaid covered service~~*or a waiver service covered by Medicaid*~~; ~~*(3-30-07)*~~( )

~~***b.***~~ ~~*The person for whom services are billed is actually transported for all the distance billed;*~~ ~~*(3-30-07)*~~

~~***c***~~**b.** The mode of transportation is the ~~*lowest in*~~ least costly ~~*to the Medicaid program*~~ that is appropriate ~~*to*~~ for the medical needs of the participant; ~~*(3-30-07)*~~( )

~~***d***~~**c.** The transportation is to the nearest medical ~~*or waiver service*~~ provider appropriate to perform the needed services, and transportation is by the most direct route practicable~~.~~ ~~*Reimbursement will be limited to the distance of the most direct route practicable*~~; ~~*and*~~ ~~*(3-30-07)*~~( )

~~***e***~~**d.** Other modes of transportation, including personal vehicle, assistance by family, friends, and charitable organizations, are unavailable or impractical under the circumstances; ~~*and*~~ ~~*(3-30-07)*~~( )

~~***f***~~**e.** The travel is authorized ~~*by the Department prior to the transportation.*~~ and scheduled by the transportation broker; and ~~*(3-30-07)*~~( )

**f.** The contracted transportation provider is in compliance with the terms of its contract with the transportation broker. ( )

~~***02.***~~ ~~***Exceptions**. Despite the preceding rules, Medicaid will cover transportation services under the following circumstances:*~~ ~~*(3-30-07)*~~

~~***a.***~~ ~~*Transportation services may be retroactively approved when a participant is found retroactively eligible, the transportation service falls within the period of retroactive eligibility, and the transporter was a Medicaid transportation provider at the time of the transport for which reimbursement is sought.*~~ ~~*(3-30-07)*~~

*b. For Subsection 872.02 of this rule, a trip is the distance a transporter carries a participant in the course of a day. Therefore, the total mileage of a round-trip transport that takes place within one (1) day will be considered in determining whether this exception applies. Even though prior approval is not required, the transporter shall maintain all records as described in Subsection 874.02 of these rules. This exception is not available to commercial providers.* *(3-30-07)*

*i. Agency Transporters. If the trip distance is less than twenty-one (21) miles per day, prior approval for non-commercial non waiver transport is not necessary.* *(3-30-07)*

*ii. Individual Transportation Providers. If the trip distance is less than two hundred (200) miles one-way or four hundred (400) miles roundtrip per day, prior approval for non-commercial non waiver transport is not necessary.* *(3-30-07)*

*c. Non-Emergency transportation for Medicaid participants who are also eligible for Medicare ("dual eligibles") when they require transportation to pick up their medications covered under Medicare, Part D.* *(3-30-07)*

***03. Services Incidental to Travel**. Medicaid will reimburse for the reasonable cost actually incurred of meals, lodging, a personal assistant and other necessary services incidental to travel, only as described in Section 873 and Subsection 875.02 of these rules.* *(3-30-07)*

***04. Non-Commercial Transportation Provider**. Non-commercial transportation services may be performed by an agency or by an individual provider. If the Medicaid participants being transported are also participants of the transportation provider for services such as residential care, mental health, developmental therapy or other services, the provider will be considered a non-commercial provider with respect to those participants, even if the provider otherwise qualifies as a commercial transporter. A provider will be considered non-commercial with respect to any Medicaid participants transported if those participants are being transported to or from another service in which the provider has any ownership or control or if the arrangement to provide transportation is not an arm's length transaction.* *(3-30-07)*

***05. Hardship Exception for Non-Commercial Transportation Providers**. The Department may grant an exception on the basis of hardship. The provider must submit information to show at minimum that its reasonable costs of vehicle operation exceed the applicable reimbursement rate. In evaluating requests for exception, the Department will consider factors such as alternative forms of services and transportation available in the area, the cost of alternatives, the appropriateness of the vehicles utilized and the benefit to participants. Special consideration may be given to any provider servicing the area through a grant from the Federal Transit Administration. The Department may limit the exception including the amount of additional reimbursement, the type of services to which transportation is being provided, and the time duration of the exception.* *(3-30-07)*

***06. Out-of-State Transport**. If payment is requested for transportation costs to receive the out-of-state medical care, the Department will determine if appropriate, comparable medical care is available closer to the participant's residence. If such care is available, the Department will limit authorization to payment for transportation costs associated with a trip to the closer*

~~*location. If it is determined necessary and appropriate for the medical care to be rendered at the out-of-state location, then the Department will authorize payment for transportation costs associated with a trip to the out-of-state location. Reimbursement for transportation costs to receive out-of-state medical care requires prior authorization.*~~ ~~*(3-30-07)*~~

**02. Travel-Related Services**. The transportation broker will reimburse a contracted transportation provider for travel-related services under the following circumstances: ( )

**a.** The reasonable cost of meals actually incurred in transit will be reimbursed for the participant when there is no other practical means of obtaining food. ( )

**b.** The reasonable cost for lodging actually incurred for the participant will be reimbursed when: ( )

i. The round trip and the needed medical service cannot be completed in the same day; and ( )

ii. No less costly alternative is available. ( )

**c.** The reasonable cost of wages for an attendant will be reimbursed when: ( )

i. An attendant is medically necessary or when the vulnerability of the participant requires accompaniment for safety; and ( )

ii. No family member or other unpaid attendant is available to accompany the participant. ( )

**d.** The reasonable cost of meals actually incurred in transit will be reimbursed for one (1) family member or one (1) attendant, when: ( )

i. Attendant care is medically necessary or when the vulnerability of the participant requires accompaniment for safety; and ( )

ii. There is no other practical means of obtaining food. ( )

**e.** The reasonable cost of lodging actually incurred will be reimbursed for one (1) family member or one (1) attendant when: ( )

i. An overnight stay is required to receive the service; ( )

ii. It is medically necessary or the vulnerability of the participant requires accompaniment for safety; and ( )

iii. No less costly alternative is available. ( )

~~***873. NON-EMERGENCY TRANSPORTATION SERVICES: PROCEDURAL REQUIREMENTS.***~~

~~*Authorization for the travel reimbursement must be requested from the Department at least*~~

~~*twenty-four (24) hours in advance of the travel excluding Saturdays, Sundays, and state holidays, unless one of the exceptions described in Subsection 872.02.a. or Subsection 872.02.b. of these rules applies.*~~ ~~*(3-30-07)*~~

### ~~***874. NON-EMERGENCY TRANSPORTATION SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.***~~

~~***01. Commercial Transportation Providers***~~~~*. Each commercial transportation provider must, at minimum, meet the following standards:*~~ ~~*(3-30-07)*~~

~~***a.***~~ ~~*Maintain all certifications and licenses for drivers and vehicles required by all public transportation laws, regulations, ordinances that apply to the transportation provider.*~~ ~~*(3-30-07)*~~

~~***b.***~~ ~~*Adhere to all laws, rules and regulations applicable to transportation providers of that type, including those requiring liability insurance. Liability insurance will be carried in an amount to cover at least five hundred thousand dollars ($500,000) personal injury and five hundred thousand dollars ($500,000) property damage per occurrence.*~~ ~~*(3-30-07)*~~

~~***c.***~~ ~~*Enter into a Medicaid provider agreement and enrollment application.*~~ ~~*(3-30-07)*~~

~~***d.***~~ ~~*Each commercial provider must maintain the following records for a minimum of five (5) years.*~~ ~~*(3-30-07)*~~

~~*i.*~~ ~~*Prior authorization documents.*~~ ~~*(3-30-07)*~~

~~*ii.*~~ ~~*Name of participant and Medicaid ID number.*~~ ~~*(3-30-07)*~~

~~*iii.*~~ ~~*Date, time, and geographical point of pick-up for each participant trip.*~~ ~~*(3-30-07)*~~

~~*iv.*~~ ~~*Date, time, and geographical point of drop-off for each participant trip.*~~ ~~*(3-30-07)*~~

~~*v.*~~ ~~*Identification of the vehicle(s) and driver(s) transporting each participant on each trip, and total miles for the trip.*~~ ~~*(3-30-07)*~~

~~***e.***~~ ~~*Verify that all staff having contact with participants have complied with IDAPA 16.05.06, "Criminal History and Background Checks."*~~ ~~*(3-30-07)*~~

~~***02. Non-Commercial Transportation Providers***~~~~*. Each non-commercial transportation provider must, at minimum, meet the following standards:*~~ ~~*(3-30-07)*~~

~~***a.***~~ ~~*Continuously maintain liability insurance that covers passengers. For agency providers, coverage must be at least one-hundred thousand ($100,000) per individual and three-hundred thousand ($300,000) each incident. Individual providers must carry at least the minimum liability insurance required by Idaho law. If an agency permits employees to transport participants in employees' personal vehicles, the agency must ensure that adequate insurance coverage is carried to cover those circumstances.*~~ ~~*(3-30-07)*~~

***b.*** *Obtain and maintain all licenses and certifications required by government to conduct business and to operate the types of vehicles used to transport participants. Agencies must maintain documentation of appropriate licensure for all employees who operate vehicles.* *(3-30-07)*

***c.*** *Adhere to all laws, rules, and regulations applicable to drivers and vehicles of the type used.* *(3-30-07)*

***d.*** *Enter into a Medicaid enrollment application and provider agreement.* *(3-30-07)*

***e.*** *Records. Each non-commercial transportation provider must, at the time of transport, collect the following information, and must maintain it for a minimum of five (5) years:* *(3-30-07)*

*i.* *Participant name and Medicaid ID number for each trip.* *(3-30-07)*

*ii.* *Date, time, geographical point of pick-up and odometer reading at pick-up for each participant trip.* *(3-30-07)*

*iii.* *Date, time, geographical point of drop-off and odometer reading at drop-off for each participant trip.* *(3-30-07)*

*iv.* *Mileage each participant was transported for each trip billed.* *(3-30-07)*

*v.* *Identification of the vehicle and driver transporting each participant on each trip.* *(3-30-07)*

*vi.* *Notice of prior authorization, when required.* *(3-30-07)*

***875. NON-EMERGENCY TRANSPORTATION SERVICES: PROVIDER REIMBURSEMENT.***

***01.*** ***Submission of Transportation Claims****. All transportation claims must be on a CMS 1500 Claim form and must include a trip-related authorization number where prior authorization is required. Payment must not be made in advance of the service being rendered.* *(3-30-07)*

***02.*** ***Claims for Travel-Related Services****. All claims for travel-related services must be supported by receipts, or other verification of the date, place, the amount of and the nature of services that were performed. Medicaid will not pay for claimed services that are not verifiable by contemporaneous documentation.* *(3-30-07)*

***a.*** *Travel covered by the service to which the participant is being transported is not reimbursable as a separate service; and* *(3-30-07)*

***b.*** *Transportation is paid on a reimbursement basis only; payment will not be issued prior to delivery of the service.* *(3-30-07)*

~~*c. The reasonable cost of meals actually incurred in transit will be approved when necessary, when there is no other practical means of obtaining food, and only when an overnight stay is required to receive the service. Reimbursement must not exceed seven dollars ($7) per meal or a maximum of twenty-one dollars ($21) per day per person. (3-30-07)*~~

~~*d. The reasonable cost actually incurred for lodging will be approved when the round trip and the needed medical service, in practicality, can not be completed in the same day. The travel must entail a one (1) way distance of at least two hundred (200) miles, or a normal one (1) way travel time of at least four (4) hours. The incidental travel expenses of a family member or other companion will be covered when medical necessity or the vulnerability of the individual requires accompaniment for safety, and no less-costly alternative is available. Lodging reimbursement will not be paid when the stay is in the home of a relative or acquaintance. (3-30-07)*~~

~~***03. Commercial Transportation**. A statewide uniform payment rate must be established through a study conducted no less frequently than each third year, that evaluates the actual charges of, and costs reasonably incurred by the typical commercial transportation provider, together with the reasonable administrative costs incurred by the typical provider in keeping records for Medicaid-related transportation and billing the Department. (3-30-07)*~~

~~***04. Non-Commercial Providers -- Agency and Individual**. (3-30-07)*~~

~~*a. Agency Provider Reimbursement. A statewide uniform payment rate must be established through a study conducted no less frequently than each third year, that evaluates the actual costs reasonably incurred by the typical agency transportation provider, together with the reasonable administrative costs incurred by the typical agency transportation provider in keeping records for Medicaid-related transportation and billing the Department. (3-30-07)*~~

~~*b. Individual Provider Reimbursement. A uniform payment rate must be established through a study conducted no less frequently than each third year, that evaluates the actual costs of fuel reasonably incurred by the typical non-commercial transportation provider whose personal vehicle averages fifteen (15) miles per gallon. (3-30-07)*~~

**87~~6~~3. -- 879. (RESERVED).**

# IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

## 16.03.09 - MEDICAID BASIC PLAN BENEFITS

## DOCKET NO. 16-0309-1003

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

**AUTHORITY:** In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, Idaho Code; also House Bills 656 and 708 passed by the 2010 legislature; the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Section 1001(d); and 42 CFR Part 455, Subpart D.

**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. These rule changes implement legislative intent language in H0656 and H0708 passed by the 2010 Legislature. The complete text of the proposed rule was published in the** September 1, 2010, Idaho Administrative Bulletin, Vol. 10-9, pages 176 through 190**.**

**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:

**Changes related to the pharmacy cost survey (H0708, 2010) will result in a cost reduction of $1.67 million to the state general fund. The total cost reduction for both state and federal funds is $8 million. This cost reduction has already been incorporated into the Division of Medicaid's 2011 appropriation. There is no anticipated fiscal impact to the state general fund related to the other changes being made in this docket.**

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning this pending rule, contact Lourie Neal at (208) 287-1162.

DATED this 24th day of November, 2010.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
P.O. Box 83720, Boise, ID 83720-0036
phone: (208) 334-5564
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***THIS NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE***

**EFFECTIVE DATE:** The effective date of the temporary rule is **July 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(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code; also House Bills 656 and 708 passed by the 2010 legislature; the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (also known as the Medicare Modernization Act), Section 1001(d); and 42 CFR Part 455, Subpart D.

**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 15, 2010.

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:

**Rules changes are being made in these rules to implement the legislative intent in House Bills 656 and 708 passed by the 2010 legislature, as well as the Medicare Modernization Act, Section 1001(d). Rule changes for this docket include:**

1. **Change in definition for Medicaid Inpatient Cost Limits to clarify the "beginning of the principal year" (H0656);**
2. **Revision of reporting requirements for DSH (Section 1001(d));**
3. **Clarification to the definition of "uninsured patient costs" in DSH requirements (Section 1001(d)); and**
4. **Pharmacy cost survey (H0708).**

**TEMPORARY RULE JUSTIFICATION:** Pursuant to Section 67-5226(1)(b), Idaho Code:

**The Governor has found that temporary adoption of the rule is appropriate in order to comply with deadlines in amendments to governing law or federal programs.**

**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.

**Changes related to the pharmacy cost survey will result in a cost reduction of $1.67 million to the state general funds. The total cost reduction for both state and federal funds is $8 million. There is no anticipated fiscal impact to the state general fund related to the other changes being made in this docket.**

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the changes are to implement the legislative intent in H0656 and H0708 passed by the 2010 legislature, and to implement Section 1001(d) of the Medicare Modernization Act.

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

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the temporary and proposed rule, contact 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 September 22, 2010.

DATED this 17th day of August, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1003***

## 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. Critical Access Hospitals (CAH)**. A rural hospital with twenty five (25) or less beds as set forth in 42 CFR Section 485.620. (    )

**0~~8~~9. Current Year**. Any hospital cost reporting period for which reasonable cost is being determined will be termed the current year. (3-30-07)

**~~09~~10. 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-one and seven-tenths percent (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. (3-29-10)

**1~~0~~1. 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)

**1~~1~~2. 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)

**1~~2~~3. 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)

**1~~3~~4.** **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)

**1~~4~~5.** **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)

**1~~5~~6.** **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)

**1~~6~~7.** **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)

**1~~7~~8.** **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)*~~(_____)

**1~~8~~9.** **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*~~20. 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)

**2~~*0*~~1. 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)

**2~~*1*~~2. 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)

**2~~*2*~~3. 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)*~~( )

**c.** For inpatient services on or after July 1, 2010 , the principal year will be the Medicare cost report period used to prepare the Medicaid cost settlement. ( )

**2~~*3*~~4. 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)

**2~~*4*~~5. 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)

**2~~*5*~~6. Reimbursement Floor Percentage**. The floor calculation for hospitals with more

than forty (40) beds is seventy-seven and four-tenths percent (77.4%) of Medicaid costs, and the floor calculation for hospitals with forty (40) or fewer beds is ninety-one and seven-tenths percent (91.7%). (3-29-10)

**2~~6~~7. TEFRA**. TEFRA is the Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248. (3-30-07)

**2~~7~~8. 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)*~~( )

**2~~8~~9. Upper Payment Limit**. The Upper Payment Limit for hospital services is defined in the Code of Federal Regulations. (3-30-07)

### *(BREAK IN CONTINUITY OF SECTIONS)*

## 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***~~**d.** 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/ID 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/ID 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. (3-29-10)

**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. (3-29-10)

(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. (3-29-10)

v. 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. 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. 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)

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.** 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. The disproportionate share payment to a Deemed DSH hospital will be the greater of: (3-29-10)

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)

**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)

**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)

**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)

**g.** To the extent that audit findings demonstrate that DSH payments exceed the documented hospital specific cost limits, the Department will collect overpayments and redistribute DSH payments. (     )

i. If at any time during an audit the Department discovers evidence suggesting fraud or abuse by a provider, that evidence, in addition to the Department's final audit report regarding that provider, will be referred to the Medicaid Fraud Unit of the Idaho Attorney General's Office. (     )

ii. The Department will submit an independent certified audit to CMS for each completed Medicaid State plan rate year, consistent with 42 CFR Part 455, Subpart D, "Independent Certified Audit of State Disproportionate Share Hospital Payment Adjustments." (     )

iii. Beginning with FFY 2011, if based on the audit of the DSH allotment distribution, the Department determines that there was an overpayment to a provider, the Department will immediately: (     )

(1) Recover the overpayment from the provider; and (     )

(2) Redistribute the amount in overpayment to providers that had not exceeded the hospital-specific upper payment limit during the period in which the DSH payments were determined. The payments will be subject to hospital-specific upper payment limits. (     )

iv. Disproportionate share payments must not exceed the DSH state allotment, except as otherwise required by the Social Security Act. In no event is the Department obligated to use State Medicaid funds to pay more than the State Medicaid percentage of DSH payments due a provider. (     )

**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)

***(BREAK IN CONTINUITY OF SECTIONS)***

**665. PRESCRIPTION DRUGS: PROVIDER REIMBURSEMENT.**

**01. Nonpayment of Prescriptions**. Prescriptions not filled in accordance with the provisions of Subsection 664.02 of these rules will be subject to nonpayment or recoupment. (3-30-07)

**02. Payment Procedures**. The following protocol must be followed for proper reimbursement. (3-30-07)

**a.** Filing Claims. Pharmacists must file claims electronically with Department-approved software or by submitting the appropriate claim form to the fiscal contractor. Upon request, the contractor will provide pharmacies with a supply of claim forms. The form must include information described in the pharmacy guidelines issued by the Department. (3-30-07)

**b.** Claim Form Review. Each claim form may be subject to review by a contract claim examiner, a pharmaceutical consultant, or a medical consultant. (3-30-07)

**c.** Billed Charges. A pharmacy's billed charges are not to exceed the usual and customary charges defined as the lowest charge by the provider to the general public for the same service including advertised specials. (3-30-07)

**d.** Reimbursement. Reimbursement to pharmacies is limited to the lowest of the following: (3-30-07)

i. Federal Upper Limit (FUL), as established by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services, plus the dispensing fee assigned by the Department; (3-30-07)

ii. State Maximum Allowable Cost (SMAC), as established by the Department, plus the assigned dispensing fee; (3-30-07)

iii. Estimated Acquisition Cost (EAC), as established by the Department following negotiations with representatives of the Idaho pharmacy profession defined as an approximation of the net cost of the drug ~~*and a reasonable operating margin*~~, plus the assigned dispensing fee; or ~~*(3-30-07)*~~(____)

iv. The pharmacy's usual and customary charge to the general public as defined in Subsection 665.02.c. of this rule. (3-30-07)

**e.** Dispensing Fees. Only one (1) dispensing fee per month will be allowed for the dispensing of each maintenance drug to any participant as an outpatient or a resident in a care facility except: (3-30-07)

i. Multiple dispensing of topical and injectable medication when dispensed in manufacturer's original package sizes, unless evidence exists, as determined by the Department, that the quantity dispensed does not relate to the prescriber's order; (3-30-07)

ii. Multiple dispensing of oral liquid maintenance medication if a reasonable quantity,

as determined by the Department, is dispensed at each filling; (3-30-07)

iii. Multiple dispensing of tablets or capsules if the quantity needed for a thirty-four (34) day supply is excessively large or unduly expensive, in the judgment of the Department; or (3-30-07)

iv. When the dose is being titrated for maximum therapeutic response with a minimum of adverse effects. (3-30-07)

**f.** Remittance Advice. Claims are processed by computer, and payments are made directly to the pharmacy or its designated bank through electronic claims transfer. A remittance advice with detailed information of each claim transaction will accompany each payment made by the Department. (3-30-07)

**g.** Return of Drugs. Drugs dispensed in unit dose packaging as defined by IDAPA 27.01.01, "Rules of the Idaho State Board of Pharmacy," Subsection 156.05, must be returned to the dispensing pharmacy when the participant no longer uses the medication as follows:(3-30-07)

i. A pharmacy provider using unit dose packaging must comply with IDAPA 27.01.01, "Rules of the Idaho State Board of Pharmacy," Subsection 156.05. (3-30-07)

ii. The pharmacy provider that receives the returned drugs must credit the Department the amount billed for the cost of the drug less the dispensing fee. (3-30-07)

iii. The pharmacy provider may receive a fee for acceptance of returned unused drugs. The value of the unused drug being returned must be cost effective as determined by the Department. (3-30-07)

**03. Periodic State Cost Surveys**. The Department will utilize periodic state cost surveys to obtain the most accurate pharmacy drug acquisition costs in establishing a pharmacy reimbursement fee schedule. Pharmacies participating in the Idaho Medicaid program are required to participate in these periodic state cost surveys by disclosing the costs of all drugs net of any special discounts or allowances. ( )

# IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

## 16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

## DOCKET NO. 16-0310-1001

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 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, 56-203, 56-250 through 56-257, Idaho Code, and 42 CFR 441.303(e).

**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 order to safeguard the provision of services under the HCBS waiver programs, this rule change aligns these rules with both federal regulations and the CMS-approved HCBS waiver requirements.**

**The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the** May 5, 2010, Idaho Administrative Bulletin, Vol. 10-5, pages 33 and 34.

**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 Susan Scheuerer at (208) 287-1156.

DATED this 1st day of October, 2010.

Tamara Prisock
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P.O. Box 83720
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***THIS 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 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 42 CFR 441.303(e).

**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 May 19, 2010.

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 safeguard the provision of services under the HCBS waiver programs, the current rules are being aligned with both federal regulations and the CMS-approved HCBS waiver requirements.**

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

**FEE SUMMARY:** Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: 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 not conducted because the rule changes are being made to align the rules with federal regulations and requirements.

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning the temporary and proposed rule, contact Susan Scheuerer at (208) 287-1156.

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 May 26, 2010.

DATED this 1st day of April, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-1001***

**020. PARTICIPATION IN THE COST OF WAIVER SERVICES.**

**01. Waiver Services and Income Limit**. A participant is not required to participate in the cost of Home and Community Based (HCBS) waiver services unless: (3-19-07)

**a.** The participant's eligibility for medical assistance is based on approval for and receipt of a waiver service; and (3-19-07)

**b.** The participant~~*'s income exceeds the eligibility requirement under the HCBS income limit contained in*~~ is eligible for Medicaid if he meets the conditions referred to under IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Section 787. ~~*(3-19-07)*~~(        )

**02. Waiver Cost-Sharing**. Participation in the cost of HCBS waiver services is determined as described in IDAPA 16.03.18, "Medicaid Cost-Sharing." (3-19-07)

# IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

## 16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

## DOCKET NO. 16-0310-1002

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 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. The effective date for these rules is July 1, 2011.

**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(7), 56-203(9), 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.

**In 2008, the Department began meeting with stakeholder groups to redesign developmental disabilities (DD) benefits for children. This project is known as the "Children's System Redesign." The Department will start a phased implementation of these redesigned benefits starting July 1, 2011. The major restructuring for the Children's System Redesign provides the following: definitions, requirements for children's DD programs, including the new services and provider qualifications.**

**In order to phase in these new benefits as seamlessly as possible, the Department will continue to operate the current children's DD benefits concurrently with the redesigned children's DD benefits. To accomplish this, the current requirements for developmental therapy, Intensive Behavioral Intervention (IBI), and other DDA services are being moved from IDAPA 16.04.11, "Developmental Disabilities Agencies (DDA)," to IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," in Sections 649 through 659 of this docket.**

**The Department has made many amendments throughout the proposed rule, based on the extensive public input received during the 21-day public comment period.**

**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 1, 2010, Idaho Administrative Bulletin, Vol. 10-9, pages 197 through 262.

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

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning the pending rule, contact Lauren Ertz at (208) 287-1169.

DATED this 23rd day of November, 2010.

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:** Three public hearings concerning this rulemaking will be held as follows:

| Wednesday, September 15, 2010<br>6:00 p.m. PDT | Wednesday, September 15, 2010<br>6:00 p.m. MDT | Wednesday, September 15, 2010<br>6:00 p.m. MDT |
|---|---|---|
| Dept. of Health & Welfare-Reg. 1<br>1120 Ironwood Drive, Suite 102<br>Lower Level Large Conf. Rm.<br>Coeur d'Alene, ID | Dept. of Health & Welfare-Reg. 4<br>1720 Westgate Drive<br>Suite A, Room 131<br>Boise, ID | Dept. Health & Welfare-Reg. 7<br>150 Shoup Avenue<br>2nd Floor, Large Conf. Rm.<br>Idaho Falls, 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:

**In 2008, the Department began meeting with stakeholder groups to redesign developmental disabilities (DD) benefits for children. This project is known as the "Children's System Redesign" and is sponsored by the Division of Medicaid and the Division of Family and Community Services. The Department is proposing a phased implementation of these redesigned benefits starting July 1, 2011. Implementation requirements are provided in Section 523 of this proposed docket.**

**In order to phase in these new benefits as seamlessly as possible, the Department is**

**proposing that we continue to operate the current children's DD benefits concurrently with the redesigned children's DD benefits. To accomplish this we are proposing that the current requirements for developmental therapy, Intensive Behavioral Intervention (IBI), and other DDA services be moved from IDAPA 16.04.11, "Developmental Disabilities Agencies," to IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," in Sections 649 through 659 of this proposed docket.**

**The major restructuring for the Children's System Redesign provides the following: definitions, requirements for children's DD programs, including the new services and provider qualifications.**

**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 is cost-neutral.

**Individualized budgets and limitations are being proposed for participants, using historical costs of developmental disabilities agency (DDA) services for children, to ensure the redesign of benefits remains cost-neutral. In addition, improved efficiencies of the redesign will safeguard against increasing program costs. Improvements include the addition of independent assessors and case managers to eliminate conflict of interest, and the creation of an array of outcome-based services and supports that align with varying health needs.**

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220, Idaho Code, informal negotiated rulemaking was conducted with stakeholders in a meeting held on Wednesday, July 14, 2010.

**The notice for this negotiated rulemaking published in the** July 7, 2010, Idaho Administrative Bulletin, Vol. 10-7, p. 26.

**INCORPORATION BY REFERENCE:** No materials are being incorporated by reference into these rules under this docket.

**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 September 22, 2010.

DATED this 17th day of August, 2010.

*THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-1002*

## 009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

**01. Compliance With Department Criminal History Check**. Agencies must verify that individuals working in the area listed in Section 009.04 of these rules whom are employed or whom they contract have complied with the provisions in IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." (3-19-07)

~~***02. Availability to Work or Provide Service***~~. ~~*(3-19-07)*~~

~~***a.*** *The employer, at its discretion, may allow an individual to provide care or services on a provisional basis once the application for a criminal history and background check is completed and notarized and the employer has reviewed the application for any disqualifying crimes or relevant records. The employer determines whether the individual could pose a health and safety risk to the vulnerable participants it serves. The individual is not allowed to provide care or services when the employer determines the individual has disclosed a disqualifying crime or relevant record.* *(3-19-07)*~~

~~***b.*** *Those individuals licensed or certified by the Department are not available to provide services or receive licensure or certification until the criminal history and background check is completed and a clearance issued by the Department.* *(3-19-07)*~~

**0~~*3*~~*2*. Additional Criminal Convictions**. Once an individual has received a criminal history clearance, any additional criminal convictions must be reported by the agency to the Department when the agency learns of the conviction. (3-19-07)

**0~~*4*~~*3*. Providers Subject to Criminal History and Background Check Requirements**. The following providers are required to have a criminal history and background check: (3-19-07)

**a.** Adult Day Care Providers. The criminal history and background check requirements applicable to providers of adult day care as provided in Sections 329 and 705 of these rules. (4-2-08)

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

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

**d.** Behavior Consultation or Crisis Management Providers. The criminal history and background check requirements applicable to behavior consultation or crisis management

providers as provided in Sections 329 and 705 of these rules. (4-2-08)

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

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

**g.** Crisis Intervention Providers. The criminal history and background check requirements applicable to crisis intervention providers as provided in Section 685 of these rules. ( )

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

**~~h~~i.** Day Rehabilitation Providers. The criminal history and background check requirements applicable to day rehabilitation providers as provided in Section 329 of these rules. (4-2-08)

**~~i~~j.** Developmental Disabilities Agencies (DDA). The criminal history and background check for DDA and staff as provided in IDAPA 16.0~~4~~3.~~1~~21, "~~Rules Governing~~ Developmental Disabilities Agencies (DDA)," Section 009. ~~(3-19-07)~~( )

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

**~~k~~l.** Mental Health Clinics. The criminal history and background check requirements applicable to mental health clinic staff as provided in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 714. (3-19-07)

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

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

**~~n~~o.** Psychiatric Consultation Providers. The criminal history and background check requirements applicable to psychiatric consultation providers as provided in Section 329 of these rules. (4-2-08)

**~~o~~p.** Psychosocial Rehabilitation Agencies. The criminal history and background check requirements applicable to psychosocial rehabilitation agency employees as provided in

Subsection 130.02 of these rules. (3-19-07)

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

~~q~~**r.** Respite Care Providers. The criminal history and background check requirements applicable to respite care providers as provided in Sections 329, 665, and 705 of these rules. ~~(4-2-08)~~( )

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

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

**u.** Therapeutic Consultant. The criminal history and background check requirements applicable to therapeutic consultation providers as provided in Section 685 of these rules. ( )

### *(BREAK IN CONTINUITY OF SECTIONS)*

### 013. DEFINITIONS P THROUGH Z.

For the purposes of these rules, the following terms are used as defined below: (3-19-07)

**01. Patient Day**. For a nursing facility or an ICF/ID, a calendar day of care which will include the day of admission and exclude the day of discharge unless discharge occurs after 3:00 p.m. or it is the date of death, except that, when admission and discharge occur on the same day, one (1) day of care will be deemed to exist. (3-19-07)

**02. Participant**. A person eligible for and enrolled in the Idaho Medical Assistance Program. (3-19-07)

**03. Patient**. The person undergoing treatment or receiving services from a provider. (3-19-07)

**04. Personal Assistance Agency**. An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for services provided, provides payroll and benefits for personal assistants working for them, and is the employer of record as well as the actual employer. (5-8-09)

**05. Personal Assistance Services (PAS)**. Services that include both attendant care for participants under an HCBS waiver and personal care services for participants under the Medicaid

State Plan. PAS means services that involve personal and medically-oriented tasks dealing with the functional needs of the participant and accommodating the participant's needs for long-term maintenance, supportive care, or instrumental activities of daily living (IADLs). These services may include personal assistance and medical tasks that can be done by unlicensed persons or delegated to unlicensed persons by a health care professional or participant. Services are based on the participant's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. (5-8-09)

**06. Physician**. A person possessing a Doctorate of Medicine degree or a Doctor of Osteopathy degree and licensed to practice medicine by a state or United States territory. (3-19-07)

**07. Physician's Assistant**. A person who meets all the applicable requirements to practice as licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants." (3-19-07)

**08. Picture Date**. A point in time when case mix indexes are calculated for every nursing facility based on the residents in the nursing facility on that day. The picture date to be used for rate setting will be the first day of the first month of a quarter. The picture date from that quarter will be used to establish the nursing facility's rate for the next quarter. (3-19-07)

**09. Plan of Care**. A written description of medical, remedial, or rehabilitative services to be provided to a participant, developed by or under the direction and written approval of a physician. Medications, services and treatments are identified specifically as to amount, type and duration of service. (3-19-07)

**10. Private Rate**. Rate most frequently charged to private patients for a service or item. (3-19-07)

**11. PRM**. The Provider Reimbursement Manual. (3-19-07)

**12. Property**. The homestead and all personal and real property in which the participant has a legal interest. (3-19-07)

**13. Property Costs**. Property costs are the total of allowable interest expense, plus depreciation, property insurance, real estate taxes, amortization, and allowable lease/rental expense. The Department may require and utilize an appraisal to establish which components are an integral part of property costs. (3-19-07)

**14. Property Rental Rate**. A rate paid per Medicaid patient day to free-standing nursing facilities and ICF/IDs in lieu of reimbursement for property costs other than property taxes, property insurance, and the property costs of major movable equipment at ICF/ID facilities. (3-19-07)

**15. Provider**. Any individual, partnership, association, corporation or organization, public or private, that furnishes medical goods or services in compliance with these rules and who has applied for and received a Medicaid provider number and has entered into a written provider agreement with the Department in accordance with IDAPA 16.03.09, "Medicaid Basic Plan

Benefits," Section 205. (3-19-07)

**16. Provider Agreement**. An written agreement between the provider and the Department, in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205. (3-19-07)

**17. Provider Reimbursement Manual (PRM)**. The Providers Reimbursement Manual, a federal publication which specifies accounting treatments and standards for the Medicare program, CMS Publications 15-1 and 15-2, which are incorporated by reference in Section 004 of these rules. (3-19-07)

**18. Psychologist, Licensed**. A person licensed to practice psychology in Idaho under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (3-19-07)

**19. Psychologist Extender**. A person who practices psychology under the supervision of a licensed psychologist as required under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners," and who is registered with the Bureau of Occupational Licenses. (3-19-07)

**20. Public Provider**. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (3-19-07)

**21. Raw Food**. Food used to meet the nutritional needs of the residents of a facility, including liquid dietary supplements, liquid thickeners, and tube feeding solutions. (3-19-07)

**22. Reasonable Property Insurance**. Reasonable property insurance means that the consideration given is an amount that would ordinarily be paid by a cost-conscious buyer for comparable insurance in an arm's length transaction. Property insurance per licensed bed in excess of two (2) standard deviations above the mean of the most recently reported property insurance costs per licensed bed of all facilities in the reimbursement class as of the end of a facility's fiscal year cannot be considered reasonable. (3-19-07)

**23. Recreational Therapy (Services)**. Those activities or services that are generally perceived as recreation such as, but not limited to, fishing, hunting, camping, attendance or participation in sporting events or practices, attendance at concerts, fairs or rodeos, skiing, sightseeing, boating, bowling, swimming, ~~*training for Special Olympics,*~~ and special day parties (birthday, Christmas, etc.). ~~*(3-19-07)*~~( )

~~***24. Regional Medicaid Services (RMS)**. Regional offices of the Division of Medicaid.*~~ ~~*(3-19-07)*~~

**2~~5~~4. Regional Nurse Reviewer (RNR)**. A registered nurse who reviews and makes determinations on applications for entitlement to and continued participation in Title XIX and Title XXI long term care for the Department. (3-19-07)

**2~~6~~5. Registered Nurse - R.N**. Which in the state of Idaho is known as a Licensed Professional Nurse and who meets all the applicable requirements to practice as a licensed

professional nurse under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01 "Rules of the Idaho Board of Nursing." (3-19-07)

**2~~7~~6. Related Entity**. An organization with which the provider is associated or affiliated to a significant extent, or has control of, or is controlled by, that furnishes services, facilities, or supplies for the provider. (3-19-07)

**2~~8~~7. Related to Provider**. The provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies. (3-19-07)

**2~~9~~8. Residential Care or Assisted Living Facility**. A facility or residence, however named, operated on either a profit or nonprofit basis for the purpose of providing necessary supervision, personal assistance, meals, and lodging to three (3) or more adults not related to the owner. In this chapter, Residential Care or Assisted Living Facilities are referred to as "facility." Distinct segments of a facility may be licensed separately, provided each segment functions independently and meets all applicable rules. (3-19-07)

**~~30~~29. Resource Utilization Groups (RUG)**. A process of grouping residents according to the clinical and functional status identified by the responses to key elements of the MDS. The RUG Grouper is used for the purposes of rate setting and determining nursing facility level of care. (4-2-08)

**3~~1~~0. Skilled Nursing Care**. The level of care for patients requiring twenty-four (24) hour skilled nursing services. (3-19-07)

**3~~2~~1. Social Security Act**. 42 USC 101 et seq., authorizing, in part, federal grants to the states for medical assistance to low-income persons meeting certain criteria. (3-19-07)

**3~~3~~2. State Plan**. The contract between the state and federal government under 42 U.S.C. section 1396a(a). (3-19-07)

**3~~4~~3. Supervision**. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (3-19-07)

**3~~5~~4. Title XVIII**. Title XVIII of the Social Security Act, known as Medicare, for the aged, blind, and disabled administered by the federal government. (3-19-07)

**3~~6~~5. Title XIX**. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources. (3-19-07)

**3~~7~~6. Title XXI**. Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children. (3-19-07)

**3~~8~~7. Third Party**. Includes a person, institution, corporation, public or private agency

that is liable to pay all or part of the medical cost of injury, disease, or disability of a participant of medical assistance. (3-19-07)

**3~~*9*~~8. Transportation**. The physical movement of a participant to and from a medical appointment or service by the participant, another person, taxi or common carrier. (3-19-07)

**~~*40*~~39. Uniform Assessment**. A set of standardized criteria to assess functional and cognitive abilities. (3-19-07)

**4~~*1*~~0. Uniform Assessment Instrument (UAI)**. A set of standardized criteria adopted by the Department of Health and Welfare to assess functional and cognitive abilities as described in IDAPA 16.03.23 "Rules Governing Uniform Assessments of State-Funded Clients." (3-19-07)

**4~~*2*~~1. Utilities**. All expenses for heat, electricity, water and sewer. (3-19-07)

**4~~*3*~~2. Utilization Control (UC)**. A program of prepayment screening and annual review by at least one (1) Regional Nurse Reviewer to determine the appropriateness of medical entitlement and the need for continued medical entitlement of applicants or participants to Title XIX and Title XXI benefits in a nursing facility. (3-19-07)

**4~~*4*~~3. Utilization Control Team (UCT)**. A team of Regional Nurse Reviewers which conducts on-site reviews of the care and services in the nursing facilities approved by the Department as providers of care for eligible medical assistance participants. (3-19-07)

**4~~*5*~~4. Vocational Services**. Services or programs which are directly related to the preparation of individuals for paid or unpaid employment. The test of the vocational nature of the service is whether the services are provided with the expectation that the participant would be able to participate in a sheltered workshop or in the general work force within one (1) year. (3-19-07)

## *(BREAK IN CONTINUITY OF SECTIONS)*

## 026. SELECTIVE CONTRACTING.

The Department may contract with a limited number of providers of certain Medicaid products and services~~*, including: dental services, eyeglasses, transportation, and some medical supplies*~~. ~~*(3-19-07)*~~(        )

## *(BREAK IN CONTINUITY OF SECTIONS)*

## 503. DEVELOPMENTAL DISABILITY DETERMINATION: TEST INSTRUMENTS.

A variety of standardized test instruments are available. Tests used to determine a developmental disability must reflect the current functional status of the individual being evaluated. Tests over

one (1) year old must be verified to reflect the current status of the individual by an appropriate professional. Instruments designed only for screening purposes must not be used to determine eligibility. (3-19-07)

**01. Test Instruments For Adults**. Unless contra-indicated, the following test instruments or subsequent revisions must be used to determine eligibility: (3-19-07)

**a.** Cognitive: Wechsler Adult Intelligence Scale-Third Edition (WAIS-III). (3-19-07)

b. Functional: Scales of Independent Behavior-Revised (SIB-R). (3-19-07)

**02. Test Instruments for Children**. The assessments utilized to determine eligibility must be based on age appropriate criteria. Evaluations must be performed by qualified personnel with experience and expertise with children; selected evaluation tools and practices should be age appropriate, based on consideration of the child's language and motor skills~~, be racially and culturally non-discriminatory, and be conducted in settings that are typically comfortable and familiar to the child~~. Unless contraindicated, *the most recent version of the following* test instruments ~~such as the following~~ must be used with children: ~~(3-19-07)~~*(        )*

**a.** Cognitive: (3-19-07)

i. Bayley Scales of Infant Development, ~~Third Edition (BSID-III)~~ for ages birth through forty-two (42) months; ~~(3-19-07)~~*(        )*

ii. Stanford Binet Intelligence Scales, ~~Fifth Edition (SB5)~~ for ages two (2) years through adult; ~~(3-19-07)~~*(        )*

iii. Wechsler Preschool and Primary Scale of Intelligence*,* ~~Third Edition (WPPSI-III)~~ for ages two (2) years, six (6) months to seven (7) years, three (3) months; ~~(3-19-07)~~*(        )*

iv. Wechsler Intelligence Scale for Children*,* ~~Fourth Edition (WISC-IV)~~ for ages six (6) through sixteen (16) years, eleven (11) months; or ~~(3-19-07)~~*(        )*

v. Wechsler Adult Intelligence Scale*,* ~~Third Edition (WAIS-III)~~ for ages sixteen (16) years to adult. ~~(3-19-07)~~*(        )*

**b.** Functional: (3-19-07)

~~i. American Association on Mental Retardation Adaptive Behavior Scale: School (ABS-S) for ages three (3) through twenty-one (21) years; (3-19-07)~~

i~~i~~. Battelle Developmental Inventory, 2nd Edition (BDI-2) for ages birth to ninety-five (95) months; (3-19-07)

~~iii. Developmental Profile II (DP-II) for ages birth through twelve (12) years; (3-19-07)~~

i~~v~~*i*. Scales of Independent Behavior (SIB-R) for ages birth through adult; *or*

*(3-19-07)*( )

*v. Vineland Adaptive Behavior Scales (VABS) for ages birth to eighteen (18) years, eleven (11) months;* *(3-19-07)*

*v*i*ii*. Mullen Scales of Early Learning (MSEL) for ages birth to three (3) years;. *(3-19-07)*( )

*vii. Preschool Language Scale - 3 (PLS-3) for ages birth to three (3) years;* *(3-19-07)*

*viii. Peabody Developmental Motor Scales for ages birth to three (3) years; or* *(3-19-07)*

*ix. Receptive-Expressive Emergent Language Scale - Third Edition (REEL- 3) for ages birth to three (3) years.* *(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 Waiver Services**. DD Waiver services as described in Sections 700 through 719 of these rules; and (3-29-10)

**02. Developmental Disabilit*y****ies* Agency Services**. Developmental Disabilit*y*ies Agency services as described in Sections 6*50*49 through 6*60*59 of these rules and IDAPA 16.0*4*3.*1*21, "Developmental Disabilities Agencies (DDA)"; 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)

### *(BREAK IN CONTINUITY OF SECTIONS)*

**516. -- 5*7*19. (RESERVED).**

## SUB-PART: CHILDREN'S DEVELOPMENTAL DISABILITIES PRIOR AUTHORIZATION (SECTIONS 520 THROUGH 528)

**520. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA).**

The purpose of the children's DD Prior Authorization is to ensure the provision of the right care, in the right place, at the right price, and with the right outcomes in order to enhance health and safety, and to promote participants' rights, self-determination, and independence. Prior authorization involves the assessment of the need for services, development of a budget, development of a plan of service, prior approval of services, and a quality improvement program. Services are reimbursable if they are identified on the authorized plan of service and are consistent with the purpose and rule for prior authorization as well as rules for the specific service. ( )

**521. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATIONS: DEFINITIONS.**

For the purposes of *Sections 520 through 528 of* these rules, the following terms are used as defined below. ( )

**01.** **Assessment**. A process that is described in Section 522 of these rules for program eligibility and in Section 526 of these rules for plan of service. ( )

**02.** **Baseline**. A participant's skill level prior to intervention written in measurable, behaviorally-stated terms. ( )

**03.** **Child**. A person who is under the age of eighteen (18) years. ( )

***04.*** ***Family****. The participant and his parent(s) or legal guardian.* ( )

**05.** **Family-Centered Planning Process**. A process facilitated by the plan developer, *by which the family-centered planning team* collaborate*s* with the participant to develop the plan of service. *( )*

**06.** **Family-Centered Planning Team**. The group who develops the plan of service. This group includes, at a minimum, *the child participant (unless otherwise determined by the family-centered planning team),* the parent or legal guardian and the plan developer. The family-centered planning team may include others identified by the family or agreed upon by the family and the Department as important to the process. *( )*

***07.*** ***ICF/ID****. Intermediate care facility for persons with intellectual disabilities.* *( )*

**08.** **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. The IFSP may serve as the plan *of service if it* meet*s* all of the components of the plan *of service.* *( )*

**09.** **Level of Support**. *The* amount of services and supports necessary to allow the individual to live independently and safely in the community. *( )*

**10.** **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 home and community-based services under a plan of service. The information is used in the assessment and authorization of a participant's services. ( )

**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 family-centered planning process. ( )

***12. Plan Monitor****. A person who oversees the provision of services on a paid or non-paid basis.* ( )

**13. Plan of Service**. An initial or annual plan that identifies all services and supports based on a family-centered planning process, *and which is developed for providing DD services to children birth through seventeen (17) years of age.* ( )

**14. Practitioner of the Healing Arts, Licensed**. A licensed physician, physician assistant, or nurse practitioner. ( )

**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 *Sections 520 and 528* these rules. ( )

**16. Provider Status Review**. The written documentation that identifies the participant's progress toward goals defined in the plan of service, *and demonstrates the continued need for the service.* ( )

**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. ( )

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

**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. ( )

***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. ( )

**21. Services**. *Evaluation, diagnostic, therapy, training, assistance, and support services that are provided to persons with developmental disabilities.* ( )

**522. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATIONS: ELIGIBILITY DETERMINATION.**

The Department will make the final determination of a child's eligibility, based upon the

assessments administered by the Department. Initial and annual assessments must be performed by the Department or its contractor. The purpose of the eligibility assessment is to determine a participant's eligibility for developmental disabilities services in accordance with Section 66-402, Idaho Code, and Sections 500 through 506 of these rules, to determine a participant's eligibility for children's home and community-based state plan option services in accordance with Section 662 of these rules, and to determine a participant's eligibility for ICF/ID level of care for children's waiver services in accordance with Section 682 of these rules. ( )

**01. Initial Eligibility Assessment**. For new applicants, an assessment must be completed by the Department or its contractor within thirty (30) *calendar* days from the date a complete application is submitted. *( )*

**02. Annual Eligibility Determination**. Eligibility determination must be completed annually for current participants. The assessor must reassess the participant, or establish and document that the existing assessments reflect the participant's current level of care needs. At least sixty (60) *calendar* days before the expiration of the current plan of service: *( )*

**a.** The eligibility determination process must be completed to determine level of care needs; and ( )

**b.** The assessor must provide the results of the eligibility determination to the participant. ( )

**03. Determination of Developmental Disability Eligibility**. ( )

**a.** The assessments that are required and completed by the Department or its contractor for determining a participant's eligibility for developmental disabilities services must include: ( )

i. Medical, Social, and Developmental Assessment Summary; ( )

ii. A functional assessment which reflects the participant's current functioning. The Department or its contractor will administer a functional assessment for use in initial eligibility determination of developmental disability eligibility. Thereafter, a new functional assessment will be required if the assessor determines that additional documentation is necessary to determine the participant's level of care criteria. *( )*

***b.*** *The Department or its contractor must obtain the following:* *( )*

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

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

**04. ICF/ID Level of Care Determination for Waiver Services**. The Department or its contractor will determine ICF/ID level of care for children in accordance with Section 584 of these rules. ( )

**05. Determination for Children's Home and Community Based State Plan Option**. The Department or its contractor will determine *if* a child meets the established criteria necessary to receive children's home and community based state plan option services in accordance with Section 662 of these rules. *( )*

**523. TRANSITION TO NEW CHILDREN'S DEVELOPMENTAL DISABILITY BENEFITS.**

**01. Phase-in Schedule**. To transition to the new benefits under Sections 520 through 528, Sections 660 through 666, and Sections 680 through 686 of these rules, a child will be phased in to the new benefits by order of his birthdate. ( )

**02. Notification**. During the phased-implementation, the Department will notify a family three (3) months prior to their child's birthdate. ( )

**03. New Applicants**. A new applicant entering the system will be enrolled in the new children's DD benefit programs. ( )

**04. Opportunity for Early Enrollment**. A family may opt to transition their child to the new benefits prior to their child's birthdate. The Department will accept application for a family *who* choose*s* to opt-in early, but transitioning a child at his scheduled transition date will be the Department's top priority. *( )*

**05. *Duplication of Services***. A child will not be able to receive both the new children's HCBS state plan option and children's waiver services listed in Section 660 through 666 and 680 through 688, at the same time he is receiving the old DDA services listed in Section 649 through 659. *( )*

**524. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATIONS: COVERAGE AND LIMITATIONS.**

The scope of these rules defines prior authorization for the following Medicaid developmental disabilities services for children: ( )

**01. Children's Home and Community Based State Plan Option Services**. Children's home and community based state plan option services as described in Sections 660 through 666 of these rules; and ( )

**02. Children's DD Waiver Services**. Children's DD waiver services as described in Sections 680 through 686 of these rules. ( )

**525. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATIONS: PROCEDURAL REQUIREMENTS.**

Prior to the development of the plan of service, the plan developer will gather *and make referrals*

*for* the following information to guide the family-centered planning process: ( )

***01.*** **Eligibility Determination Documentation**. Eligibility determination documentation completed by the Department or its contractor as defined in Subsection 522.03 of these rules. ( )

***02.*** **History and Physical**. A current history and physical completed by a practitioner of the healing arts is required at least annually or more frequently as determined by the practitioner. For participants in Healthy Connections, the Healthy Connections physician must conduct the history and physical, and may refer the participant for other evaluations. ( )

***03.*** ***Discipline-Specific Assessments***. *Participants must be referred for an occupational therapy, physical therapy, or speech-language pathology assessment when the participant has a targeted need in one of these disciplines. The assessment is used to guide the provision of services identified on the plan of service.* ( )

***04.*** **Additional Information**. *Gather a*ssessments and information related to the participant's medical conditions, risk of deterioration, living conditions, individual goals, and behavioral or psychiatric needs. ( )

**526. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATIONS: PLAN OF SERVICE PROCESS.**

In collaboration with the participant, the Department must ensure that the participant has one (1) plan of service. This plan of service is *developed within* the individualized participant budget referred to in Section 527 of these rules and must identify all services and supports. The participant and his parent or legal guardian may develop their own plan or *use* a paid or non-paid plan developer *to assist with plan development*. The plan of service must identify services and supports *if* available outside of Medicaid-funded services that can help the participant meet desired goals. ( )

**01.** **Plan Develop*ment and Monitoring***. *P*aid plan develop*ment and monitoring* must be provided by the Department or its contractor. *Non-paid plan development and monitoring may be provided by the family, or a person of their choosing, when this person is not a paid provider of services identified on the child's plan of service.* ( )

**02.** **Plan of Service Development**. The plan of service must be developed with the parent or legal guardian, *and the child participant (unless otherwise determined by the family-centered planning team)*. With the parent or legal guardian's consent, the family-centered planning team may include other family members or individuals who are significant to the participant. ( )

***a.*** In developing the plan of service, the family-centered planning team must identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. ( )

***b.*** *The plan of service must identify, at a minimum, the type of service to be delivered, goals to be addressed within the plan year, target dates, and methods for collaboration.* ( )

**03.** **No Duplication of Services**. The plan developer must ensure that there is no duplication of services. ( )

**04.** **Plan Monitoring**. The family-centered planning team must identify the frequency of monitoring, which must be at least every six (6) months. The plan developer must meet face-to-face with the participant at least annually. Plan monitoring must include the following: ( )

**a.** Review of the plan of service with the parent or legal guardian to identify the current status of programs and changes if needed; ( )

**b.** Contact with service providers to identify barriers to service provision; ( )

**c.** Discuss with parent or legal guardian satisfaction regarding quality and quantity of services; an ( )

**d.** Review of provider status reviews. ( )

**05.** **Provider Status Reviews**. The service providers in Sections *664* and *684* of th*ese* rule*s* must report to the plan *monitor* the participant's progress toward goals. The provider must complete a six (6) month and annual provider status review. The provider status review *must be submitted to the plan monitor within forty-five (45) calendar days prior to the expiration of the existing plan of service.* ( )

**06.** **Informed Consent**. The participant and his parent or legal guardian 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. ( )

**07.** **Provider Implementation Plan**. *Provider*s of *children's waiver* services *listed under Section 684 of these rules* 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. ( )

***a.*** The implementation plan must be completed within fourteen (14) *calendar* days after the initial provision of service, and revised whenever participant needs change. ( )

***b.*** 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, and the signature of the person making the change complete with his title and the date signed. ( )

***08.*** **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 requires a parent's or legal guardian's signature and may be subject to prior authorization by the Department. ( )

***09.*** **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. ( )

***a.*** *Annual Eligibility Determination Results. An annual determination must be completed in accordance with Section 522 of these rules.* *( )*

***b.*** 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) *calendar* days prior to the expiration date of the current plan. Prior to this, the plan developer must: *( )*

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

ii. Obtain a copy of the current annual provider status review from each provider for use by the family-centered planning team. Each provider status review must meet the requirements in Subsection 526.06 of these rules. ( )

iii. Convene the family-centered planning team to develop a new plan of service. ( )

***c.*** 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 520 and 526 of these rules. ( )

***d.*** 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. ( )

***e.*** Reapplication After a Lapse in Service. For participants who are re-applying for service after *at least* a *thirty (30) calendar day* lapse in service, the assessor must evaluate whether assessments are current and accurately describe the status of the participant. *( )*

**527. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION: PROVIDER REIMBURSEMENT.**

Providers are reimbursed on a fee-for-service basis *for services identified on the participant's plan of service and within the* participant*'s individualized* budget. *The Department will monitor the budget setting methodology on an ongoing basis to ensure that participant needs are accurately reflected in the methodology.* *( )*

**01.** **Individualized Budget *Methodology***. *The following five (5) categories are used when determining individualized budgets for children with developmental disabilities:* *( )*

***a.*** *HCBS State Plan Option. Children meeting developmental disabilities criteria.* *( )*

***b.*** *Children's DD Waiver - Level I.* *( )*

*i. Children meeting ICF/ID level of care criteria who qualify based on functional limitations when their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; or* ( )

*ii. Children who have an overall age equivalency up to fifty-three percent (53%) of their chronological age when combined with a General Maladaptive Index between minus seventeen (-17), and minus twenty-one (-21) inclusive.* ( )

***c.*** *Children's DD Waiver - Level II.* ( )

*i. Children meeting ICF/ID level of care criteria who qualify based on functional limitations when their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; and* ( )

*ii. Have an autism spectrum disorder diagnosis.* ( )

***d.*** *Children's DD Waiver - Level III. Children meeting ICF/ID level of care criteria who qualify based on maladaptive behaviors when their General Maladaptive Index is minus twenty-two (-22) or less.* ( )

***e.*** *Act Early Waiver.* ( )

*i. Children age three (3) through six (6) meeting ICF/ID level of care criteria who qualify based on maladaptive behaviors when their General Maladaptive Index is minus twenty-two (-22) or less, and their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; or* ( )

*ii. Children age three (3) through six (6) meeting ICF/ID level of care criteria who have an autism spectrum disorder diagnosis.* ( )

**02. Participant Notification of Budget Amount**. The Department notifies each participant of his set budget amount *as part of the eligibility determination process*. The notification will include how the participant may appeal the set budget amount. ( )

**03. Annual Re-Evaluation**. 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. ( )

**528. CHILDREN'S DEVELOPMENTAL DISABILITIES PRIOR AUTHORIZATION: *DEPARTMENT'S* QUALITY ASSURANCE AND IMPROVEMENT *PROCESSES*.**

**01. Quality Assurance**. Quality Assurance consists of audits and reviews to ensure compliance with the Department's rules and regulations. If problems are identified during the review or audit, the provider must implement a corrective action plan within forty-five (45) *calendar* days after the results are received. The Department may terminate authorization of service *or the provider agreement* for providers who do not comply with the corrective action plan. *If the Department finds a provider's deficiency or deficiencies immediately jeopardize the*

*health or safety of its participants, the Department may immediately terminate the provider agreement.* *( )*

**02. Quality Improvement**. The Department may gather and utilize information from *participants and* providers to evaluate customer satisfaction, participant satisfaction, outcomes monitoring, care management, quality assurance, quality improvement activities, and health and safety. These findings lead to quality improvement activities to improve provider processes and outcomes for participants. *( )*

**03. *Plan of Service* Review**. The Department will obtain the necessary information to determine that participants continue to meet eligibility criteria, services continue to be clinically necessary, services continue to be the choice of the participant, and services constitute appropriate care to warrant continued authorization or need for the service. *( )*

**529. -- 579. (RESERVED).**

***(BREAK IN CONTINUITY OF SECTIONS)***

**634. -- 6497. (RESERVED).**

**648. INTRODUCTION TO DEVELOPMENTAL DISABILITIES AGENCIES SECTION.**

*Sections 649 through 659 of these rules include the requirements for developmental disabilities agencies delivering services to children and adults. The benefit requirements for developmental therapy, Intensive Behavioral Intervention (IBI), and other DDA services were moved from IDAPA 16.04.11, "Developmental Disabilities Agencies (DDA)," to this section of rules. IDAPA 16.04.11, "Developmental Disabilities Agencies (DDA)," has been rewritten and renamed to: IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA).* *( )*

***01. Background of the Children's System Redesign**.* *( )*

***a.** In 2008, the Department began meeting with stakeholder groups to redesign developmental disabilities (DD) benefits for children. This project is known as the "Children's System Redesign." The Department will begin phased implementation of these redesigned benefits starting July 1, 2011. Implementation requirements are provided in Section 523 of these rules.* *( )*

***b.** In order to phase in these new benefits as seamlessly as possible, the Department will continue to operate the current children's DD benefits concurrently with the redesigned children's DD benefits.* *( )*

*i. The current children's DD benefits are found under Sections 649 to 659 of these rules.* *( )*

*ii. The redesigned children's DD benefits are found under Sections 520 through 528,*

660 through 666, and 680 through 686 of these rules. ( )

**02. Developmental Disabilities Agency Services for Adults Age Eighteen and Older**. Current DDA services for adults have not been modified and are covered under Sections 649 to 659 of these rules. ( )

**6~~50~~49. DEVELOPMENTAL DISABILITIES AGENCIES (DDA).**

Under 42 CFR 440.130(d), the Department will pay for rehabilitative services including medical or remedial services provided by facilities that have entered into a provider agreement with the Department and are certified as developmental disabilities agencies by the Department. Services provided by a developmental disabilities agency to children birth to three (3) years of age must meet the requirements and provisions of the Individuals with Disabilities Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. These requirements include adherence to procedural safeguards and time lines, multi-disciplinary assessments, evaluations, individualized family service plans, provision of early intervention services in the natural environment, transition planning, and enrollment and reporting requirements. (3-19-07)

~~**651. (RESERVED).**~~

**65~~2~~0. DEVELOPMENTAL DISABILITIES AGENCY (DDA) SERVICES: ELIGIBILITY.**

**01. DDA Services Eligibility**. Prior to receiving services in a DDA an individual must be determined to have a developmental disability under Sections 500 through 506 of these rules and Section 66-402, Idaho Code. ~~(3-19-07)~~( )

**02. Intensive Behavioral Intervention (IBI) Service Eligibility**. IBI is available to children with developmental disabilities through the month of their twenty-first birthday, who have the following characteristics: ( )

**a.** Self-injurious, aggressive, or severely maladaptive behavior as evidenced by a General Maladaptive Index score of minus twenty-two (-22) or below on the Scales of Independent Behavior - Revised (SIB-R) or other behavioral assessment indicators identified by the Department; and ( )

**b.** A severe deficit, defined as equivalent to fifty percent (50%) or less of chronological age, in at least one (1) of the following areas: ( )

i. Verbal and nonverbal communication as evidenced by the SIB-R Social Interaction & Communication Skills cluster score; ( )

ii. Social interaction as evidenced by the SIB-R Social Interaction subscale score; or ( )

iii. Leisure and play skills as evidenced by the SIB-R Home/Community Orientation subscale score. ( )

**65~~3~~1. DDA SERVICES: COVERAGE REQUIREMENTS AND LIMITATIONS.**
Developmental disabilities agency services must be recommended by a physician or other practitioner of the healing arts. The following therapy services are reimbursable when provided in accordance with these rules. ( )

**01.** ~~***Requirement for Plan of Service and Prior Authorization***~~ **Required DDA Services**. Each DDA is required to provide developmental therapy; in addition, each DDA must provide or make available the following services: psychotherapy, occupational therapy, physical therapy, and speech and hearing therapy. Developmental therapy must be provided by qualified employees of the agency. Psychotherapy, occupational therapy, physical therapy, and speech and hearing therapy must either be provided by qualified employees of the agency or through a formal written agreement. ~~*(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."*~~ Sufficient Quantity and Quality. All required services provided must be sufficient in quantity and quality to meet the needs of each person receiving services, and must be provided by qualified individuals in accordance with the requirements in Section *657* of these rules. ~~*(3-19-07)*~~( )

**b.** ~~*All therapy services for adults with developmental disabilities 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."*~~ When a Required Service Is Not Available. When a required service, other than developmental therapy, is not provided by the agency due to a documented shortage of available providers in a specific geographic area, the DDA must document its effort to secure the service or facilitate the referral for the needed service, including notifying the service coordinator, when the participant has one. ~~*(3-29-10)*~~( )

**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":*~~ **Requirements to Deliver Developmental Therapy**. Developmental therapy may be delivered in a developmental disabilities agency center-based program, the community, or the home of the participant. Participants living in a certified family home must not receive home-based developmental therapy in a certified family home. Developmental therapy includes individual developmental therapy and group developmental therapy. Developmental therapy services must be delivered by Developmental Specialists or paraprofessionals qualified in accordance with these rules, based on a comprehensive developmental assessment completed prior to the delivery of developmental therapy. ~~*(3-19-07)*~~( )

**a.** ~~*Comprehensive Developmental Assessment;*~~ Areas of Service. These services must be directed toward the rehabilitation or habilitation of physical or mental disabilities in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. ~~*(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;*~~ Age-Appropriate. Developmental therapy includes instruction in daily living skills the participant has not gained at the normal developmental stages in his life, or is not likely to develop without training or therapy. Developmental therapy must be age-appropriate. ~~*(3-19-07)*~~( )

**c.** ~~*Occupational Therapy Assessment*~~ Tutorial Activities and Educational Tasks are Excluded. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the participant's disability. ~~*(3-19-07)*~~( )

**d.** ~~*Physical Therapy Assessment;*~~ Settings for Developmental Therapy. Developmental therapy, in both individual and group formats, must be available in both community-based and home-based settings, and be based on participant needs, interests, or choices. ~~*(3-19-07)*~~( )

**e.** ~~*Speech and Language Assessment;*~~ Staff-to-Participant Ratio. When group developmental therapy is center-based, there must be a minimum of one (1) qualified staff, who may be a paraprofessional or a Developmental Specialist, providing direct services for every twelve (12) participants. Additional staff must be added, as necessary, to meet the needs of each individual served. ~~*(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.** **Psycho~~*T*~~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."*~~ The following psychotherapy services must be available through each agency and based on assessment(s) conducted by the professional qualified to deliver the service: ~~*(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.*~~ Individual psychotherapy; ~~*(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:*~~ Group psychotherapy in which there is a minimum ratio of one (1) qualified staff person for every twelve (12) individuals in group therapy; and ~~*(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.*~~ Family-centered psychotherapy that includes the participant and at least one (1) other family member at any given time. ~~*(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.*~~ Psychotherapy services, alone or in combination with supportive counseling, are limited to a maximum of forty-five (45) hours in a calendar year, including individual, group, and family-centered. ~~*(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.*~~ Psychotherapy services must be provided by one (1) of the following qualified professionals: ~~*(4-2-08)*~~(____)

i. Licensed Psychiatrist; (____)

ii. Licensed Physician; (____)

iii Licensed Psychologist; (____)

iv. Licensed Clinical Social Worker; (____)

v. Licensed Clinical Professional Counselor; (____)

vi. Licensed Marriage and Family Therapist; (____)

vii. Certified Psychiatric Nurse (RN), licensed in accordance with Title 54, Chapter 14, Idaho Code, or certified by a recognized national certification organization, and have a minimum of a master's degree; (____)

viii. Licensed Professional Counselor whose provision of psychotherapy is supervised by persons qualified above under Subsections 651.03.*e*.i. through 651.03.*e*.vii. of this rule;*(____)*

ix. Registered Marriage and Family Therapist Intern whose provision of psychotherapy is supervised as described in 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." ( )

x. 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 ( )

xi. A Psychologist Extender, registered with the Bureau of Occupational Licenses, whose provision of psychotherapy is supervised as described in IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." ( )

*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* Occupational Therapy Services**. *The following services are excluded for Medicaid payments:* 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. Occupational therapy services must be available and provided by a licensed occupational therapist and be based on the results of an occupational therapy assessment completed in accordance with Section 655 of these rules. *(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***~~ **Physical Therapy Services**. ~~*Therapy services may not exceed the limitations as specified below.*~~ 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. Physical therapy services must be available and provided by a licensed physical therapist and be based on the results of a physical therapy assessment completed in accordance with Section 655 of these rules. ~~*(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)*~~

**06.** **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. Speech–language pathology services must be available and provided by a qualified speech-language pathologist, as defined in these rules, and be based on the results of a speech and language assessment completed in accordance with Section 655 of these rules. ( )

**07.** **Optional Services**. DDAs may opt to provide any of the following services: pharmacological management, psychiatric diagnostic interviews, community crisis supports, collateral contact, Intensive Behavioral Intervention (IBI), and supportive counseling. All services must be provided by qualified individuals in accordance with the requirements in Section 657 of these rules. ( )

**08.** **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. ( )

**09. Psychiatric Diagnostic Interview**. A psychiatric diagnostic interview must include a history, a current mental status examination, and offer recommendations for treatment interventions needed, if any. If the interview exam results in a recommendation for additional intervention and the recommendation is accepted by the participant and his parent or legal guardian, if applicable, the recommendation must be incorporated into the participant's plan of service with the type, amount, frequency, and duration of service specified. ( )

**a.** Physician Requirement. In order for a DDA to conduct a psychiatric diagnostic interview, the agency must have a physician on contract for the purpose of overseeing the services on the plan. ( )

**b.** On Plan of Service. A psychiatric diagnostic interview must be incorporated into the participant's plan of service. ( )

**c.** Staff Qualifications. A psychiatric diagnostic interview must be conducted by one (1) of the following professionals, in direct face-to-face contact with the participant: ( )

i. Psychiatrist; ( )

ii. Physician or other practitioner of the healing arts; ( )

iii. Psychologist; ( )

iv. Clinical social worker; or ( )

v. Clinical professional counselor. ( )

**10. Community Crisis Supports**. Community crisis supports are interventions for adult 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. DDAs that choose to provide these services must do so in accordance with Sections 507 through 515 of these rules. ( )

**11. Collateral Contact**. Collateral contact is consultation with or treatment direction given to a person with a primary relationship to a participant for the purpose of assisting the participant to live in the community. Collateral contact must be: ( )

**a.** Conducted by Agency Professionals. Be conducted by agency professionals qualified to deliver services and be necessary to gather and exchange information with individuals having a primary relationship to the participant. ( )

**b.** Face to Face or by Telephone. Be conducted either face-to-face or by telephone when telephone contact is the most expeditious and effective way to exchange information. Collateral contact does not include general staff training, general staffings, regularly scheduled parent-teacher conferences, general parent education, or treatment team meetings, even when the parent is present. ( )

**c.** On the Plan of Service. Have a goal and objective stated on the plan of service that

identifies the purpose and outcome of the service and is conducted only with individuals specifically identified on the plan of service. Program Implementation Plans are not required for collateral contact objectives. ( )

**12.** **Intensive Behavioral Intervention**. DDA's that choose to offer Intensive Behavioral Intervention (IBI) must provide IBI services in accordance with Sections 656 of these rules. ( )

**a.** IBI is limited to a lifetime limit of thirty-six (36) months. ( )

**b.** The DDA must receive prior authorization from the Department prior to delivering IBI services. ( )

**c.** IBI must only be delivered on an individualized, one-to-one (1 to 1) basis. ( )

**d.** Established Developmental Therapy Program. After July 1, 2006, agencies must have provided developmental therapy for at least one (1) year and not be operating under a provisional certification prior to providing IBI services. ( )

**e.** Exception. Agencies that were providing IBI services prior to July 1, 2006, are exempt from the requirement under Subsection 651.12.d. of th*is* rule. *( )*

**f.** IBI Consultation. IBI consultation, as described in Section 656 of these rules, is included in the thirty-six (36) month IBI limitation. The DDA must receive prior authorization from the Department prior to providing IBI Consultation. ( )

**13.** **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. ( )

**a.** Psychological Assessment. The initial and ongoing need for the service of supportive counseling must be recommended in a current psychological assessment. ( )

**b.** On Plan of Service. Supportive counseling must be provided in accordance with the requirements for the plan of service. The type, amount, frequency, and duration of this service must be specified on the plan of service. ( )

**c.** Staff Qualifications. Supportive counseling must be provided by a professional listed under Subsection 651.03.e. of these rules or by a licensed social worker (LSW). ( )

**14.** **Excluded Services**. The following services are excluded for Medicaid payments: ( )

**a.** Vocational services; ( )

**b.** Educational services; and ( )

**c.** Recreational services. ( )

**15. Limitations on DDA Services**. Therapy services may not exceed the limitations as specified below. ( )

**a.** The combination of therapy services listed in Subsections 651.02 through 651.06, 651.12, and 651.13 of th*is* rule must not exceed twenty-two (22) hours per week. ( )

**b.** Therapy services listed in Subsections 651.02 through 651.06, 651.12, and 651.13 of th*is* rule, provided in combination with Community Supported Employment services under Subsection 703.04 of these rules, must not exceed forty (40) hours per week. ( )

**c.** When an 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. ( )

**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. ( )

**REQUIREMENTS FOR DEVELOPMENTAL DISABILITIES AGENCIES PROVIDING SERVICES**
**(Sections 652 through 659)**

**652. REQUIREMENTS FOR A DDA PROVIDING SERVICES TO PERSONS EIGHTEEN YEARS OF AGE OR OLDER.**

This Section 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 653 of these rules for those adults. ( )

**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. ( )

**a.** For persons seeking Medicaid-funded DDA services who are eighteen (18) years of age or older, the Department or its designee determines eligibility for services. ( )

**b.** For persons eighteen (18) years of age or older who are not Medicaid participants, the DDA must follow the requirements under Subsection 653.01 of these rules. ( )

**02. Intake**. ( )

**a.** For *Medicaid* participants eighteen (18) years of age or older, prior to the delivery of any Medicaid-funded DDA services: ( )

i. The Department or its designee will have provided the DDA with current medical, social, and developmental information; and ( )

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. ( )

**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: ( )

i. Have DDA services prior authorized by the Department or its designee; and( )

ii. DDAs must complete an Individual Program Plan (IPP) that meets the standards described in Subsections 653.04 through 653.06 of these rules. IPPs for these individuals do not require the signature of a physician or other practitioner of the healing arts. ( )

**c.** For participants eighteen (18) years of age or older who are not Medicaid participants, the DDA must follow the requirements under Subsection 653.02 of these rules. ( )

**03.** **Assessments**. Requirements for assessments are found under *Subs*ections 6*55.01* through 6*55.06* of these rules. *( )*

**04.** **Individual Service Plan (ISP)**. For participants eighteen (18) years of age or older 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. ( )

**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. ( )

## 653. 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.

**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: ( )

**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 ( )

**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. ( )

**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. ( )

**02.** **Intake**. The DDA must obtain information that accurately reflects the current status and needs of the participant prior to the delivery of services. ( )

**a.** The person must have been determined by the DDA to be eligible for DDA services. ( )

**b.** The DDA must obtain or complete a comprehensive medical and medical/social history. ( )

**03.** **Assessments**. Requirements for assessments are found under Subsections 655.0*1* through 655.0*6* of these rules. *( )*

**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. ( )

**a.** Type of service refers to the kind of service described in terms of: ( )

i. Discipline; ( )

ii. Group, individual, or family; and ( )

iii. Whether the service is home, community, or center-based. ( )

**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. ( )

**c.** Frequency of service is the number of times service is offered during a week or month. ( )

**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. ( )

**05.** **Individual Program Plan (IPP)**. For participants three (3) through seventeen (17) years of age and for adults receiving EPDST services, the DDA is required to complete an IPP. ( )

**a.** The IPP must be developed following obtainment or completion of all applicable assessments consistent with the requirements of this chapter. ( )

**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 his 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 652.02.b.ii. of these rules. ( )

**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. ( )

**d.** The IPP must be supported by the documentation required in the participant's record in accordance with IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)" record requirements. ( )

**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: ( )

i. The participant's name and medical diagnosis; ( )

ii. The name of the assigned Developmental Specialist, the date of the planning meeting, and the names and titles of those present at the meeting; ( )

iii. The dated signature of the physician or other practitioner of the healing arts indicating his recommendation of the services on the plan; ( )

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; ( )

v. A list of the participant's current personal goals, interests and choices; ( )

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; ( )

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; ( )

viii. The discipline professional or Developmental Specialist responsible for each objective; ( )

ix. The target date for completion of each objective; ( )

x. The review date; and ( )

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. ( )

**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: ( )

**a.** The reason for the change; ( )

**b.** Documentation of coordination with other services providers, where applicable; ( )

**c.** The date the change was made; and ( )

**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. ( )

**654.~~ -- 655.~~ ~~(RESERVED)~~ REQUIREMENTS FOR A DDA PROVIDING SERVICES TO CHILDREN BIRTH TO THREE YEARS OF AGE (INFANT TODDLER).**

Services provided by a DDA to children birth to three (3) years of age must meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. These requirements include: adherence to procedural safeguards and time lines, use of multi-disciplinary assessments and Individualized Family Service Plans (IFSPs), provision of early intervention services in the natural environment, transition planning, and program enrollment and reporting requirements. For children birth to age three (3), the IFSP will be used in lieu of the

Individual Program Plan (IPP). ( )

**01. Eligibility Determination**. For a child birth to three (3) years of age, prior to the delivery of any DDA services: ( )

**a.** In accordance with 34 CFR 303.321(e), the Department's regional Infant Toddler Program will determine eligibility for DDA services in accordance with Section 66-402, Idaho Code. ( )

**b.** Upon request from the DDA, and after receiving consent from the parent or legal guardian for release of information, the Department's regional Infant Toddler Program will provide the DDA with documentation of the child's eligibility including a copy of the current IFSP, addendum(a) to the IFSP, assessments, and service records related to current DDA services. ( )

**02. Intake**. Prior to the delivery of DDA services: ( )

**a.** The DDA must obtain both a copy of the current IFSP and a copy of all current assessment(s) used by the Department's regional Infant Toddler Program to determine eligibility for DDA services; and ( )

**b.** The DDA must conduct a meeting with the child's family, in cooperation with the child's service coordinator, to review the current IFSP and confirm the family's resources, priorities, and concerns with regard to the child's current developmental status and therapeutic needs. ( )

**03. Individualized Family Service Plan (IFSP)**. The Department or its designee will develop the initial IFSP for each eligible child, birth to three (3) years of age. Each DDA that provides DDA services to an eligible child, birth to three (3) years of age, must implement services according to the IFSP for that child as required by the Individuals with Disabilities Education Act, (P.L. 108-446, December 2004), Part C, Section 636 (d) and Title 16, Chapter 1, Idaho Code. The DDA must use the Department-approved IFSP form in accordance with 34 CFR 303.344. The procedures for IFSP development, review, and assessment must be in accordance with 34 CFR 303.342. ( )

**a.** Development of the IFSP. For a child who has been evaluated for the first time and has been determined to be eligible for DDA services, the initial IFSP developed by the Department must be completed within a forty-five (45) day time period in accordance with 34 CFR 303.321(e). ( )

**b.** Periodic Reviews. In cooperation with the child's service coordinator and other service providers, the DDA must participate in a review of the IFSP to be conducted every six (6) months, or more frequently, if conditions warrant or if the family requests such a review. The purpose of the periodic review is to identify progress made toward each objective and to determine whether these current outcomes and objectives need modification or revision. The review may be carried out in a meeting or by another means that is acceptable to the parent or legal guardian and other participants. These reviews must include the degree to which progress toward achieving the outcomes is being made. ( )

i. The DDA must provide the child's service coordinator with any current assessments and other information from the ongoing assessment of the child to determine what services are needed and will be provided. ( )

ii. The DDA must identify outcomes and objectives for inclusion in the IFSP for any services to be provided through the DDA. ( )

**c.** Participants in the IFSP meetings and periodic reviews must be in accordance with 34 CFR 303.343. IFSP meetings and periodic reviews must include the parent or legal guardian, the service coordinator working with the family, persons providing direct services to the child and family as appropriate, and persons directly involved in conducting the assessments of the child. The family is encouraged to invite any family member, advocate, or friend to the meeting to assist in the planning process. ( )

**d.** The IFSP or IFSP addendum must be in accordance with 34 CFR 303.344, and include the following: ( )

i. A statement of the outcome; ( )

ii. Steps to support transitions; ( )

iii. Behaviorally-stated objectives toward meeting that outcome; ( )

iv. Frequency, intensity, and method of delivering a service to meet the outcome; ( )

v. Measurability criteria, strategies, and activities; ( )

vi. Start and end dates; ( )

vii. A description of the natural environments in which early intervention services are appropriately provided, including a justification of the extent, if any, to which services will not be provided in a natural environment; and ( )

viii. A list of who will be involved in the direct intervention. ( )

**e.** There must be an order by a physician or other practitioner of the healing arts for all DDA services included on the IFSP. ( )

**f.** Transition to preschool programs must be in accordance with 34 CFR 303.148. ( )

i. At the IFSP review closest to the child's second birthday, outcomes must be written to address the steps needed to ensure appropriate services for the child at age three (3). ( )

ii. At least six (6) months prior to the child's third birthday, the DDA must document contact with the child's service coordinator and participation in the transition planning process at

the time of referral of the child to his local school district for IDEA, Part B, eligibility determination. ( )

**04. Parental Consent and Right to Decline Service**. Written parental consent must be obtained before: ( )

**a.** Conducting the assessment of a child; and ( )

**b.** Initiating the provision of services. ( )

**05. Ongoing Assessment of the Child**. The assessment of each child must: ( )

**a.** Be conducted by personnel trained to utilize appropriate methods and procedures; ( )

**b.** Be based on informed clinical opinion; and ( )

**c.** Include the following: ( )

i. A review of pertinent records related to the child's current health status and medical history. ( )

ii. An assessment of the child's level of functioning in cognitive development, physical development including vision and hearing, communication development, social or emotional development, and adaptive development. ( )

iii. An assessment of the unique needs of the child in terms of each of the developmental areas mentioned above in Subsection 654.05.c.ii. of this rule, including the identification of services appropriate to meet those needs. ( )

**06. Services in the Natural Environment**. Natural environments are settings that are natural or normal for the child's age peers who have no disability. To the maximum extent appropriate, in order to meet the needs of the child, early intervention services must be provided in natural environments, including the home and community settings in which children without disabilities participate. ( )

**07. Documentation of Program Changes**. Documentation of required plan or Program Implementation Plan changes must be included in the participant's record. This documentation must include, at a minimum, the reason for the change, documentation of coordination with other services providers, where applicable, 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 the Program Implementation Plan that affect the IFSP, an addendum to the IFSP must be completed: ( )

**a.** In cooperation with the service coordinator; ( )

**b.** With consent of the parent; ( )

**c.** With an order by the child's physician or other practitioner of the healing arts; ( )

**d.** With all changes documented on the enrollment form; and ( )

**e.** A copy of the addendum and the enrollment form must be submitted to the Department. ( )

## 655. DDA SERVICES: PROCEDURAL REQUIREMENTS.

**01. 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: ( )

**a.** Comprehensive Developmental Assessment; ( )

**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 Subsection 655.01 *of this rule*; *( )*

**c.** Occupational Therapy Assessment; ( )

**d.** Physical Therapy Assessment; ( )

**e.** Speech and Language Assessment; ( )

**f.** Medical/Social History; and ( )

**g.** Psychological Assessment. Includes psychological testing and psychiatric diagnostic interview. ( )

**02. Comprehensive Assessments Conducted by the DDA**. Assessments must be conducted by qualified professionals defined under Section 657 of these rules for the respective discipline or areas of service. ( )

**a.** Comprehensive Assessments. A comprehensive assessment must: ( )

i. Determine the necessity of the service; ( )

ii. Determine the participant's needs; ( )

iii. Guide treatment; ( )

iv. Identify the participant's current and relevant strengths, needs, and interests when these are applicable to the respective discipline; and ( )

v. For medical or psychiatric assessments, formulate a diagnosis. For psychological assessments, formulate a diagnosis and recommend the type of therapy necessary to address the participant's needs. For other types of assessments, recommend the type and amount of therapy necessary to address the participant's needs. ( )

**b.** Current Assessments Required. When the DDA determines developmental disabilities eligibility, current assessments must be completed or obtained as necessary. ( )

**c.** Date, Signature, and Credential Requirements. Assessments must be signed and dated by the professional completing the assessment and include the appropriate professional credential or qualification of that person. ( )

**d.** Assessment must be completed within forty-five (45) days. ( )

i. With the exception noted under Subsection *655.02.d.ii.* of this rule, each assessment must be completed within forty-five (45) calendar days of the date it was recommended by the physician or other practitioner of the healing arts. If the assessment is not completed within this time frame, the participant's records must contain participant-based documentation justifying the delay. *( )*

ii. This forty-five (45) day requirement does not apply to participant plans of service authorized under Sections 507 through 515 of these rules. ( )

**03. Requirements for Current Assessments**. Assessments must accurately reflect the current status of the participant. ( )

**a.** Current Assessments for Ongoing Services. To be considered current, assessments must be completed or updated at least annually for service areas in which the participant is receiving services on an ongoing basis. ( )

**b.** Updated Assessments. Assessments or updates are required in disciplines in which services are being delivered and when recommended by a professional. At the time of the required review of the assessment(s), the qualified professional in the respective discipline must determine whether a full assessment or an updated assessment is required for the purpose of reflecting the participant's current status in that service area. If, during the required review of the assessment(s), the latest assessment accurately represents the status of the participant, the file must contain documentation from the professional stating so. ( )

**c.** Medical/Social Histories and Medical Assessments. Medical/social histories and medical assessments must be completed at a frequency determined by the recommendation of a professional qualified to conduct those assessments. ( )

**d.** Intelligence Quotient (IQ) Tests. Once initial eligibility has been established, annual assessment of IQ is not required for persons whose categorical eligibility for DDA services is based on a diagnosis of mental retardation. IQ testing must be reconducted on a

frequency determined and documented by the agency psychologist or at the request of the Department. ( )

**e.** Completion of Assessments. Assessments must be completed or obtained prior to the delivery of therapy in each type of service. ( )

**f.** Psychological Assessment. A current psychological assessment must be completed or obtained: ( )

i. When the participant is receiving a behavior modifying drug(s); ( )

ii. Prior to the initiation of restrictive interventions to modify inappropriate behavior(s); ( )

iii. Prior to the initiation of supportive counseling; ( )

iv. When it is necessary to determine eligibility for services or establish a diagnosis; ( )

v. When a participant has been diagnosed with mental illness; or ( )

vi. When a child has been identified to have a severe emotional disturbance. ( )

**04.** **Assessments for Adults**. DDAs must obtain assessments required under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 507 through 515 of these rules. All specific skill assessments must be conducted in accordance with Subsection 655.06 of these rules. ( )

**05.** **Types of Comprehensive Assessments**. ( )

**a.** Comprehensive Developmental Assessment. A comprehensive developmental assessment must be conducted by a qualified Development Specialist and reflect a person's developmental status in the following areas: ( )

i. Self-care; ( )

ii. Receptive and expressive language; ( )

iii. Learning; ( )

iv. Gross and fine motor development; ( )

v. Self-direction; ( )

vi. Capacity for independent living; and ( )

vii. Economic self-sufficiency. ( )

**b.** Comprehensive Intensive Behavioral Intervention (IBI) Assessment. The requirements for the comprehensive IBI assessment are found under Subsection 656.03 of these rules. ( )

**c.** Occupational Therapy Assessment. Occupational therapy assessments must be conducted by an occupational therapist qualified under Section 657 of these rules and include gross and fine motor abilities, and recommendation of therapy necessary to address the participant's needs. ( )

**d.** Physical Therapy Assessment. Physical therapy assessments must be conducted by a physical therapist qualified under Section 657 of these rules and include gross and fine motor abilities, and recommendation of therapy necessary to address the participant's needs. ( )

**e.** Speech and Language Assessment. Speech and language assessments must be conducted by a Speech-Language Pathologist who is qualified under Section 657 of these rules. ( )

**f.** Medical Assessments. Medical assessments must be completed by a physician or other practitioner of the healing arts who is qualified in accordance with Section 657 of these rules and accurately reflects the current status and needs of the person. ( )

**g.** Medical/Social History. Medical/social histories must be completed by a licensed social worker or other qualified professional working within the scope of his license. The medical/social history is a narrative report that must include: ( )

i. Medical history including age of onset of disability, prenatal and postnatal birth issues, other major medical issues, surgeries, and general current health information; ( )

ii. Developmental history including developmental milestones and developmental treatment interventions; ( )

iii. Personal history including social functioning/social relationships, recreational activities, hobbies, any legal and criminal history, and any history of abuse; ( )

iv. Family history including information about living or deceased parents and siblings, family medical history, relevant family cultural background, resources in the family for the participant; ( )

v. Educational history including any participation in special education; ( )

vi. Prevocational or vocational paid and unpaid work experiences; ( )

vii. Financial resources; and ( )

viii. Recommendation of services necessary to address the participant's needs. ( )

**h.** Hearing Assessment. A hearing assessment must be conducted by an audiologist who is qualified under Section 657 of these rules. ( )

**i.** Psychological Assessment. A psychological assessment includes psychological testing for diagnosis and assessment of personality, psychopathology, emotionality, or intellectual abilities (IQ test). The assessment must include a narrative report. Psychological assessment encompasses psychological testing and the psychiatric diagnostic interview. ( )

**j.** Psychological Testing. Psychological testing refers to any measurement procedure for assessing psychological characteristics in which a sample of a person's behavior is obtained and subsequently evaluated and scored using a standardized process. This does not refer to assessments that are otherwise conducted by a professional within the scope of his license for the purposes of determining a participant's mental status, diagnoses, or functional impairments. ( )

i. Psychological testing may be provided when in direct response to a specific assessment question. ( )

ii. The psychological report must contain the reason for the performance of this service. ( )

iii. Agency staff may deliver this service if they meet one (1) of the following qualifications: ( )

(1) Licensed Psychologist; ( )

(2) Psychologist Extender; or ( )

(3) A qualified therapist listed in Subsection 651.03.e. of these rules who has documented evidence of education or training qualifying him to administer, score, interpret, and report findings for the psychological test he will be performing. ( )

**k.** Psychiatric Diagnostic Interview. A psychiatric diagnostic interview must be conducted in accordance with Subsection 651.09 of these rules. ( )

**06.** **Requirements for Specific Skill Assessments**. Specific skill assessments must: ( )

**a.** Further Assessment. Further assess an area of limitation or deficit identified on a comprehensive assessment. ( )

**b.** Related to a Goal. Be related to a goal on the IPP, ISP, or IFSP. ( )

**c.** Conducted by Qualified Professionals. Be conducted by qualified professionals for the respective disciplines as defined in this chapter. ( )

**d.** Determine a Participant's Skill Level. Be conducted for the purposes of determining a participant's skill level within a specific domain. ( )

**e.** Determine Baselines. Be used to determine baselines and develop the program

implementation plan. ( )

**07. DDA 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. ( )

**a.** General Requirements for Program Documentation. For each participant the following program documentation is required: ( )

i. Daily entry of all activities conducted toward meeting participant objectives. ( )

ii. Sufficient progress data to accurately assess the participant's progress toward each objective; and ( )

iii. 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. ( )

iv. 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 the reason(s) why he continues to need services. ( )

**b.** Additional Requirements for Participants Eighteen Years or Older. For participant's eighteen (18) years of age or older, DDAs must also submit provider status reviews to the plan monitor in accordance with Sections 507 through 515 *of these rules*. ( )

**c.** 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 the collaboration requirements in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." ( )

**d.** 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 654.01 of these rules: ( )

i. Documentation of the six (6) month and annual reviews; ( )

ii. Documentation of participation in transition planning at the IFSP developed closest to the child's second birthday to ensure service continuity and access to community services as early intervention services end at age three (3); ( )

iii. Documentation that participant rights have been met in accordance with IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." ( )

iv. Documentation of participation in the transition meeting with the school district; and ( )

v. Documentation of consultation with other service providers who are identified on the IFSP. ( )

**08. DDA Program Implementation Plan Requirements**. For each participant, the DDA must develop a Program Implementation Plan for each DDA objective included on the participant's required plan of service. All Program Implementation Plans must be related to a goal or objective on the participant's plan of service. The Program Implementation Plan must be written and implemented within fourteen (14) days after the first day of ongoing programming and be revised whenever participant needs change. If the Program Implementation Plan is not completed within this time frame, the participant's records must contain participant-based documentation justifying the delay. The Program Implementation Plan must include the following requirements: ( )

**a.** Name. The participant's name. ( )

**b.** Baseline Statement. A baseline statement addressing the participant's skill level and abilities related to the specific skill to be learned. ( )

**c.** Objectives. Measurable, behaviorally-stated objectives that correspond to those goals or objectives previously identified on the required plan of service. ( )

**d.** Written Instructions to Staff. These instructions may include curriculum, interventions, task analyses, activity schedules, type and frequency of reinforcement, and data collection including probe, directed at the achievement of each objective. These instructions must be individualized and revised as necessary to promote participant progress toward the stated objective. ( )

**e.** Service Environments. Identification of the type of environment(s) where services will be provided. ( )

**f.** Target Date. Target date for completion. ( )

**g.** Results of the Psychological or Psychiatric Assessment. When a participant has had a psychological or psychiatric assessment, the results of the psychological or psychiatric assessment must be used when developing objectives to ensure therapies provided in the DDA accommodate the participant's mental health needs and to ensure that none of the therapeutic methods are contra-indicated or delivered in a manner that presents a risk to the participant's mental health status. ( )

**656. REQUIREMENTS FOR THE DELIVERY OF INTENSIVE BEHAVIORAL INTERVENTION (IBI).**

**01. Individualized and Comprehensive Interventions**. IBI consists of individualized, comprehensive interventions that have been shown to be effective and are used on a short term, one-to-one basis. These interventions: ( )

**a.** Produce measurable outcomes that diminish behaviors that interfere with the

development and use of language and appropriate social interaction skills; or ( )

**b.** Broaden an otherwise severely restricted range of interest; and ( )

**c.** Increase the child's ability to participate in other therapies and environments. ( )

**02.** **IBI Authorization and Review**. IBI services must be reviewed and prior authorized for each service year as follows: ( )

**a.** Initial IBI Authorization. The Department determines IBI eligibility based on information submitted by the DDA and other information gathered by the Department as deemed necessary. At least twenty (20) working days prior to the intended start date of IBI services, the DDA must use Department-approved forms to submit; ( )

i. Evidence of the child's eligibility for Intensive Behavioral Intervention; ( )

ii. The comprehensive IBI assessments; ( )

iii. The Program Implementation Plans; ( )

iv. The number of hours of service requested; and ( )

v. Measurable objectives. ( )

**b.** Three- (3) Month Review. The agency must conduct and document a formal review of therapy objectives and direction for future therapy for each objective. ( )

**c.** Six- (6) Month Review and Authorization. At least fifteen (15) working days prior to the expiration of prior authorized IBI services the agency must submit: ( )

i. The three- (3) month review; ( )

ii. Documentation of the child's progress on IBI goals and outcomes of the IBI objectives for those six (6) months; and ( )

iii. When continuing IBI services are requested, the Program Implementation Plans, the number of hours of service requested, and the measurable objectives, using Department-approved forms. Continued services will not be authorized when little or no progress has been documented and justification is inadequate to continue IBI services. ( )

**d.** Nine- (9) Month Review. The agency must conduct and document a formal review of therapy objectives and direction for future therapy for each objective. ( )

**e.** Annual Review and Authorization. At least fifteen (15) working days prior to the expiration of prior authorized IBI services the agency must submit: ( )

i. The nine- (9) month review; ( )

ii. Documentation of the child's progress on IBI goals and outcomes of the IBI objectives for that year; and ( )

iii. When continuing IBI services are requested: ( )

(1) A new SIB-R that reflects the child's current status and any additional information required to establish continuing eligibility; ( )

(2) The Program Implementation Plans; and ( )

(3) The number of hours of service requested and the measurable objectives, using Department-approved forms. Continued services will not be authorized when little or no progress has been documented and justification is inadequate to continue IBI services. ( )

**03. Comprehensive IBI Assessment**. A comprehensive IBI assessment must be completed by a certified IBI professional prior to the initial provision of IBI or IBI Consultation. The results of the assessment must form the basis for planning interventions. The assessment must include the following: ( )

**a.** Review of Assessments and Relevant Histories. ( )

i. Medical history, medications, and current medical status; ( )

ii. Medical/social history that includes a developmental history and onset of developmental disability; ( )

iii. Comprehensive developmental assessment reflecting the child's current status; ( )

iv. Specific skill assessment, when such an assessment is completed; ( )

v. SIB-R Maladaptive Index and a list of the child's maladaptive behaviors; ( )

vi. Baseline of the child's maladaptive behavior(s), if available; ( )

vii. Psychological assessments and results of psychometric testing, or for very young children, a developmental assessment with equivalent age-appropriate social-emotional status, if available; ( )

viii. A mental health or social and emotional assessment, such as the Child and Adolescent Functional Assessment Scale (CAFAS), when one has been completed; ( )

ix. Public school or Infant Toddler Program records including relevant birth records, multidisciplinary team assessments, recommendations, and Individualized Education Programs (IEPs) or Individualized Family Service Plans (IFSPs); and ( )

x. Other relevant assessments that may be available, including those for speech and

hearing and physical and occupational therapy. ( )

**b.** Interviews. Interviews must be conducted with the child, if possible, and to the extent of the child's abilities; the child's parent or legal guardian, or the primary care provider; and any other individuals who spend significant amounts of time with the child. These interviews must result in a written summary of the findings of each interview and include the following: ( )

i. Description of the child's desired and problem behaviors; ( )

ii. Opinion about environmental stimuli that appear to precede problem behaviors; ( )

iii. Opinion about the internal states or setting events that precede desired and problem behaviors; ( )

iv. Opinion about identification of stimuli that maintain the desired or problem behaviors; and ( )

v. Opinion about factors that alleviate problem behaviors and increase desired behaviors. ( )

**c.** Observation of the Child. Observations of the child must occur in environments in which the child spends significant amounts of time and where problem behaviors have been reported. Results of the observations must include the following: ( )

i. Specific descriptions and frequencies of problem behaviors; ( )

ii. Identification of environmental stimuli that appear to precede problem behaviors; ( )

iii. Identification of internal states or setting events that appear to precede problem behaviors; ( )

iv. Identification of stimuli that maintain the desired or problem behaviors; and( )

v. Identification of factors that alleviate problem behaviors and increase desired behaviors. ( )

**d.** Clinical Opinion. Clinical opinion about the underlying causes, antecedents, motivations, and communicative intent of desired and problem behaviors. ( )

**04. IBI Program Implementation Plans Requirements**. In addition to the requirements under Subsections 655.08.a. through 655.08.g. of these rules, the following are also required for IBI Implementation Plans: ( )

**a.** All IBI Implementation Plans must be completed on the Department-approved form. ( )

**b.** On all IBI Implementation Plan cover sheets, the signature of a parent or legal guardian is required. If the signatures of 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. ( )

**05.** **IBI Transition Plan**. An IBI transition plan must be developed when it is anticipated that IBI services will be terminated within the next Department or agency review period and the child will be moving into natural learning environments or less intensive therapy settings. The IBI transition plan may not be used as a substitute for, nor does it replace the transition plans required under Sections 653 and 654 of these rules. IBI transition plans must include the following steps to support the transition and the timelines for those steps: ( )

**a.** Setting. The setting to which the child will be moving and the therapists or persons who will be interacting with the child; and ( )

**b.** Training of New Therapists or Other Persons. How behavioral intervention techniques will be shared with new therapists or other persons in the new environments to encourage generalization and maintenance of appropriate behavior and action to be taken if the child demonstrates regression in the new setting in skills learned through IBI. ( )

**06.** **IBI Consultation**. Professionals may provide IBI consultation to parents and other family members, professionals, paraprofessionals, school personnel, child care providers, or other caregivers who provide therapy or care for an IBI eligible child in other disciplines to ensure successful integration and transition from IBI to other therapies, services, or types of care. IBI consultation objectives and methods of measurement must be developed in collaboration with the person receiving IBI consultation. ( )

**a.** Service Delivery Qualification. IBI consultation must be delivered by an IBI professional who meets the requirements in Section 657 of these rules. ( )

**b.** Measurable Progress. IBI consultation must result in measurable improvement in the child's behavior. It is not intended to be used for educational purposes only. ( )

**c.** Evidence of Progress. Persons who receive IBI consultation must meet with the IBI professional, agree to follow an IBI Implementation Plan, and provide evidence of progress. ( )

**d.** Individualized. IBI consultation may not be reimbursed when it is delivered to a group of parents. IBI consultation is specific to the unique circumstances of each child. ( )

## 657. DDA SERVICES: DDA PROVIDER QUALIFICATIONS AND DUTIES.

**01.** **Audiologist, Licensed**. A person licensed to conduct hearing assessment and therapy, in accordance with the Speech and Hearing Services Practice Act, Title 54, Chapter 29, Idaho Code, who either possesses a certificate of clinical competence in audiology from the American Speech, Language and Hearing Association (ASHA) or will be eligible for certification within one (1) year of employment. The agency's personnel records must reflect the expected date

of certification. ( )

**02. Counselor, Licensed Clinical Professional**. A person licensed to practice as a clinical professional counselor 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. Counselor, Licensed Professional**. A person licensed to practice as a professional counselor 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." ( )

**04. Marriage and Family Therapist**. ( )

**a.** Licensed Marriage and Family Therapist. A person licensed to practice as a marriage and family therapist 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." ( )

**b.** Registered Marriage and Family Therapist Intern. A person registered to practice as a marriage and family therapist intern under the direct supervision of a Licensed Marriage and Family Therapist, 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." ( )

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

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

**b.** Possess a bachelor's or master's degree in an area not listed above in Subsection *657*.05.a. of this rule and have: *( )*

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

ii. Passed a competency examination approved by the Department. ( )

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

**06. Developmental Specialist for Children Three Through Seventeen**. A Developmental Specialist providing developmental assessment and therapy services to children ages three (3) through seventeen (17) must meet the requirements for a Developmental Specialist for adults, and must also meet the following requirements: ( )

**a.** Successfully complete a competency course approved by the Department that relates to developmental assessment and therapy for children; and ( )

**b.** Pass a competency examination approved by the Department. ( )

**07. Developmental Therapy Paraprofessionals Delivering Services to Participants Age Three and Older**. Paraprofessionals, such as aides or therapy technicians, may be used by an agency to provide developmental therapy to children age (3) and older if they are under the supervision of a Developmental Specialist. A developmental therapy paraprofessional must be at least seventeen (17) years of age. ( )

**08. Developmental Specialist for Children Birth to Three**. ( )

**a.** To provide developmental assessments and therapy to children birth to three (3) years of age, a person must have a minimum of two hundred forty (240) hours of professionally-supervised experience with young children who have developmental disabilities and one (1) of the following: ( )

i. An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education; or ( )

ii. A Blended Early Childhood/Early Childhood Special Education (EC/ECSE) Certificate; ( )

iii. A bachelor's or masters degree in special education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, or nursing plus a minimum of twenty-four (24) semester credits in Early Childhood/Early Childhood Special Education (EC/ECSE) from an accredited college or university. Courses taken must appear on college or university transcripts and must cover the following standards in their content: ( )

(1) Promotion of development and learning for children from birth to three (3) years; ( )

(2) Assessment and observation methods for developmentally appropriate assessment of young children; ( )

(3) Building family and community relationships to support early interventions; ( )

(4) Development of appropriate curriculum for young children, including IFSP and IEP development; ( )

(5) Implementation of instructional and developmentally effective approaches for

early learning, including strategies for children who are medically fragile and their families; and ( )

(6) Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development. ( )

**b.** Electives closely related to the content under Subsection *657*.08.a.iii. *of this rule* may be approved by the Department with a recommendation from an institution of higher education. *( )*

**c.** A developmental specialist who possesses a bachelor's or master's degree listed above under Subsection *657*.08.a.ii. of this rule, must have completed a minimum of twenty (20) semester credits in EC/ECSE, and with Department approval are serving children under three (3) years of age as of July 1, 2005, will be allowed to continue providing services in accordance with his approved, conditional hiring agreement. *( )*

**d.** When the Department in its role as lead agency for implementation of Part C of the Individuals with Disabilities Education Act (IDEA) has determined that there is a shortage of such qualified personnel to meet service needs in a specific geographic area: ( )

i. The Department may approve the most qualified individuals who are demonstrating satisfactory progress toward completion of applicable course work in accordance with the individual's approved plan to meet the required standard within three (3) years of being hired. ( )

ii. Satisfactory progress will be determined on an annual review by the Department. ( )

iii. An individual who has an approved plan for completion of twenty (20) semester credits in EC/ECSE prior to July 1, 2005, will be allowed to continue providing services so long as he demonstrates satisfactory progress on the plan and complete the requirements on the plan within three (3) years of his date of hire. ( )

**09. Developmental Therapy Paraprofessionals Delivering Services to Children Birth to Three**. Paraprofessionals, such as aides or therapy technicians, may be used by an agency to provide developmental therapy to children birth to three (3) years of age if they are under the supervision of a Developmental Specialist fully qualified to provide services to participants in this age group. Developmental therapy paraprofessionals serving infants and toddlers from birth to three (3) years of age must meet the following qualifications: ( )

**a.** Be at least eighteen (18) years of age; ( )

**b.** Be a high school graduate or have a GED; and ( )

**c.** Have transcripted courses for a minimum of a Child Development Associate degree (CDA) or the equivalent through completion of twelve (12) semester credits from an accredited college or university in child development, special education or closely-related

coursework; or ( )

**d.** Have three (3) years of documented experience providing care to infants, toddlers, or children less than five (5) years of age with developmental delays or disabilities under the supervision of a child development professional, certified educator, licensed therapist, or Developmental Specialist. ( )

**10. Intensive Behavioral Intervention (IBI) Professional Delivering Services to Participants Three to Twenty-One**. A person qualified to provide or direct the provision of Intensive Behavioral Intervention (IBI) must meet the following requirements: ( )

**a.** Degree. A qualified IBI professional must hold at least a bachelor's degree in a health, human services, educational, behavioral science, or counseling field from a nationally accredited university or college. ( )

**b.** Experience. An individual applying for IBI paraprofessional or professional certification must be able to provide documentation of one (1) year's supervised experience working with children with developmental disabilities. The year's experience must be gained through paid employment or university practicum experience or internship and be documented to include one thousand (1,000) hours of direct contact or care of children with developmental disabilities in a behavioral context. ( )

**c.** Training and Certification. Qualified IBI professionals and paraprofessionals must comply with the requirements under *IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA),"* Section 41*0*. *( )*

**11. IBI Paraprofessionals Delivering Services to Participants Three to Twenty-One**. A certified IBI paraprofessional may be used to provide IBI under the supervision of a certified IBI professional and must comply with Section *658* of these rules. An IBI paraprofessional must also: *( )*

**a.** Be at least eighteen (18) years of age; ( )

**b.** Experience. An individual applying for IBI paraprofessional or professional certification must be able to provide documentation of one (1) year of supervised experience working with children with developmental disabilities. The year of experience must be gained through paid employment or university practicum experience or internship and be documented to include one thousand (1,000) hours of direct contact or care of children with developmental disabilities in a behavioral context. ( )

**c.** Training and Certification. Qualified IBI professionals and paraprofessionals must comply with the requirements under *IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA),"* Section 41*0*. *( )*

**12. IBI Professionals Delivering Services to Children Birth to Three**. A person qualified to provide or direct the provision of IBI to children under three (3) years of age must meet the staff qualifications described under Subsections *657*.08.a.ii. through *657*.08.d. *of these rules*, *657*.10.b. and *657*.10.*c*. of these rules and the certification and training requirements above

under Subsections *658.01.e.* and *658.01.f.* of these rules. ( )

**13.** **IBI Paraprofessionals Delivering Services to Children Birth to Three**. A paraprofessional serving infants and toddlers from birth to three (3) years of age must meet the following qualifications: ( )

**a.** Be at least eighteen (18) years of age; ( )

**b.** Be a high school graduate or have a GED; and ( )

**c.** Have transcripted courses for a minimum of a Child Development Associate degree (CDA) or the equivalent through completion of twelve (12) credits in child development, special education, or closely-related coursework; or ( )

**d.** Have three (3) years of documented experience providing care to infants, toddlers or children under five (5) years of age under the supervision of a child development professional, certified educator, or licensed therapist or Developmental Specialist. ( )

**e.** Qualified IBI professionals and paraprofessionals must comply with the requirements under *IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA),"* Section 41*0, and Subsections 658.01.e. and 658.01.f.* of these rules. *( )*

**14.** **Nurse Practitioner**. A licensed professional nurse (RN) who has met all the applicable requirements to practice as nurse practitioner under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." ( )

**15.** **Occupational Therapist**. A person qualified to conduct occupational therapy assessments and therapy in accordance with the requirements in IDAPA 22.01.09, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants." ( )

**16.** **Physical Therapist**. A person qualified to conduct physical therapy assessments and therapy in accordance with the requirements in IDAPA 22.01.05, "Licensure of Physical Therapists Idaho State Board of Medicine and Physical Therapist Assistants." ( )

**17.** **Physician**. A person licensed to practice medicine in Idaho in accordance with the provisions of the Medical Practice Act, Title 54, Chapter 18, Idaho Code. ( )

**18.** **Physician Assistant**. A person who is licensed by the Idaho Board of Medicine and who meets at least one (1) of the following provisions: ( )

**a.** Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians; or ( )

**b.** Has satisfactorily completed a program for preparing physician's assistants that: ( )

i. Was at least one (1) academic year in length; and ( )

ii. Consisted of supervised clinical practice and at least four (4) months, in the aggregate, of classroom instruction directed toward preparing students to deliver health care; and ( )

iii. Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation. ( )

**19. Psychiatric Nurse, Certified**. A licensed professional nurse (RN), licensed in accordance with Title 54, Chapter 14, Idaho Code, or certified by a recognized national certification organization, and have a minimum of a master's degree. ( )

**20. Psychiatrist**. A person licensed to practice medicine in Idaho in accordance with the provisions of the Medical Practice Act, Title 54, Chapter 18, Idaho Code, and who meets the requirements for certification in psychiatry by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry. ( )

**21. Psychologist**. A person licensed to practice psychology in Idaho under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." ( )

**22. Psychologist Extender**. A person who practices psychology under the supervision of a licensed psychologist as required under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners," and who is registered with the Bureau of Occupational Licenses. ( )

**23. Social Worker, Licensed**. A person licensed in accordance with the Social Work Licensing Act, Title 54, Chapter 32, Idaho Code and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners." ( )

**24. Masters Social Worker, Licensed**. A person who is licensed as a masters social worker (LMSW) in accordance with Title 54, Chapter 32, Idaho Code and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners." ( )

**25. Clinical Social Worker, Licensed**. A person who is licensed as a clinical social worker (LCSW) in accordance with Title 54, Chapter 32, Idaho Code and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners." ( )

**26. Speech-Language Pathologist, Licensed**. A person licensed to conduct speech-language assessment and therapy in accordance with the Speech and Hearing Services Practice Act, Title 54, Chapter 29, Idaho Code, who possesses a certificate of clinical competence in speech-language pathology from the American Speech, Language and Hearing Association (ASHA) or who will be eligible for certification within one (1) year of employment. The agency's personnel records must reflect the expected date of certification. ( )

***27. Requirements for Collaboration with Other Providers***. *When participants are receiving rehabilitative or habilitative services from other providers, each DDA must coordinate each participant's DDA program with these providers to maximize skill acquisition and generalization of skills across environments, and to avoid duplication of services. The DDA must*

*maintain documentation of this collaboration. This documentation includes other plans of services such as the Individual Education Plan (IEP), Personal Care Services (PCS) plan, Residential Habilitation plan, and the Psychosocial Rehabilitation (PSR) plan. The participant's file must also reflect how these plans have been integrated into the DDA's plan of service for each participant.* ( )

**658. GENERAL STAFFING REQUIREMENTS FOR AGENCIES.**

**01. Standards for Paraprofessionals Providing Developmental Therapy and IBI**. When a paraprofessional provides either developmental therapy or IBI, the agency must ensure adequate supervision by a qualified professional during its service hours. All paraprofessionals must meet the training requirements under *IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA),"* Section 41*0* and must meet the qualifications under Section *657* of these rules. A paraprofessional providing IBI must be supervised by an IBI professional; a paraprofessional providing developmental therapy must be supervised by a Developmental Specialist. Paraprofessionals providing developmental therapy to children birth to three (3) years of age must work under the supervision of a Developmental Specialist fully qualified to provide services to participants in this age group. For paraprofessionals to provide developmental therapy or IBI in a DDA, the agency must adhere to the following standards: ( )

**a.** Limits to Paraprofessional Activities. The agency must ensure that paraprofessionals do not conduct participant assessments, establish a plan of service, develop a Program Implementation Plan, or conduct collateral contact or IBI consultation. These activities must be conducted by a professional qualified to provide the service. ( )

**b.** Frequency of Supervision. The agency must ensure that a professional qualified to provide the service must, for all paraprofessionals under his supervision, on a weekly basis or more often if necessary: ( )

i. Give instructions; ( )

ii. Review progress; and ( )

iii. Provide training on the program(s) and procedures to be followed. ( )

**c.** Professional Observation. The agency must ensure that a professional qualified to provide the service must, on a monthly basis or more often if necessary, observe and review the work performed by the paraprofessional under his supervision, to ensure the paraprofessional has been trained on the program(s) and demonstrates the necessary skills to correctly implement the program(s). ( )

**d.** Limitations to Service Provision by an IBI Paraprofessional. IBI provided by a paraprofessional is limited to ninety percent (90%) of the direct intervention time, per individual participant. The remaining ten percent (10%) of the direct intervention time must be provided by the professional qualified to provide and direct the provision of IBI. ( )

**e.** Additional Training Requirements for IBI Professionals and IBI Paraprofessionals. Qualified IBI professionals and IBI paraprofessionals must complete and pass a Department-

approved training course and examination for certification. The training must include a curriculum that addresses standards of competence for the provision of IBI and ethical standards. Specifically, the curriculum must include: ( )

i. Assessment of individuals; ( )

ii. Behavioral management; ( )

iii. Services or treatment of individuals; ( )

iv. Supervised practical experience; and ( )

v. Successful completion of a student project that includes an observation of demonstrated competencies for all individuals applying for initial certification or recertification after July 1, 2003. ( )

**f.** Continuing Training Requirements for IBI Professionals and IBI Paraprofessionals. Each IBI professional and IBI paraprofessional, in order to maintain certification, must complete at least twelve (12) hours of yearly training, six (6) hours of which must cover behavior methodology or interventions shown to be effective. ( )

i. The initial IBI certification training meets the yearly training requirement for the calendar year in which the IBI professional or paraprofessional was first certified. ( )

ii. If the individual has not completed the required training during any yearly training period, he may not provide IBI services beginning with the anniversary date of the following period, and thereafter, until the required number of training hours have accumulated. As training hours accumulate, they will be accounted first to any training-deficient prior yearly period before being applied to the current annual training period. Training hours may not be earned in a current annual training period to be applied to a future training period. ( )

iii. An individual may remain IBI certified, despite being unable to bill for services, through two (2) consecutive annual training periods during which that individual has deficient training hours. A DDA may begin billing for the certified IBI Professional or Paraprofessional again after the required training hours are accumulated. ( )

iv. If an individual completes three (3) consecutive annual training periods without having accumulated sufficient training to satisfy the training requirement for the first of those periods, that individual's IBI certification is automatically rescinded and will no longer be recognized. To be recertified, the individual must retake the state IBI exam and complete the IBI Student Project, if not previously completed. ( )

**02. General Staffing Requirements for Agencies**. ( )

**a.** Administrative Staffing. Each DDA must have an agency administrator who is accountable for all service elements of the agency and who must be employed on a continuous and regularly scheduled basis. The agency administrator is accountable for the overall operations of the agency including ensuring compliance with this chapter of rules, overseeing and managing

staff, developing and implementing written policies and procedures, and overseeing the agency's quality assurance program. ( )

i. When the administrator is not a Developmental Specialist as defined in these rules, the DDA must employ a Developmental Specialist on a continuous and regularly scheduled basis who is responsible for the service elements of the agency; and ( )

ii. The Developmental Specialist responsible for the service elements of the agency must have two (2) years of supervisory or management experience providing developmental disabilities services to individuals with developmental disabilities. ( )

**b.** Other required staffing. The agency must have available, at a minimum, the following personnel, qualified in accordance with Section 657 of these rules, as employees of the agency or through formal written agreement: ( )

i. Speech-language pathologist or audiologist; ( )

ii. Developmental Specialist; ( )

iii. Occupational therapist; ( )

iv. Physical therapist; ( )

v. Psychologist; and ( )

vi. Social worker, or other professional qualified to provide the required services under the scope of his license. ( )

**65~~6~~9. DDA SERVICES: PROVIDER REIMBURSEMENT.**
Payment for agency services must be in accordance with rates established by the Department. (3-19-07)

~~*657. -- 699. (RESERVED).*~~

**CHILDREN'S HOME AND COMMUNITY BASED SERVICES (HCBS) STATE PLAN OPTION**
**(Sections 660 through 669)**

**660. CHILDREN'S HOME AND COMMUNITY BASED SERVICES (HCBS) STATE PLAN OPTION.**
In accordance with 1915i of the Social Security Act, the Department will pay for home and community based services provided by individuals or agencies that have entered into a provider agreement with the Department. Services provided by a developmental disabilities agency to children birth to three (3) years of age must meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the

Idaho State Plan for Early Intervention Services under IDEA, Part C. These requirements include adherence to procedural safeguards and time lines, multi-disciplinary assessments, evaluations, individualized family service plans, provision of early intervention services in the natural environment, transition planning, and enrollment and reporting requirements. ( )

**661. CHILDREN'S HCBS STATE PLAN OPTION: DEFINITIONS.**
For the purposes of these rules, *the definitions in Section 521 of these rules apply. Additionally,* the following terms *apply to the Children's Home and Community Based Services State Plan Option:* ( )

**0*1*.** **Agency**. A developmental disabilities agency (DDA) as defined in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." ( )

**02.** **Annual**. Every three hundred sixty-five (365) days except during a leap year which equals three hundred sixty-six (366) days. ( )

***03.*** ***Clinical Supervisor****. The professional responsible for the supervision of DDA staff as outlined in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)."* ( )

**04.** **Community**. Natural, integrated environments outside of the home, school, or DDA center-based settings. ( )

**05.** **Developmental Disabilities Agency (DDA)**. A DDA is an agency that is: ( )

**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; ( )

**b.** Certified by the Department to provide home and community based services to people with developmental disabilities, in accordance with these rules; ( )

**c.** A business entity, open for business to the general public; and ( )

**d.** Primarily organized and operated to provide home and community based services and the corresponding assessments to people with developmental disabilities. DDA services include evaluations, diagnostic, treatment, and support 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. ( )

**0*6*.** **Home and Community Based Services State *(HCBS)* Plan Option**. The federal authority under section 1915(i) of the Social Security Act that allows a state to provide through a state plan amendment, medical assistance for home and community-based services for elderly and individuals with disabilities, without determining that without the provision of services the individuals would require institutional level of care. ( )

***07.*** ***Human Services Field****. A particular area of academic study in health care, social services, education, behavioral science or counseling.* ( )

***08.*** **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. ( )

***09.*** **Paraprofessional**. A *person qualified to* provide direct support services which include respite and habilitative supports. *( )*

**1*0*.** **Professional**. A *person qualified to* provide direct intervention services which include habilitative intervention, therapeutic consultation, family education, family training, interdisciplinary training, and crisis intervention. *( )*

**1*1*.** **Support Services**. Support services may provide supervision for a participant, as well as may provide assistance to a participant by facilitating integration into the community. *( )*

**662. CHILDREN'S HCBS STATE PLAN OPTION: PARTICIPANT ELIGIBILITY.**

Children's Home and Community Based State Plan Option eligibility will be determined by the Department as described in Section 520 of these rules. *HCBS state plan option* participants must meet the following requirements: *( )*

**01.** **Age of Participants**. Participants eligible to receive children's HCBS must be birth through seventeen (17) years of age. ( )

**02.** **Eligibility Determinations**. The Department must determine that prior to receiving children's HCBS state plan option services, an individual must be determined to have a developmental disability under Sections 500 through 506 of these rules and Section 66-402, Idaho Code, and have a demonstrated need for Children's HCBS state plan option services. ( )

***03.*** ***Financial Eligibility****. The Department must determine that prior to receiving children's HCBS state plan option services, the individual is in an eligibility group covered under the Medicaid State plan, and meets one (1) of the following criteria: ( )*

***a.*** *Has an income that does not exceed one hundred fifty percent (150%) of the Federal Poverty Level (FPL); or ( )*

***b.*** *Has an income that does not exceed three hundred percent (300%) of the Supplemental Security Income (SSI) Federal benefit rate (FBR), and is eligible for, but does not have to be enrolled in, HCBS under a 1915(c), (d), or (e) waiver, or 1115 demonstration program. ( )*

**663. CHILDREN'S HCBS STATE PLAN OPTION: COVERAGE AND LIMITATIONS.**

All children's home and community based services must be identified on a plan of service developed by the family-centered planning team, including the plan developer*, and must be recommended by a physician or other practitioner of the healing arts*. The following services are reimbursable when provided in accordance with these rules: *( )*

**01.** **Respite**. Respite provides supervision to the participant on an intermittent or short-

term basis because of the need for relief of the primary unpaid caregiver. Respite is available in response to a family emergency or crisis, or may be used on a regular basis to provide relief to the caregiver. Respite may be provided in the participant's home, the private home of the respite provider, a DDA, or in the community. Payment for respite services are not made for room and board. ( )

**a.** Respite must only be offered to participants living with an unpaid caregiver who requires relief. ( )

***b.*** *Respite cannot exceed fourteen (14) consecutive days.* *( )*

***c.*** Respite must not be provided at the same time other Medicaid services are being provided. ( )

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

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

***f.*** When respite is provided as group respite, the following applies: ( )

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

ii. When group respite is community-based, there must be a minimum of one (1) qualified staff providing direct services to every three (3) participants. As the number and severity of the participants with functional impairments *or behavioral issues* increases, the staff-*to*-participant ratio *must* be adjusted accordingly. *( )*

***g.*** *Respite cannot be provided as group- or center-based respite when delivered by an independent respite provider.* *( )*

***h.*** *For Act Early waiver participants, the cost of respite services cannot exceed ten (10) percent of the child's individualized budget amount to ensure the child receives the recommended amount of intervention based on evidence-based research.* *( )*

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

**a.** Only be provided in community settings and have integration into the community as an identified goal on the plan of service; ( )

**b.** Not supplant services provided in school or therapy, or supplant the role of the primary caregiver; ( )

**c.** Ensure the participant is *involved* in age-appropriate activities and is engaging with typical peers *according to the ability of the participant*; and ( )

**d.** Have a minimum of one (1) qualified staff providing direct services to every three (3) participants when provided as group habilitative supports. As the number and severity of the participants with functional impairments increases, the staff participant ratio shall be adjusted accordingly. ( )

**03. Family Education**. Family education is professional assistance to families to help them better meet the needs of the participant. It offers education to the parent or legal guardian that is specific to the individual needs of the family and child as identified on the plan of service. Family education is delivered to families to provide an orientation to developmental disabilities and to educate families on generalized strategies for behavioral modification and intervention techniques specific to their child's diagnoses. ( )

**a.** Family education may also provide assistance to the parent or legal guardian in educating other unpaid caregivers regarding the needs of the participant. ( )

**b.** The family education providers must maintain documentation of the training in the participant's record documenting the provision of activities outlined in the plan of service. ( )

**c.** Family education may be provided in a group setting not to exceed *five (5) participants' families.* ( )

**04. Family-Directed Community Supports**. *Families of p*articipants eligible for the children's home and community based state plan option may choose to direct their individualized budget rather than receive the traditional services described in S*ubsections 663.01 through 663.03* of *this* rule *when the participant lives at home with his parent or legal guardian*. The requirements for this option are outlined in IDAPA 16.03.13 "Consumer-Directed Services." ( )

**05. Limitations**. ( )

**a.** HCBS state plan option services are *limited by* the participant's individualized budget *amount*. ( )

***b.*** For the children's HCBS state plan option services listed in Subsections 663.01, 663.02*, and 663.04 of this rule*, the following are excluded for Medicaid payment: ( )

i. Vocational services; and ( )

ii. Educational services. ( )

## 664. CHILDREN'S HCBS STATE PLAN OPTION: PROCEDURAL REQUIREMENTS.

**01. General Requirements for Program Documentation**. The provider must maintain records for each participant served. Each participant's record must include documentation of the participant's involvement in and response to the services provided. For each participant, the following program documentation is required: ( )

**a.** Direct service provider information *that* includes written documentation of *the* service provided *during each visit made* to the participant, and contains, at a minimum, the following information: *( )*

i. Date and time of visit; and ( )

ii. Intervention and support services provided during the visit; and ( )

iii. A statement of the participant's response to the service; and *( )*

iv. Length of visit, including time in and time out; and ( )

v. Specific place of service. ( )

vi. A copy of the above information will be maintained by the independent provider or DDA. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. ( )

**02. Habilitative Supports Documentation**. In addition to the general requirements listed in Subsection 664.01 of this rule, the following must be completed: ( )

**a.** On a monthly basis, the habilitative support staff must complete a summary of the participant's response to the support service and submit the monthly summary to the clinical supervisor. *( )*

**b.** The clinical supervisor reviews the summary on a monthly basis and when recommendations for changes to the type and amount of support are identified, submits the recommendations to the plan developer. *( )*

**03. Family Education Documentation**. In addition to the general requirements listed in Subsection 664.01 of this rule, the DDA must survey the parent or legal guardian's satisfaction of the service immediately following a family education session. ( )

**04. Reporting Requirements**. The clinical supervisor must complete at a minimum, six- (6) month and annual *provider status* reviews for *habilitative support* services provided. *These provider status reviews must be completed more* frequently*, when so required* on the plan of service. *( )*

***a.*** Documentation of the six- (6) month and annual reviews must be submitted to the plan *monitor.* *( )*

**b.** *The provider must use Department-approved forms for provider status reviews.* *( )*

**665. CHILDREN'S HCBS STATE PLAN OPTION: PROVIDER QUALIFICATIONS AND DUTIES.**

All providers of HCBS state plan option services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. ( )

**01. Respite**. Respite services may be provided by an agency that is certified as a DDA and is capable of supervising the direct services provided, or by an independent respite provider. An independent respite provider is an individual who has entered into a provider agreement with the Department. Providers of respite services must meet the following minimum qualifications: *( )*

**a.** Must be at least sixteen (16) years of age when employed by a DDA; or ( )

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

**c.** Meet the qualifications prescribed for the type of services to be rendered, or must be an individual selected by the participant, the family, or the participant's guardian; *and* *( )*

**d.** Have received instructions in the needs of the participant who will be provided the service; *and* *( )*

**e.** Demonstrate the ability to provide services according to a plan of service; *and* *( )*

***f.*** *M*ust satisfactorily complete a criminal history background check in accordance with IDAPA 16.05.06 "Criminal History and Background Checks"*; and* *( )*

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

**02. Habilitative Support Staff**. Habilitative supports must be provided by an agency certified as a DDA with staff who are capable of supervising the direct services provided. Providers of habilitative supports must meet the following minimum qualifications: *( )*

**a.** Must be at least eighteen (18) years of age; ( )

**b.** Must be a high school graduate or have a GED; ( )

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

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

**e.** *M*ust have six (6) months supervised experience working with children with developmental disabilities. This can be achieved in the following ways: ( )

i. *Have p*revious work experience gained through paid employment, university practicum experience, or internship; or ( )

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

**f.** Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide habilitative supports. ( )

**g.** *In addition to the habilitative support qualifications listed in Subsections 665.02.a. through f. of this rule, habilitative support staff serving infants and toddlers from birth to three (3) years of age must meet the following qualifications:* ( )

*i.* *Have transcripted courses for a minimum of a Child Development Associate degree (CDA) or the equivalent through completion of twelve (12) semester credits from an accredited college or university in child development, special education, or closely-related coursework; or* ( )

*ii.* *Have three (3) years of documented experience providing care to infants, toddlers, or children less than five (5) years of age with developmental delays or disabilities under the supervision of a child development professional, certified educator, licensed therapist, or Developmental Specialist.* ( )

**03.** **Family Education**. Family education must be provided by an agency certified as a DDA with staff who are capable of supervising the direct services provided. Providers of family education must meet the following minimum qualifications: ( )

**a.** Must hold at least a bachelor's degree in a human services field from a nationally-accredited university or college, and has: ( )

i. One (1) year experience providing care to children with developmental disabilities; ( )

ii. Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide family education; *or* ( )

**b.** Individuals *working* as Developmental Specialists for children ages birth through three (3) or three (3) through seventeen (17), and individuals certified as Intensive Behavioral Interventionist *professionals* prior to July 1, 2011, are qualified to provide family education until June 30, 2013. *T*he individual must meet the requirements of the Department-approved

competency coursework *by June 30, 2013, to maintain his certification.* *(     )*

*c.* *Each professional providing family education services must complete at least twelve (12) hours of yearly training, six (6) hours of which must cover behavior methodology or interventions shown to be effective. If the individual has not completed the required training during any yearly training period, he may not provide family education services beginning with the anniversary date of the following period, and thereafter, until the required number of training hours have accumulated. As training hours accumulate, they will be accounted first to any training-deficient prior yearly period before being applied to the current annual training period. Training hours may not be earned in a current annual training period to be applied to a future training period.* *(     )*

***04.*** ***Family Education for Children Birth to Three****. In addition to the family education qualifications listed in Subsections 665.03.a. through c. of this rule, family education staff serving infants and toddlers from birth to three (3) years of age must have a minimum of two hundred forty (240) hours of professionally-supervised experience with young children who have developmental disabilities and one (1) of the following:* *(     )*

*a.* *An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education; or* *(     )*

*b.* *A Blended Early Childhood/Early Childhood Special Education (EC/ECSE) Certificate; or* *(     )*

*c.* *A bachelor's or master's degree in special education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, or nursing plus a minimum of twenty-four (24) semester credits in Early Childhood/Early Childhood Special Education (EC/ ECSE) from an accredited college or university. Courses taken must appear on college or university transcripts and must cover the following standards in their content:* *(     )*

*i.* *Promotion of development and learning for children from birth to three (3) years;* *(     )*

*ii.* *Assessment and observation methods for developmentally appropriate assessment of young children;* *(     )*

*iii.* *Building family and community relationships to support early interventions;* *(     )*

*iv.* *Development of appropriate curriculum for young children, including IFSP and IEP development;* *(     )*

*v.* *Implementation of instructional and developmentally effective approaches for early learning, including strategies for children who are medically fragile and their families; and* *(     )*

*vi.* *Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development.*

( )

**d.** Electives closely related to the content under Subsection 665.04.c.iii. of this rule may be approved by the Department with a recommendation from an institution of higher education. ( )

**e.** Developmental specialists who possess a bachelor's or master's degree listed above under Subsection 665.04.c.ii. of this rule, have completed a minimum of twenty (20) semester credits in EC/ECSE, and with Department approval are serving children under three (3) years of age as of July 1, 2005, will be allowed to continue providing services in accordance with their approved, conditional hiring agreement. ( )

**f.** When the Department in its role as lead agency for implementation of Part C of the Individuals with Disabilities Education Act (IDEA) has determined that there is a shortage of such qualified personnel to meet service needs in a specific geographic area: ( )

i. The Department may approve the most qualified individuals who are demonstrating satisfactory progress toward completion of applicable course work in accordance with the individual's approved plan to meet the required standard within three (3) years of being hired. ( )

ii. Satisfactory progress will be determined on an annual review by the Department. ( )

iii. Individuals who have an approved plan for completion of twenty (20) semester credits in EC/ECSE prior to July 1, 2005, will be allowed to continue providing services so long as they demonstrate satisfactory progress on the plan and complete the requirements on the plan within three (3) years of their date of hire. ( )

**05. Requirements for Clinical Supervision**. All DDA services must be provided under the supervision of a clinical supervisor. The clinical supervisor must meet the qualifications to provide habilitative intervention as defined in Section 685 of these rules. Clinical supervisor(s) are professionals employed by a DDA on a continuous and regularly scheduled basis. ( )

**a.** The clinical supervisor is responsible for the oversight and supervision of service and support elements of the agency, including face-to-face supervision of agency staff providing direct services. ( )

**b.** The clinical supervisor must observe and review the direct services performed by all paraprofessional and professional staff on a monthly basis, or more often as necessary, to ensure staff demonstrate the necessary skills to correctly provide the services and support. ( )

**c.** Each DDA must employ an adequate number of clinical supervisors to ensure quality service delivery and participant satisfaction. ( )

**06. Requirements for Collaboration**. Providers of home and community based services must coordinate with the family-centered planning team as specified on the plan of service. ( )

**07. Requirements for Quality Assurance**. Providers of children's home and community based state plan option services must demonstrate high quality of services through an internal quality assurance review process. ( )

**08. DDA Services**. In order for a DDA to provide respite, habilitative supports, and family education the DDA must be certified to provide support services. Each DDA is required to provide habilitative supports. ( )

## 666. CHILDREN'S HCBS STATE PLAN OPTION: PROVIDER REIMBURSEMENT.

**01. *Reimbursement***. *The statewide reimbursement rate for children's HCBS state plan option services listed in Subsections 663.01 through 663.03 of these rules was derived by using Bureau of Labor Statistics mean wage for the direct care staff providing the service, adjusted for employment-related expenditures, program-related costs, and general and administrative costs based on a cost survey as described in Subsection 666.02 of this rule. Reimbursement rates are set at a percentage of the statewide target reimbursement rate. The Department will take into consideration the factors of efficiency, economy, quality of care, and access to care when determining rates.* ( )

***02. Cost Survey***. *The Department will conduct a cost survey every five (5) years from a statistically appropriate number of provider association representatives in order to obtain cost data for employment-related expenditures, program-related costs, and general and administrative costs.* ( )

**03. 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. ( )

**04. Rates**. The reimbursement rates calculated for children's HCBS 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. ( )

## 667. -- 679. (RESERVED).

## CHILDREN'S WAIVER SERVICES
## (Sections 680 through 699)

## 680. CHILDREN'S WAIVER SERVICES.

Under 42 CFR Section 440.180, it is the intention of the Department to provide waiver services to eligible children 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/ID.

( )

## 681. CHILDREN'S WAIVER SERVICES: DEFINITIONS.

*For the purposes of Sections 680 through 686 of these rules,* the following *terms are used as defined below; in addition, the definitions in Sections 521 and 661 of these rules apply.* ( )

**01.** **Crisis**. An unanticipated event, circumstance, or life situation that places a participant at risk of at least one of the following: ( )

**a.** Hospitalization; ( )

**b.** Loss of housing; ( )

**c.** Loss of employment; ( )

**d.** Incarceration; or ( )

**e.** Physical harm to self or others, including family altercation or psychiatric relapse. ( )

**02.** **Intervention Services**. Intervention services *include* outcome-based therapeutic services, *professional consultation services, and education and training for families caring for participants with developmental disabilities.* ( )

**03.** **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. ( )

**04.** **Probe**. A probe is data gathered on an intermittent basis, after a baseline is established, to measure a participant's level of independent performance as related to an identified objective. ( )

**05.** **Program Implementation Plan**. A plan that details how intervention goals from the plan of service will be accomplished. ( )

***06.*** ***Specific Skill Assessment****. A type of assessment used to determine the baseline or the need for further supports or intervention for the discipline area being assessed.* ( )

***07.*** ***Telehealth****. Telehealth is an electronic real-time synchronized audio-visual contact between a consultant and participant related to the treatment of the participant. The consultant and participant interact as if they were having a face-to-face service.* ( )

***08.*** ***Treatment Fidelity****. Accurately and consistently administering a program or intervention from a manual, protocol, or model.* ( )

## 682. CHILDREN'S WAIVER SERVICES: ELIGIBILITY.

Waiver eligibility will be determined by the Department as described in Section 522 of these

rules. *Children's* waiver participants must meet the following requirements: ( )

**01. Age of Participants**. The following waiver programs are available for children: ( )

**a.** Children's DD Waiver. Children's DD waiver participants must be birth through seventeen (17) years of age. ( )

**b.** Act Early Waiver. Act Early waiver participants must be three (3) through six (6) years of age. ( )

**02. Eligibility Determinations**. The Department must determine that: ( )

**a.** The participant would qualify for ICF/ID level of care as set forth in Section 584 of these rules, if the waiver services listed in Section 683 of these rules were not made available; and ( )

**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 *family*-centered planning team. *P*rior to any denial of services, *it must* be determined by the plan developer that services to correct the concerns of the team are not available. *( )*

**c.** The average annual cost of waiver services and other medical services to participant*s* would not exceed the average annual cost to Medicaid of ICF/ID care and other medical costs. *( )*

**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. ( )

**03. Additional Act Early Waiver Requirements**. In addition to the requirements listed in Subsections 682.01 and 682.02 of this rule, a participant must have the following characteristics to qualify for Act Early waiver services: ( )

**a.** An autism spectrum diagnosis; or ( )

**b.** Self-injurious, aggressive, or severely maladaptive behavior as evidenced by a General Maladaptive Index score of minus twenty-two (-22) or below on the Scales of Independent Behavior - Revised (SIB-R) or other behavioral assessment indicators identified by the Department and a severe deficit, defined as having a composite full scale functional age equivalency of fifty percent (50%) or less of the participant's chronological age. ( )

**04. Children's Waiver Eligible Participants**. A participant who is determined by the Department to be eligible for services under the children's waivers may elect not to u*s*e waiver services, but may choose admission to an ICF/ID. *( )*

**05. Home and Community-Based Waiver Participant Limitations**. The number of Medicaid participants to receive waiver services under the children's waivers for participants with developmental disabilities 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 June 30th of each new waiver year. ( )

**683. CHILDREN'S WAIVER SERVICES: COVERAGE AND LIMITATIONS.**

All children's DD waiver services must be identified on a plan of service developed by the family-centered planning team, including the plan developer*, and must be recommended by a physician or other practitioner of the healing arts*. In addition to the children's home and community based state plan option services described in Section 663 of these rules, the following services are available for waiver eligible participants and are reimbursable services when provided in accordance with these rules: ( )

**01. Family Training**. Family training is professional one-on-one (1 on 1) instruction to families to help them better meet the needs of the waiver participant receiving intervention services. ( )

**a.** Family training is limited to training in the implementation of intervention techniques as outlined in the plan of service. ( )

**b.** Family training must be provided to the participant's parent or legal guardian when the participant is present. ( )

**c.** The family training provider must maintain documentation of the training in the participant's record documenting the provision of activities outlined in the plan of service. ( )

**d.** The parent or legal guardian of the waiver participant is required to participate in family training when the participant is receiving habilitative interventions. The following applies for each waiver program: ( )

i. For participants enrolled in the Children's DD Waiver, the amount, duration, and frequency of the training must be determined by the family-centered planning team and the parent or legal guardian, and must be listed as a service on the plan of service. ( )

ii. For participants enrolled in the Act Early Waiver, the parent or legal guardian will be required to be present and actively participate during the intervention service session for at least twenty percent (20%) of the intervention time provided to the child. ( )

**02. Interdisciplinary Training**. Interdisciplinary training is professional instruction to the direct service provider. Interdisciplinary training must only be provided during the provision of a support or intervention service. Interdisciplinary training is provided to assist the direct provider to meet the needs of the waiver participant. ( )

**a.** Interdisciplinary training includes: ( )

i. Health and medication monitoring; ( )

ii. Positioning and transfer; ( )

iii. Intervention techniques; ( )

iv. Positive Behavior Support; ( )

v. Use of equipment; ( )

**b.** Interdisciplinary training must only be provided to the direct service provider when the participant is present. ( )

**c.** The interdisciplinary training provider must maintain documentation of the training in the participant's record documenting the provision of activities outlined in the plan of service. ( )

**d.** Interdisciplinary training between a habilitative interventionist and a therapeutic consultant is not a reimbursable service. ( )

**e.** Interdisciplinary training between employees of the same discipline is not a reimbursable service. ( )

**03. Habilitative Intervention Evaluation**. The purpose of the habilitative intervention evaluation is to guide the *formation* of *developmentally-appropriate* objectives and intervention strategies related to goals identified through the family-centered planning process. The habilitative interventionist must complete an evaluation prior to the initial provision of habilitative intervention services. The evaluation must include: *( )*

**a.** Specific skills assessments for deficit areas identified through the eligibility assessment; ( )

**b.** Functional behavioral *analysis*; *( )*

**c.** Review of all assessments and relevant histories provided by the plan developer; and ( )

**d.** Clinical Opinion. Professional summary that interprets and integrates the results of the testing. This summary includes functional, developmentally appropriate recommendations to guide treatment. ( )

**04. Habilitative Intervention**. Habilitative intervention services must be consistent, aggressive, and continuous and are provided to improve a child's *functional skills* and *minimize* problem behavior. Services include individual or group behavioral interventions and skill development activity. Habilitative intervention must be based upon the well-known and widely regarded principles of evidence-based treatment. Evidence-based treatment (EBT) refers to the use of mental and behavioral health interventions for which systematic empirical research has provided evidence of statistically significant effectiveness as treatments for specific problems. As "promising practices" meet statistically significant effectiveness, they could be included as

approved approaches. ( )

**a.** Habilitative intervention must be provided to *meet the intervention needs of the participant by developing adaptive skills for all participants, and addressing maladaptive behaviors for participants who exhibit them.* ( )

i. When goals to address maladaptive behavior are identified on the plan of service, the intervention must include the development of replacement behavior rather than merely the elimination or suppression of maladaptive behavior that interferes with the child's overall general development, community, and social participation. ( )

ii. When goals to address skill development are identified on the plan of service, the intervention must provide for the acquisition of skills that are functional. ( )

**b.** Habilitative intervention must be provided in the participant's home or community setting, and in addition may be provided in a center-based setting. ( )

**c.** *Group intervention may be provided in the community and center.* When habilitative intervention is provided as group intervention, the following applies: ( )

i. There must be a minimum of one (1) qualified staff providing direct services for every three (3) participants. As the number and severity of the participants with functional impairments *or behavioral issues* increases, the staff participant ratio *must* be adjusted accordingly. ( )

ii. When group intervention is community-based, the child must be integrated in the community in a natural setting with typically developing peers. ( )

iii. Group intervention must be directly related to meeting the needs of the child, and be identified as an objective in accordance with a plan of service goal. ( )

**05. Therapeutic Consultation**. *Therapeutic consultation provides a higher level of expertise and experience to support participants who exhibit severe aggression, self-injury, and other dangerous behaviors.* Therapeutic consultation is provided when a participant receiving habilitative intervention has been assessed as requiring a more *advanced* level of training and assistance based on the participant's complex needs. A participant requires therapeutic consultation when interventions are not demonstrating outcomes and it is anticipated that a crisis event may occur without the consultation service. ( )

***a.*** The therapeutic consultant assists the habilitative interventionist by: ( )

*i.* Performing advanced assessments *as necessary*; ( )

*ii.* Developing and overseeing the implementation of a positive behavior support plan; ( )

*iii.* Monitoring the progress and coordinating the implementation of the *positive behavioral support* plan across environments; and ( )

iv. Providing consultation to other service providers and families. ( )

**b.** *Telehealth resources may be used by a therapeutic consultant to provide consultation as appropriate and necessary.* ( )

**c.** Therapeutic consultation providers are subject to the following limitations: ( )

i. Therapeutic consultation cannot be provided as a direct intervention service.( )

ii. Participants must be receiving habilitative intervention services prior to accessing therapeutic consultation, with the exception of crisis situations. ( )

iii. Therapeutic consultation is limited to *eighteen* (18) hours per year per participant. ( )

iv. Therapeutic consultation must be prior authorized by the Department. ( )

**06. Crisis Intervention**. Crisis intervention services provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience a psychological, behavioral, or emotional crisis. The need for crisis intervention must meet the definition of crisis in Section 681 of these rules. This service may provide training and staff development related to the needs of a participant, and also provides emergency back-up involving the direct support of the participant in crisis. *Children's crisis intervention services:* ( )

**a.** *Are* provided in the home *and community.* ( )

**b.** *Are* provided on a short-term basis typically not to exceed thirty (30) days. ( )

**c.** *Cannot exceed fourteen (14) days of out-of-home placement.* ( )

**d.** *M*ust be prior authorized by the Department. ( )

*i. Authorization for crisis intervention may be requested retroactively as a result of a crisis, defined in Section 681 of these rules, when no other means of support is available to the participant. In retroactive authorizations, the crisis intervention provider must submit a request for crisis intervention to the Department within seventy-two (72) hours of providing the service.* ( )

*ii. If staying in the home endangers the health and safety of the participant, the family, or both, the provider may request short-term out of home placement for the participant. Out of home placement must be prior authorized by the Department.* ( )

***e.*** *Must use positive behavior interventions prior to and in conjunction with the implementation of any restrictive intervention.* ( )

***f.*** *Telehealth resources may be used by a crisis interventionist to provide consultation*

*in a crisis situation.* ( )

**07. Family-Directed Community Supports**. *Families of p*articipants eligible for *the* children's *DD* waiver may choose to direct their individualized budget rather than receive the traditional services described in S*ub*section*s 683.01 through 683.06* of *this* rule *when the participant lives at home with the parent or legal guardian*. The requirements for selecting and participating in this option are outlined in IDAPA 16.03.13 "Consumer Directed Services." *Act Early Waiver participants do not have the option to choose the family-directed services path. The Act Early Waiver is intended to be a more structured program that requires increased involvement from families, and ensures children receive an intense amount of services based on evidence-based research.* ( )

**08. Service limitations**. Children's waiver services are subject to the following limitations: ( )

**a.** Place of Service Delivery. Waiver services may be provided in the participant's personal residence, community, or DDA. The following living situations are specifically excluded as a place of service for waiver services: ( )

i. Licensed skilled or intermediate care facilities, certified nursing facility (NF) or hospital; and ( )

ii. Licensed Intermediate Care Facility for persons with Intellectual Disabilities (ICF/ID); and ( )

iii. Residential Care or Assisted Living Facility; ( )

iv. Additional limitations to specific services are listed under that service definition. ( )

**b.** *According to 42 CFR 440.180,* Medicaid Waiver services cannot be used to pay for special education and related services that are included in a child's Individual Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA)*, that are otherwise available through a local educational agency.* ( )

**c.** Children's waiver services are *limited by* the participant's individualized budget *amount*, excluding crisis intervention. ( )

**d.** For the children's waiver services listed in Subsections 683.01 through 683.07 of these rules, the following are excluded for Medicaid payment: ( )

i. Vocational services; ( )

ii. Educational services; and ( )

iii. Recreational services. ( )

## 684. CHILDREN'S WAIVER SERVICES: PROCEDURAL REQUIREMENTS.

**01. Authorization of Services on a Written Plan**. All children's waiver services must be identified on the plan of service and authorized by the Department. The plan of service must be reviewed by a plan developer at least every six (6) months or at a frequency determined by the family-centered planning team. ( )

**02. General Requirements for Program Documentation**. Children's waiver providers 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. For each participant the following program documentation is required: ( )

**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: ( )

i. Date and time of visit; and ( )

ii. Services provided during the visit; and ( )

iii. A statement of the participant's response to the service, including any changes in the participant's condition; and ( )

iv. Length of visit, including time in and time out; and ( )

v. Specific place of service. ( )

**b.** A copy of the above information will be maintained by the independent provider or DDA. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. ( )

**03. Program Implementation Plan Requirements**. For each participant receiving intervention *and family training* services, the DDA must develop a program implementation plan to determine objectives to be included on the participant's required plan of service. *( )*

***a.*** All program implementation plan objectives must be related to a goal on the participant's plan of service. *( )*

***b.*** The program implementation plan must be written, implemented, *and submitted to the plan developer* within fourteen (14) days after the first day of ongoing programming and be revised whenever participant needs change. If the *program implementation* plan is not completed within this time frame, the participant's records must contain participant-based documentation justifying the delay. *( )*

***c.*** The program implementation plan must *be completed by the habilitative interventionist, and must* include the following requirements: *( )*

*i.* The participant's name. *( )*

*ii.* A baseline *statement.* *( )*

*iii.* Measurable, behaviorally-stated objectives that correspond to those goals or objectives previously identified on the required plan of service. *( )*

*iv.* Written instructions *to the staff that* may include curriculum, interventions, task analyses, activity schedules, type and frequency of reinforcement and data collection including probe, directed at the achievement of each objective. These instructions must be individualized and revised as necessary to promote participant progress toward the stated objective. *( )*

*v.* Identification of the type of environment(s) and specific location(s) where services will be provided. *( )*

*vi.* *A description of the evidence-based treatment approach used for the service provided.* *( )*

*vii.* *When the child has a current positive behavior support plan, it must be incorporated into the program implementation plan.* *( )*

*viii.* *When interdisciplinary training is provided, identification of the type of interdisciplinary training and the objectives related to the training must be included on the program implementation plan.* *( )*

*ix.* Target date for completion, *not to exceed one (1) year.* *( )*

*x.* The program implementation plan must be reviewed and approved by the DDA clinical supervisor*, as indicated by signature, credential, and date on the plan*. *( )*

**04.** **Reporting Requirements**. The *clinical supervisor* must complete*, at a minimum,* six- (6) month and annual *provider status* reviews for *habilitative intervention and family training* services provided. *These provider status reviews must be completed more frequently when so required on the plan of service.* *( )*

***a.*** Documentation of the six (6) month and annual reviews must be submitted to the plan developer. *( )*

***b.*** *The provider must use Department-approved forms for provider status reviews.* *( )*

**05.** **Provider Responsibility for Notification**. It is the responsibility of the service provider to notify the plan developer when any significant changes in the participant's condition, *as defined by the family-centered planning team,* are noted during service delivery. Such notification will be documented in the service record. *( )*

**06.** **Records Maintenance**. 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. ( )

**685. CHILDREN'S WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.**

**01. Family Training**. Providers of family training must meet the requirements *for h*abilitative intervention provider*s* defined in Subsection*s* 685.03 *and 685.04* of th*is* rule. ( )

**02. Interdisciplinary Training**. Providers of interdisciplinary training must meet the following requirements: ( )

**a.** Occupational Therapist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; ( )

**b.** Physical Therapist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; ( )

**c.** Speech-Language Pathologist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; ( )

**d.** Practitioner *of the healing arts*; ( )

***e.*** Habilitative intervention provider as defined in Subsections 685.03 *and 685.04* of th*is* rule; *or* ( )

***f.*** Therapeutic consultation provider as defined in Subsection 685.05 of th*is* rule. ( )

**03. Habilitative Intervention**. Habilitative intervention must be provided by a DDA certified to provide both support and intervention services under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," and is capable of supervising the direct services provided. Providers of habilitative intervention must meet the following minimum qualifications: ( )

**a.** Must hold at least a bachelor's degree in a human services field from a nationally-accredited university or college; ( )

**b.** Must be able to provide documentation of one (1) year's supervised experience working with children with developmental disabilities. Experience must be gained through paid employment or university practicum experience or internship; ( )

**c.** Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide habilitative intervention; *or* ( )

***d.*** Individuals *working* as Developmental Specialists for children age birth through three (3) or three (3) through 17, and individuals certified as Intensive Behavioral Intervention *professionals* prior to July 1, 2011, are qualified to provide habilitative intervention until June 30,

2013. *T*he individual must meet the requirements of the Department-approved competency coursework *by June 30, 2013 to maintain his certification.* *(    )*

***04. Habilitative Intervention for Children Birth to Three****. In addition to the habilitative intervention qualifications listed in Subsections 685.04.a. through d. of this rule, habilitative intervention staff serving infants and toddlers from birth to three (3) years of age must have a minimum of two hundred forty (240) hours of professionally-supervised experience with young children who have developmental disabilities and one (1) of the following:* *(    )*

***a.*** *An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education; or* *(    )*

***b.*** *A Blended Early Childhood/Early Childhood Special Education (EC/ECSE) Certificate; or* *(    )*

***c.*** *A bachelor's or master's degree in special education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, or nursing plus a minimum of twenty-four (24) semester credits in Early Childhood/Early Childhood Special Education (EC/ ECSE) from an accredited college or university. Courses taken must appear on college or university transcripts and must cover the following standards in their content:* *(    )*

*i. Promotion of development and learning for children from birth to three (3) years;* *(    )*

*ii. Assessment and observation methods for developmentally appropriate assessment of young children;* *(    )*

*iii. Building family and community relationships to support early interventions;* *(    )*

*iv. Development of appropriate curriculum for young children, including IFSP and IEP development;* *(    )*

*v. Implementation of instructional and developmentally effective approaches for early learning, including strategies for children who are medically fragile and their families; and* *(    )*

*vi. Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development.* *(    )*

***d.*** *Electives closely related to the content under Subsection 685.04.c.iii. of this rule may be approved by the Department with a recommendation from an institution of higher education.* *(    )*

***e.*** *Developmental specialists who possess a bachelor's or master's degree listed above under Subsection 685.04.c.ii. of this rule, have completed a minimum of twenty (20) semester credits in EC/ECSE, and with Department approval are serving children under three (3)*

*years of age as of July 1, 2005, will be allowed to continue providing services in accordance with their approved, conditional hiring agreement.* ( )

*f.* *When the Department in its role as lead agency for implementation of Part C of the Individuals with Disabilities Education Act (IDEA) has determined that there is a shortage of such qualified personnel to meet service needs in a specific geographic area:* ( )

*i.* *The Department may approve the most qualified individuals who are demonstrating satisfactory progress toward completion of applicable course work in accordance with the individual's approved plan to meet the required standard within three (3) years of being hired.* ( )

*ii.* *Satisfactory progress will be determined on an annual review by the Department.* ( )

*iii.* *Individuals who have an approved plan for completion of twenty (20) semester credits in EC/ECSE prior to July 1, 2005, will be allowed to continue providing services so long as they demonstrate satisfactory progress on the plan and complete the requirements on the plan within three (3) years of their date of hire.* ( )

**05.** **Therapeutic Consultation**. Therapeutic consultation may be provided by a DDA certified to provide both supports and intervention services under IDAPA 16.03.21, "Developmental Disabilities Services (DDA)," or by an independent Medicaid provider under agreement with the Department. Providers of therapeutic consultation must meet the following minimum qualifications: ( )

**a.** Doctoral or Master's degree in psychology, education, applied behavioral analysis, or have a related discipline with one thousand five hundred (1500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, or behavior analysis (may be included as part of degree program); and ( )

**b.** Two (2) years relevant experience in designing and implementing comprehensive behavioral therapies for children with DD and challenging behavior. ( )

**c.** Therapeutic consultation providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

***d.*** *Therapeutic consultation providers employed by a DDA must be certified in CPR and first aid in accordance with the general training requirements under IDAPA 16.03.21 "Developmental Disabilities Services (DDA)." Independent therapeutic consultation providers must be certified in CPR and first aid prior to delivering services, and must maintain current certification thereafter.* ( )

**06.** **Crisis Intervention**. Crisis intervention may be provided by a DDA certified to provide support and intervention services under IDAPA 16.03.21, "Developmental Disabilities Services (DDA)," or by an independent Medicaid provider under agreement with the Department.

Providers of crisis intervention must meet the following minimum qualifications: ( )

**a.** *Crisis Intervention professionals must meet the minimum therapeutic consultation provider qualifications described in Subsection 685.04 of this rule.* ( )

***b.*** Emergency intervention technician providers must meet the minimum habilitative support provider qualifications described under S*ubs*ection 665.*02* of these rules. ( )

***c.*** Crisis intervention providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

***07.*** ***Continuing Training Requirements for Professionals****. Each professional providing waiver services must complete at least twelve (12) hours of yearly training, six (6) hours of which must cover behavior methodology or interventions shown to be effective. If the individual has not completed the required training during any yearly training period, he may not provide waiver services beginning with the anniversary date of the following period, and thereafter, until the required number of training hours have accumulated. As training hours accumulate, they will be accounted first to any training-deficient prior yearly period before being applied to the current annual training period. Training hours may not be earned in a current annual training period to be applied to a future training period.* ( )

**0*8*.** ***Requirements for Clinical* Supervision**. *All DDA services must be provided under the supervision of a clinical supervisor. The clinical supervisor must meet the qualifications to provide habilitative intervention as defined in this rule. Clinical supervisor(s) are professionals employed by a DDA on a continuous and regularly scheduled basis.* ( )

***a.*** *The clinical supervisor is responsible for the oversight and supervision of service and support elements of the agency, including face-to-face supervision of agency staff providing direct services.* ( )

***b.*** *The clinical supervisor must observe and review the direct services performed by all paraprofessional and professional staff on a monthly basis, or more often as necessary, to ensure staff demonstrate the necessary skills to correctly provide the services and support.* ( )

***c.*** *Each DDA must employ an adequate number of clinical supervisors to ensure quality service delivery and participant satisfaction.* ( )

**0*9*.** **Requirements for Collaboration with Other Providers**. Providers of waiver services must coordinate with the family-centered planning team as specified on the plan of service. When a participant has had a psychological or psychiatric assessment, the results of the psychological or psychiatric assessment must be used when developing objectives to ensure therapies provided in the DDA accommodate the participant's mental health needs and to ensure that none of the therapeutic methods are contra-indicated or delivered in a manner that presents a risk to the participant's mental health status. ( )

***10.*** **Requirements for Quality Assurance**. Providers of children's waiver services must demonstrate high quality of services, *including treatment fidelity,* through an internal quality

assurance review process. ( )

***11.*** **DDA Services**. In order for a DDA to provide waiver services, the DDA must be certified to provide both support and intervention services. Each DDA is required to provide habilitative supports. When a DDA opts to provide habilitative intervention services, the DDA must also provide habilitative supports and family training. ( )

**686. CHILDREN'S WAIVER SERVICES: PROVIDER REIMBURSEMENT.**

**01.** ***Reimbursement***. *The statewide reimbursement rate for children's HCBS state plan option services listed in Subsections 683.01 through 683.06 of these rules was derived by using Bureau of Labor Statistics mean wage for the direct care staff providing the service, adjusted for employment-related expenditures, program-related costs, and general and administrative costs based on a cost survey as described in Subsection 686.02 of this rule. Reimbursement rates are set at a percentage of the statewide target reimbursement rate. The Department will take into consideration the factors of efficiency, economy, quality of care, and access to care when determining rates.* ( )

***02.*** ***Cost Survey***. *The Department will conduct a cost survey every five (5) years from a statistically appropriate number of provider association representatives in order to obtain cost data for employment-related expenditures, program-related costs, and general and administrative costs.* ( )

**0*3*.** **Claim Forms**. Provider claims for payment will be submitted on claim forms provided by or approved by the Department. Billing instructions will be provided by the Department. ( )

**0*4*.** **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. ( )

**687. -- 699. (RESERVED).**

**ADULTS WITH DEVELOPMENTAL DISABILITIES WAIVER SERVICES**
**(Sections 700 through 719)**

**700. ~~*INDIVIDUALS*~~ ADULTS WITH DEVELOPMENTAL DISABILITIES WAIVER SERVICES.**

Under 42 CFR Section 440.180, it is the intention of the Department to provide waiver services to eligible adult participants to prevent unnecessary institutional placement, provide for the greatest degree of independence possible, enhance the quality of life, encourage individual choice, and achieve and maintain community integration. For an adult participant to be eligible, the Department must find that the participant requires services due to a developmental disability that impairs 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/ID. ~~*(3-29-10)*~~( )

**701. (RESERVED).**

**702. ADULT DD WAIVER SERVICES: ELIGIBILITY.**

Waiver eligibility will be determined by the Department as described in Section 509 of these rules. The participant must be financially eligible for Medical Assistance as described in 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: (3-29-10)

**01. Age of Participants**. DD waiver participants must be eighteen (18) years of age or older. (3-29-10)

**02. Eligibility Determinations**. The Department must determine that: (3-19-07)

**a.** The participant would qualify for ICF/ID 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/ID 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 DD may elect not to utilize waiver services but may choose admission to an ICF/ID. (3-29-10)

**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/ID, 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 of each new waiver year. (3-29-10)

**703. ADULT DD 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 16.0~~4~~3.~~1~~21, "Developmental Disabilities Agencies (DDA)." ~~(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 16.0~~4~~3.~~1~~21, "Developmental Disabilities Agencies (DDA)." ~~(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 Intellectual Disabilities (ICF/ID); 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. ADULT DD WAIVER SERVICES: PROCEDURAL REQUIREMENTS.

**01. Authorization of Services on a Written Plan**. All waiver services must be identified on the plan of service and authorized by the process described in 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. ADULT DD WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.**

All providers of waiver services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (3-19-07)

**01. Residential Habilitation**. 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 Intellectual Disabilities Professional (QIDP) 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 Subsection 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 Intellectual Disabilities Professional (QIDP). (3-19-07)

**e.** Emergency back-up providers must meet the minimum residential habilitation provider qualifications described under IDAPA 16.04.17, "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. ADULT DD 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)

# IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

## 16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

## DOCKET NO. 16-0310-1003

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

**AUTHORITY:** In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, Idaho Code; also House Bills 701 and 708 passed by the 2010 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. These rule changes implement legislative intent language in House Bills 701 and 708 passed by the 2010 Legislature regarding nursing facilities. The complete text of the proposed rule was published in the** September 1, 2010, Idaho Administrative Bulletin, Vol. 10-9, pages 263 through 272.

**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:

**Changes related to House Bill 701 will result in a reduction of $193,000 to the state general fund. The total cost reduction is $965,000 for state and federal funds combined.**

**Changes related to House Bill 708 will result in a cost reduction of $1.09 million to the state general fund. Total cost reduction is $5.4 million for state and federal funds combined. This cost reduction has already been incorporated into the Division of Medicaid's 2011 appropriation.**

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning this pending rule, contact Robert Kellerman at (208) 364-1994.

DATED this 24th day of November, 2010.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
P.O. Box 83720, Boise, ID 83720-0036
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***THIS NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE***

**EFFECTIVE DATE:** The effective date of the temporary rule is **July 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(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code; also House Bills 701 and 708 passed by the 2010 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 September 15, 2010.

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:

**Rule changes are being made in these rules to implement the legislative intent in House Bills 701 and 708 passed by the 2010 legislature. Rule changes for this docket include:**

1. **Clarification of nursing facility coverage and limitations;**
2. **Nursing facility inflation freeze;**
3. **Nursing facility efficiency incentive;**
4. **Nursing facility special rate payment offset clarification; and**
5. **Incentive changes for Intermediate Care Facilities for the Mentally Retarded (ICF/MR).**

**TEMPORARY RULE JUSTIFICATION:** Pursuant to Section 67-5226(1)(b), Idaho Code:

**The Governor has found that temporary adoption of the rule is appropriate in order to comply with deadlines in amendments to governing law or federal programs.**

**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:

**Changes related to House Bill 701 will result in a reduction of $193,000 to the state general fund (cost reduction of $965,000 in total funds (state and federal combined)).**

**Changes related to House Bill 708 will result in a cost reduction of $1.09 million to the state general fund (cost reduction of $5.4 million in total funds (state and federal combined)).**

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the changes are being made to implement the legislative intent in H0701 and H0708 passed by the 2010 legislature.

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

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the temporary and proposed rule, contact 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 September 22, 2010.

DATED this 13th day of August, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-1003***

**039. ACCOUNTING TREATMENT.**
Generally accepted accounting principles, concepts, and definitions will be used except as otherwise specified. Where alternative treatments are available under GAAP, the acceptable treatment will be the one that most clearly attains program objectives. (3-19-07)

**01. Final Payment**. A final settlement will be made based on the reasonable cost of services as determined by audit, limited in accordance with other sections of this chapter. ~~*In addition, an efficiency incentive will be allowed to low cost providers in accordance with the provisions of Section 296 of these rules.*~~ ~~*(3-19-07)*~~( )

**02. Overpayments**. As a matter of policy, recovery of overpayments will be attempted as quickly as possible consistent with the financial integrity of the provider. (3-19-07)

**03. Other Actions**. Generally, overpayment will result in two (2) circumstances: (3-19-07)

**a.** If the cost report is not filed, the sum of the following will be due: (3-19-07)

i. All payments included in the period covered by the missing report(s). (3-19-07)

ii. All subsequent payments. (3-19-07)

**b.** Excessive reimbursement or non-covered services may precipitate immediate audit and settlement for the period(s) in question. Where such a determination is made, it may be necessary that the interim reimbursement rate (IRR) will be reduced. This reduction will be designated to effect at least one (1) of the following: (3-19-07)

i. Discontinuance of overpayments (on an interim basis). (3-19-07)

ii. Recovery of overpayments. (3-19-07)

***(BREAK IN CONTINUITY OF SECTIONS)***

**225. NURSING FACILITY: COVERAGE AND LIMITATIONS.**
An institution must provide, on a regular basis, health-related care and services to individuals; who because of their mental or physical condition require care and services above the level of room, board, and supervision. (3-19-07)

**01. Nursing Facility Care**. The minimum content of care and services for nursing facility patients must include the following: (3-19-07)

**a.** Room and board; (3-19-07)

**b.** Bed and bathroom linens; (3-19-07)

**c.** Nursing care, including special feeding if needed; (3-19-07)

**d.** Personal services; (3-19-07)

**e.** Supervision as required by the nature of the patient's illness and duration of his stay in the nursing facility; ~~(3-19-07)~~(____)

**f.** Special diets as prescribed by a patient's physician; (3-19-07)

**g.** All common medicine chest supplies ~~which do not require a physician's prescription~~ that are over-the-counter including ~~but not limited to~~ mouthwashes, analgesics, laxatives, emollients, burn ointments, first aid cream, protective creams and liquids, cough and cold preparations, and simple eye preparations; ~~(3-19-07)~~(____)

**h.** Dressings; (3-19-07)

**i.** Administration of intravenous, subcutaneous, or intramuscular injections and

infusions, enemas, catheters, bladder irrigations, and oxygen; (3-19-07)

**j.** Application or administration of all drugs; (3-19-07)

**k.** All medical supplies including but not limited to gauzes, bandages, tapes, compresses, cottons, sponges, hot water bags, ice bags, disposable syringes, thermometers, cellucotton, incontinent supplies, or any other type of pads used to save labor or linen, and disposable gloves; ~~(3-19-07)~~(    )

**l.** Social and recreational activities; and (3-19-07)

**m.** Each ~~I~~items ~~which are~~ that is utilized by individual patients ~~but which are~~ and is reusable and expected to be available, such as bed rails, canes, crutches, walkers, wheel chairs, traction equipment, and other durable medical equipment. ~~(3-19-07)~~(    )

**02. Skilled Services**. Skilled services include services which could qualify as either skilled nursing or skilled rehabilitative services, which include: (3-19-07)

**a.** Overall management and evaluation of the care plan. The development, management, and evaluation of a resident's care plan, based on the physician's orders, constitute skilled services when, in terms of the patient's physical or mental condition, such development, management, and evaluation necessitate the involvement of technical or professional personnel to meet his needs, promote his recovery, and assure his medical safety. This would include the management of a plan involving only a variety of personal care services where, in light of the patient's condition, the aggregate of such services necessitates the involvement of technical or professional personnel. Where the patient's overall condition would support a finding that his recovery and safety could be assured only if the total care he requires is planned, managed, and evaluated by technical or professional personnel, it would be appropriate to infer that skilled services are being provided. (3-19-07)

**b.** Observation and assessment of the resident's changing condition. When the resident's condition is such that the skills of a licensed nurse or other technical or professional person are required to identify and evaluate the patient's need for possible modification of treatment and the initiation of additional medical procedures until his condition is stabilized, such services constitute skilled services. (3-19-07)

**03. Direct Skilled Nursing Services**. Direct skilled nursing services include the following: (3-19-07)

**a.** Intravenous injections; intravenous feedings; intramuscular or subcutaneous injection required on more than one (1) shift; (3-19-07)

**b.** Nasopharyngeal feedings; (3-19-07)

**c.** Nasopharyngeal and tracheotomy aspiration; (3-19-07)

**d.** Insertion and sterile irrigation and replacement of catheters; (3-19-07)

**e.** Application of dressings involving prescription medications or aseptic techniques; (3-19-07)

**f.** Treatment of extensive decubitus ulcers or other widespread skin disorders; (3-19-07)

**g.** Heat treatments which have been specifically ordered by a physician as part of treatment and which require observation by nurses to adequately evaluate the resident's progress; and (3-19-07)

**h.** Initial phases of a regimen involving administration of oxygen. (3-19-07)

**04. Direct Skilled Rehabilitative Services**. Direct skilled rehabilitative services include the following: (3-19-07)

**a.** Ongoing assessment of rehabilitation needs and potential, services concurrent with the management of a resident's care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders; (3-19-07)

**b.** Therapeutic exercises or activities which, because of the type of exercises employed or the condition of the resident, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the resident and the effectiveness of the treatment; (3-19-07)

**c.** Gait evaluation and training furnished by a physical or occupational therapist to restore function in a resident whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality; and (3-19-07)

**d.** Ultrasound, short-wave, and microwave therapy treatments by a licensed physical therapist. (3-19-07)

**05. Other Treatment and Modalities.** Other treatment and modalities which include hot pack, hydroculator, infrared treatments, paraffin baths, and whirlpool, in cases where the resident's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications, and the skills, knowledge, and judgement of a licensed physical therapist are required. (3-19-07)

## *(BREAK IN CONTINUITY OF SECTIONS)*

### 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 fifty percent (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. (3-29-10)*~~

**0~~7~~6. 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)

**0~~8~~7. Property Reimbursement**. The property reimbursement component is calculated in accordance with Section 275 and Subsection 240.19 of these rules. (3-19-07)

**0~~9~~8. 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)

***(BREAK IN CONTINUITY OF SECTIONS)***

**270. NURSING FACILITY: SPECIAL RATES.**

A special rate consists of a facility's daily reimbursement rate for a patient plus an add-on amount. Section 56-117, Idaho Code, provides authority for the Department to pay facilities an amount in addition to the daily rate when a patient has needs that are beyond the scope of facility services and when the cost of providing for those additional needs is not adequately reflected in the rates calculated pursuant to the principles found in Section 56-102, Idaho Code. This special rate add-on amount for such specialized care is in addition to any payments made in accordance with other provisions of this chapter and is excluded from the computation of payments or rates under other provisions of Section 56-102, Idaho Code, and these rules. (3-19-07)

**01. Determination**. The Department determines to approve a special rate on a patient-by-patient basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid source. A special rate request must be based on an identified condition that will continue for a period greater than ~~*two*~~ thirty (~~2~~30) ~~*weeks*~~ days. ~~*(3-19-07)*~~( )

**02. Effective Date**. Upon approval, a special rate is effective on the date the application was received~~*, unless the provider requests a retroactive effective date. Special rates*~~

~~*may be retroactive for up to thirty (30) days prior to receipt of the application*~~. ~~*(3-19-07)*~~(____)

**03. Reporting**. Costs equivalent to "grossed up" payments for special rate add-on amounts must be removed from the cost components subject to limits, and be reported separately by the provider. The grossed up amount is determined by dividing the Medicaid incremental revenue by Medicaid days and multiplying the result by total patient days. ~~*(3-19-07)*~~(____)

**04. Limitation**. A special rate cannot exceed the provider's charges to other patients for similar services. (3-19-07)

**05. Prospective Rate Treatment**. Prospective treatment of special rates became effective July 1, 2000. Subsections 270.06 and 270.07 of these rules provide clarification of how special rates are paid under the prospective payment system. (3-19-07)

**06. Determination of Payment for Qualifying Residents**. Special rate add-on amounts are calculated using one (1) of the methods described in Subsections 270.06.a. through 270.06.e. of these rules. (3-19-07)

**a.** Special Care Units. If a facility operates a special care unit, such as a behavioral unit or a Traumatic Brain Injury (TBI) unit, reimbursement is determined as described in Subsections 270.06.a.i. through 270.06.a.v. of these rules. (3-19-07)

i. If the facility is below the direct care cost limit with special care unit costs included, no special rate is paid for the unit. (3-19-07)

ii. If the facility is over the direct care cost limit with special care unit costs included, a special rate add-on amount will be calculated. The special rate add-on amount for the unit is the lesser of the per diem amount by which direct care costs exceed the limit or a calculated add-on amount. The calculated special rate add-on is derived as follows: each Medicaid resident is assigned a total rate equal to the Medicare rate that would be paid if the resident were Medicare eligible. The resident's acuity adjusted Medicaid rate, based on each resident's individual Medicaid CMI, is subtracted from the Medicare rate. The average difference between the Medicaid and the Medicare rates for all special care unit residents is the calculated special rate add-on amount. The calculated special rate add-on amount is compared to the per diem amount by which the provider exceeds the direct care limit. The lesser of these two amounts is allowed as the special rate add-on amount for the unit. (3-19-07)

iii. New Unit Added After July 1, 2000. The Department must approve special rates for new special care units or increases to the number of licensed beds in an existing special care unit. Since a new unit will not have the cost history of an existing unit, the provider's relationship to the cap will not be considered in qualifying for a special rate. New units approved for special rates will have their special add-on amount calculated as the difference between the applicable Medicare price under PPS, and the acuity adjusted Medicaid rate for all unit residents as explained in Section 311.06.a.iii. of these rules. However, the average of these amounts is not limited to the amount the provider is over the direct care cost limit, as the costs of the unit are not in the rate calculation. (3-19-07)

iv. One Hundred Percent (100%) Special Care Facility Existing July 1, 2000. If on

July 1, 2000, an entire facility was a special care unit which included Medicaid residents, the facility's direct care cost per diem will not be subject to the direct care cost limit. However, the direct care costs are case mix adjusted based on the ratio of the facility's Medicaid CMI for the rate period to the facility-wide CMI for the cost reporting period. (3-19-07)

v. Unit Routine Customary Charge. If the cost to operate a special care unit is being included in a facility's rate calculation process, the facility must report its usual and customary charge for a semi-private room in the unit on the quarterly reporting form, in addition to the semi-private daily room rate for the general nursing home population. A weighted average routine customary charge is computed to represent the composite of all Medicaid residents in the facility based on the type of rooms they occupy, including the unit. (3-19-07)

**b.** Equipment and Non-Therapy Supplies. Equipment and non-therapy supplies not addressed in Section 225 of these rules or adequately addressed in the current RUG system, as determined by the Department, are reimbursed ~~*at invoice cost*~~ in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 755, as an add-on amount. ~~*(3-19-07)*~~(______)

**c.** Ventilator Dependent Residents and Residents Receiving Tracheostomy Care. The facility need not exceed the direct care limit to receive a special rate for ventilator care and tracheostomy care. In the case of ventilator dependent and tracheostomy residents, a two (2) step approach is taken to establish an add-on amount. The first step is the calculation of a staffing add-on for the cost, if any, of additional direct care staff required to meet the exceptional needs of these residents that is higher than the amount indicated on the resident's most recent Medicaid RUG score. The add-on is calculated following the provisions in Subsection 270.06.d. of ~~*these*~~ this rule~~*s*~~, adjusted for the appropriate skill level of care staff. The second step is the calculation of an add-on for equipment~~*, supplies, or both up to the invoice cost or rental amount*~~ and non-therapy supplies following the provision in Subsection 270.06.b. of this rule. The combined amount of these two (2) components is considered the special add-on amount to the facility's rate for approved residents receiving this care. ~~*(3-19-07)*~~(______)

**d.** Residents Not Residing in a Special Care Unit Requiring One-to-One Staffing Ratios. Facilities may at times have residents who require unusual levels of staffing, such as one-to-one staffing ratios to meet the exceptional needs of that resident. If the staffing level is higher than the amount indicated on the resident's most recent Medicaid RUG score, the facility may request a special rate. If the resident qualifies for a special rate for additional direct care staff required to meet the exceptional needs of that resident, an hourly add-on rate is computed for reimbursement of approved one-to-one (1 to 1) hours in excess of the minimum staffing requirements in effect for the period. The hourly add-on rate is equal to the current WAHR CNA wage rate plus a benefits allowance ~~*of thirty percent (30%)*~~ based on annual cost report data, then weighted to remove the CNA Minimum daily staffing time. ~~*(3-19-07)*~~(______)

~~***e.*** *Varying Levels of One-to-One Care. For varying levels of one-to-one care, such as eight (8) hours or twenty-four (24) hours, the total special rate add-on amount is calculated as the number of hours approved for one- to-one care times the hourly add-on rate as described in Subsection 270.06.d. The WAHR CNA wage rate as described in Section 307 of these rules will be updated prior to the July 1st rate setting each year. Should the WAHR survey be discontinued, the Department may index prior amounts forward, or conduct a comparable survey.* *(3-19-07)*~~

**07. Treatment of the Special Rate Cost for Future Rate Setting Periods**. Special rates are established on a prospective basis similar to the overall facility rate. When the cost report used to set a prospective rate contains non-unit special rate cost, an adjustment is made to "offset," or reduce costs by an amount equal to total "grossed up" incremental revenues, or add-on payments received by the provider during the cost reporting period. The amount received is calculated by multiplying the special rate add-on amount paid for each qualifying resident by the number of days that were paid. This calculated Medicaid amount will be grossed up by dividing the Medicaid incremental revenue by Medicaid days and multiplying the result by total patient days. No related adjustment is made to the facility's CMIs. ~~*(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/ID, and establish the weighted average hourly rates (WAHR) for nursing facility industry employees in comparable positions (i.e. RN, QMRP, certified and non-certified nurse's aides) in Idaho to be used in calculating the reimbursement rate to be effective on July 1st of that year. (3-29-10)

**04. Payment for Personal Assistance Agency**. ( )

**a.** The Department will establish Personal Assistance Agency rates for personal assistance services 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:*~~ in accordance with Section 39-5606, Idaho Code. For State Fiscal Year 2011, this rate will only be adjusted if the prevailing hourly rate for comparable positions is less than the rate paid during State Fiscal Year 2010.

| Personal Assistance Agencies | WAHR x ~~*1.55*~~ supplemental component | = | $ amount/hour |
|---|---|---|---|

~~(3-29-10)~~( )

**b.** Beginning with State Fiscal Year 2011, every five (5) years the Department will conduct a survey of all Personal Assistance Agencies which requests the number of hours of all Direct Care Staff and the costs involved for all travel, administration, training, and all payroll taxes and fringe benefits. Based on the survey conducted, the Department will calculate a supplemental component using costs reported for travel, administration, training, and all payroll taxes and fringe benefits. The survey data is the cost information collected during the prior State Fiscal Year. ( )

**c.** Based on the survey conducted, provided that at least eighty-five percent (85%) of all Personal Assistance Agencies respond, the Department will calculate a supplemental component using costs reported for travel, administration, training, and all payroll taxes and fringe benefits. The survey data is the cost information collected during the prior State Fiscal Year. If less than eighty-five percent (85%) of all Personal Assistance Agencies respond, the rate will remain at the WAHR rate without the supplemental component. ( )

**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, intellectual disability, or Alzheimer's disease. If an individual is assessed as Level III with a diagnosis of mental illness, intellectual disability, or Alzheimer's disease the provider reimbursement rate will be the higher amount as described in Subsection 307.05.c. of these rules. (3-19-07)

**06. Attending Physician Reimbursement Level**. The attending physician or authorized provider will be 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:~~ in accordance with Section 39-5606, Idaho Code. Beginning with State Fiscal Year 2011, every five (5) years the Department will conduct a survey of all Personal Assistance Agency's which requests the number of hours of all Direct Care Staff and the indirect costs involved such as administration, and training. Based on the survey conducted, the Department will calculate a supplemental component using costs reported for administration, and training. The survey data is the cost information collected during the prior State Fiscal Year.

| PCS Family Alternate Care Home | Children's PCS Assessment Weekly Hours x (WAHR x (~~1.55 minus payroll taxes and fringe benefits cost percentage~~ supplemental component) | = | $ amount/week |
|---|---|---|---|

~~(3-29-10)~~(____)

***(BREAK IN CONTINUITY OF SECTIONS)***

**625. ~~*ICF/ID - EFFICIENCY INCREMENT*~~ (RESERVED).**
~~*An efficiency increment will be included as a component of the prospective rate, or retrospective settlement if the allowable capped per diem costs are less than the cap.*~~ ~~*(3-19-07)*~~

~~***01.*** ***Computing Efficiency Increment****. The efficiency increment will be computed by subtracting the projected or, for facilities subject to retrospective settlement the actual allowable per diem costs incurred by the provider, from the applicable cap. This difference will be divided by five (5). The allowable increment is twenty cents ($.20) per one dollar ($1) below the cap up to a maximum increment of three dollars ($3) per participant day.*~~
~~*(7-1-97)*~~

~~***02.*** ***Determining Reimbursement****. Total reimbursement determined by adding amounts determined to be allowable, will not exceed the provider's usual and customary charges for these services as computed in accordance with this chapter and PRM. In computing participant days for the purpose of determining per diem costs, in those cases where the Medicaid Program or the participant is making payment for holding a bed in the facility, the participant will not be considered to be discharged and thus those days will be counted in the total.*~~ ~~*(3-19-07)*~~

# IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

## 16.03.13 - CONSUMER-DIRECTED SERVICES

## DOCKET NO. 16-0313-1002

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 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. The effective date for this chapter of rules is July 1, 2011.

**AUTHORITY:** In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, Idaho Code.

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

**The proposed rules for the redesign of children's developmental disabilities benefits included options for children. Changes are being made in the pending rule to stipulate decision-making responsibilities for children, and the definition of participant was amended. 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 1, 2010, Idaho Administrative Bulletin, Vol. 10-9, pages 277 through 291**.**

**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 is cost neutral, because the individualized budgets and limitations for participants are being based on historical costs of developmental disabilities agency (DDA) services for children.**

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning the pending rule, contact Lauren Ertz at (208) 287-1169.

DATED this 12th day of November, 2010.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
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(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 56-202, 56-203, and 56-250 through 257, Idaho Code.

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

| Wednesday, September 15, 2010<br>6:00 p.m. PDT | Wednesday, September 15, 2010<br>6:00 p.m. MDT | Wednesday, September 15, 2010<br>6:00 p.m. MDT |
|---|---|---|
| Dept. of Health & Welfare-Reg. 1<br>1120 Ironwood Drive, Suite 102<br>Lower Level Large Conf. Rm.<br>Coeur d'Alene, ID | Dept. of Health & Welfare-Reg. 4<br>1720 Westgate Drive<br>Suite A, Room 131<br>Boise, ID | Dept. Health & Welfare-Reg. 7<br>150 Shoup Avenue<br>2nd Floor, Large Conf. Rm.<br>Idaho Falls, 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:

**These proposed rules for the redesign of children's developmental disabilities benefits include a Family-Directed Services (FDS) option as part of Home and Community Based Services (HCBS) waivers for children and a related State Plan option. This option is very similar to the Consumer-Directed (CD) option available under the Adult DD Waiver program. Changes are being made to this chapter to incorporate the new FDS option and to update the definitions section.**

**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 is cost neutral, because the individualized budgets and limitations for participants are being based on historical costs of developmental disabilities agency (DDA) services for children.

**NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, informal negotiated rulemaking was conducted with stakeholders in a meeting held on Wednesday,**

**July 14, 2010. The notice for this negotiated rulemaking published in the** July 7, 2010, Idaho Administrative Bulletin, Vol. 10-7, p. 27.

**INCORPORATION BY REFERENCE:** No materials are being incorporated by reference into these rules under this docket.

**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 September 22, 2010.

DATED this 11th day of August, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0313-1002***

**001. TITLE AND SCOPE.**

**01. Title**. The title of these rules is IDAPA 16.03.13, "Consumer-Directed Services." (3-29-10)

**02. Scope**. ~~*Self*~~Consumer-Directed Community Supports (~~*S*~~CDCS) is a flexible program option for participants eligible for the Children's Home and Community Based Services ~~*- Developmental Disabilities*~~ (HCBS~~*-DD*~~) State Plan Option, and Adult and Children's Developmental Disabilities (DD) waivers. CDCS is not a covered option for participants enrolled in the Children's Act Early Waiver. The ~~*S*~~CDCS 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)***

**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. Consumer-Directed Community Supports (CDCS)**. For the purposes of this chapter, consumer-directed supports include Self-Directed Community Supports (SDCS) and Family-Directed Community Supports (FDCS). (        )

**05. Family-Directed Community Supports (FDCS)**. A program option for children eligible for the Children's Developmental Disabilities (DD) Waiver and the Children's Home and Community Based Services State Plan Option described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (        )

**0~~4~~6. Financial Management Services (FMS)**. Services provided by a fiscal employer agent that include: (3-29-10)

**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)

**0~~5~~7. Fiscal Employer Agent (FEA)**. An agency that provides financial management services to participants who have chosen the ~~S~~CDCS 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). ~~(3-29-10)~~(        )

**0~~6~~8. Goods**. Tangible products or merchandise that are authorized on the support and spending plan (3-30-07)

**0~~7~~9. Guiding Principles for the ~~S~~CDCS Option**. ~~Self~~Consumer-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)

**10. Participant**. *A person eligible for and enrolled in the Consumer-Directed Services Programs* *(    )*

**~~*08*~~11. 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. (3-29-10)

**12. Self-Directed Community Supports (SDCS)**. A program option for adults eligible for the Adult Developmental Disabilities (DD) Waiver described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." *(    )*

**~~*09*~~13. 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*~~consumer-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. ~~*(3-29-10)*~~*(    )*

**1~~*0*~~4. 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)

**1~~*1*~~5. 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~~*2*~~6. Support Broker Services**. Services provided by a support broker to assist the participant with planning, negotiating, and budgeting. (3-30-07)

**1~~*3*~~7. Traditional ~~*HCBS*~~ Adult DD Waiver Services**. A program option for participants eligible for the ~~*Home and Community-Based Services*~~ Adult 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*~~.
~~*(3-29-10)*~~*(    )*

**18. Traditional Children's DD Waiver Services**. A program option for children eligible for the Children's Developmental Disabilities (DD) Waiver consisting of the specific Medicaid Enhanced Plan Benefits described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." *(    )*

**19. Traditional Children's HCBS State Plan Option Services**. A program option for children eligible for the Children's Home and Community-Based Services (HCBS) State Plan Option consisting of the specific Medicaid Enhanced Plan Benefits described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." *(    )*

**~~*14*~~20. Waiver Services**. A collective term that refers to services provided under a Medicaid Waiver program. (3-29-10)

**011. -- 0919. (RESERVED).**

**020. RESPONSIBILITY FOR DECISION-MAKING.**
*Under this chapter of rules, decisions are to be made as follows:* ( )

**01. Children**. *The parent or legal guardian is responsible for decisions made on behalf of a child participant.* ( )

**02. Adults**. *The participant, or legal guardian if one exists, is responsible for decisions made on behalf of an adult participant.* ( )

**021. -- 099. (RESERVED).**

**100. SELFCONSUMER-DIRECTED COMMUNITY SUPPORTS (SCDCS) OPTION.**
The SCDCS option requires the participant to have a support broker to assist the participant to make informed choices, participate in a person-centered planning process, and become skilled at managing his own supports. The participant must use a fiscal employer agent to provide Financial Management Services (FMS) for payroll and reporting functions. (3-30-07)( )

**101. ELIGIBILITY.**

**01. Determination of Medicaid and Home and Community Based Services - DD Requirements**. In order to choose the SCDCS option, the participant must first be determined Medicaid-eligible and must be determined to meet existing (HCBS DD) waiver programs or HCBS State Plan Option 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 SCDCS 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 SCDCS option. (3-30-07)( )

**102. -- 109. (RESERVED).**

**110. PAID SELFCONSUMER-DIRECTED COMMUNITY SUPPORTS.**
The participant must purchase Financial Management Services (FMS) and support broker services to participate in the SCDCS option, except for under the family-directed services option

where the qualified parent or legal guardian may act as an unpaid support broker. The participant must purchase goods and community supports through the fiscal employer agent who is providing the FMS. ~~(3-29-10)~~(     )

**01. Financial Management Services**. The Department will 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~~consumer-directed option. ~~(3-29-10)~~(     )

**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 ~~S~~CDCS 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 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. (3-29-10)

**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)

***(BREAK IN CONTINUITY OF SECTIONS)***

**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~~Consumer-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. Under Family-Directed Community Supports (FDCS), children's support brokers must attend the initial training. 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.** For Self-Directed Community Supports (SDCS), ~~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)*~~<u>(____)</u>

**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~~.~~<u>; and</u> ~~*(3-30-07)*~~<u>(____)</u>

<u>**i.** Assist children enrolled in the Family-Directed Community Supports (FDCS) Option as they transition to adult DD services.</u> <u>(____)</u>

**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, for FDCS, must not be the parent or legal guardian 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. Self-Directed Community Supports (SDCS)**. A legal guardian can be a paid community support worker but must not be paid from the individualized budget for the following: ( )

**~~*01*~~a. ~~*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*~~b. ~~*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)*~~( )

**02. Family-Directed Community Supports (FDCS)**. A parent or legal guardian cannot be a paid community support worker. A paid community support worker: ( )

**a.** Must not supplant the role of the parent or legal guardian; ( )

**b.** Cannot be paid to fulfill any obligations that the parent or legal guardian is legally responsible to fulfill for their child. ( )

### *(BREAK IN CONTINUITY OF SECTIONS)*

### 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*~~consumer-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 ~~*S*~~CDCS option. Because a participant cannot receive these traditional services and ~~*self*~~consumer-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 ~~*S*~~CDCS 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*~~consumer-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)

**_(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. (3-29-10)

**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. For the SDCS, ~~W~~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 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. (3-29-10)

**01. 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*~~ to appeal the set budget amount determined by the Department. ~~(3-30-07)~~(____)

**02. 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*~~consumer-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*~~consumer-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*~~CONSUMER-DIRECTED COMMUNITY SUPPORTS (~~*S*~~CDCS) OPTION.**

The following requirements must be met or the Department may require the participant to discontinue the ~~*S*~~CDCS 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. (3-29-10)

**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. (3-29-10)

**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. -- 299. (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: (3-29-10)

**01. Employee**. A community support worker employed by a participant receiving services under the ~~S~~CDCS option. ~~(3-29-10)~~(     )

**02. Employer**. A participant receiving services under the ~~S~~CDCS option. ~~(3-29-10)~~(     )

**03. Provider**. The term "provider" specifically refers to the fiscal employer agent providing financial management services to individuals participating in ~~self~~consumer-direction. ~~(3-29-10)~~(     )

**04. SFTP**. Secure File Transfer Protocol. A secure means of transferring data that allows certain Department staff to access information regarding ~~self~~consumer-direction participants. ~~(3-29-10)~~(     )

**05. Vendor**. Provides goods and services rendered by agencies and independent contractors in accord with a participant's support and spending plan. (3-29-10)

**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. (3-29-10)

**301. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES: ~~SELF~~CONSUMER-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: (3-29-10)

**a.** Maintain copies of the participant's FEIN, IRS FEIN notification letter, and Form SS-4 Request for FEIN in the participant's file. (3-29-10)

**b.** Retire participant's FEIN when the participant is no longer an employer under ~~self~~consumer-directed community supports (~~S~~CDCS). ~~(3-29-10)~~(     )

**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; (3-29-10)

**03. Procedures Restricting FMS to Adult and Children's DD Waiver and Children's HCBS State Plan Option Participants**. The provider must not act as a fiscal employer agent and provide fiscal management services to a~~n HCBS~~ DD waiver or Children's

HCBS State Plan Option participant for whom it also provides any other services funded by the Department. ~~(3-29-10)~~(____)

**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. (3-29-10)

**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. (3-29-10)

**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. (3-29-10)

**07. SFTP Site**. The provider must provide an 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. (3-29-10)

**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: (3-29-10)

**a.** IRS Form 2678; (3-29-10)

**b.** IRS Approval Letter; (3-29-10)

**c.** IRS Form 2678 revocation process; (3-29-10)

**d.** Initial IRS Form 2848; and (3-29-10)

**e.** Renewal IRS Form 2848. (3-29-10)

**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. (3-29-10)

**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. (3-29-10)

## 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: (3-29-10)

**a.** Provide staff with customer service training with an emphasis on ~~*self*~~consumer-direction. ~~*(3-29-10)*~~(        )

**b.** Ensure staff are trained and have the skills to assist participants with enrollment and to help them understand their account statements. (3-29-10)

**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. (3-29-10)

**d.** Provide translation and interpreter services (i.e., American Sign Language and services for persons with limited English proficiency). (3-29-10)

**e.** Provide prompt and consistent response to verbal and written communication. Specifically: (3-29-10)

i. All voice mail messages must be responded to within one (1) business day; and (3-29-10)

ii. All written and electronic correspondence must be responded to within five (5) business days. (3-29-10)

**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. (3-29-10)

**g.** Maintain a toll-free fax line that is available all day, every day, exclusively for participants and their employees. (3-29-10)

**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: (3-29-10)

**a.** Respond to all written and electronic correspondence within five (5) days. (3-29-10)

**b.** Respond to verbal complaints within one (1) business day. (3-29-10)

**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. (3-29-10)

**d.** Log and track complaints received from the Department pertaining to fiscal

employer agent services. (3-29-10)

**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. (3-29-10)

**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. (3-29-10)

# IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

## 16.03.19 - CERTIFIED FAMILY HOMES

## DOCKET NO. 16-0319-1001

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 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 39-3505, 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. These rule changes updated guardianship, safety, and sanitation requirements for certified family homes. The complete text of the proposed rule was published in the** September 1, 2010 Idaho Administrative Bulletin, Vol. 10-9, pages 292 through 297**.**

**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 Karen Vasterling at (208) 239-6260.

DATED this 4th day of November, 2010.

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 39-3505, Idaho Code.

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

| Wednesday, September 8, 2010<br>6:00 p.m. PDT | Wednesday, September 8, 2010<br>6:00 p.m. MDT | Wednesday, September 8, 2010<br>6:00 p.m. MDT |
|---|---|---|
| Dept. of Health & Welfare-Reg. 2<br>1118 "F" Street<br>3rd Floor Conf. Room<br>Lewiston, ID | Dept. of Health & Welfare-Reg. 3<br>3402 Franklin Road<br>Main Conf. Room<br>Caldwell, ID | Dept. of Health & Welfare-Reg. 6<br>1070 Hiline<br>2nd Floor, Large Conf. Room<br>Pocatello, ID |

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

**These rule changes update safety and sanitation requirements for certified family homes. Manufactured homes and modular homes must meet certain requirements at the time of manufacture. Recreational vehicles, commercial coaches, or unregulated or unapproved modifications to approved manufactured or modular homes, and manufactured housing constructed prior to June 15, 1976, are prohibited for use as a certified family home without Department assessment and approval. Non-municipal sewage disposal requirements for proof the septic tank was pumped has been changed from 3 to 5 years. Also, rules governing guardianship of residents by the certified family home provider have been amended.**

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

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

This rulemaking has no anticipated fiscal impact to state general funds.

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(2), Idaho Code, informal negotiated rulemaking was conducted with certified family home providers, residents, and advocacy groups.

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

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN**

**COMMENTS:** For assistance on technical questions concerning the proposed rule, contact Karen Vasterling at (208) 239-6260.

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 22, 2010.

DATED this 29th day of July, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0319-1001***

**100. CERTIFICATION REQUIREMENTS.**
Certification is required in order to operate a certified family home in the State of Idaho. The Department will issue a certificate to a home when all certification requirements are met.. (4-11-06)

**01. Certificate Issued in the Name of Provider**. The certificate is issued in the name of the provider applying for certification, and only to the address of the home stated in the application. A new certificate is required if the provider or the location of the certified family home changes. (4-11-06)

**02. Accessibility to the Home**. The home, physical premises, and all records required under these rules, must be accessible at all times to the Department for the purposes of inspection, with or without prior notification. (4-11-06)

**03. Number of Residents in the Home**. A home cannot be certified for more than two (2) residents. An exception may be granted by the Department as described in Section 140 of these rules. (4-11-06)

**04. Certification Limitations**. (4-11-06)

**a.** A home cannot be certified if it also provides room or board to any person who is not a resident as defined by these rules or a family member. A waiver may be granted by the Department when the individual receiving room or board is the spouse of the resident and does not require certified family home care or any higher level of care; (4-11-06)

**b.** A home cannot be certified as a certified family home and a child foster home at the same time. (4-11-06)

**c.** A certified family home provider may not be the guardian of any resident unless the guardian is a parent, child, sibling, or grandparent of the resident. (    )

**05. Certification Study Required**. Following receipt of an acceptable application and

other required documents, the Department will begin a certification study within thirty (30) days. The certification study, along with the application and other required material, will serve as the basis for issuing or denying a certificate. The study will include the following: (4-11-06)

**a.** A review of all material submitted; (4-11-06)

**b.** A scheduled home inspection; (4-11-06)

**c.** An interview with the proposed provider; (4-11-06)

**d.** An interview with provider's family, if necessary; (4-11-06)

**e.** A review of the number, age, and sex of children or other adults in the home to evaluate the appropriateness of a placement to meet the needs of the resident; (4-11-06)

**f.** A medical or psychological examination of the provider or family members, if the Department determines it is necessary; and (4-11-06)

**g.** Other information necessary to verify that the home is in compliance with these rules. (4-11-06)

**06. Provider Training Requirements**. As a condition of initial certification, all providers must receive training in the following areas: (4-11-06)

**a.** Resident rights; (4-11-06)

**b.** Certification in first aid and Cardio-Pulmonary Resuscitation (CPR) which must be kept current; (4-11-06)

**c.** Emergency procedures; (4-11-06)

**d.** Fire safety, fire extinguishers, and smoke alarms; (4-11-06)

**e.** Completion of approved “Assistance with Medications” course; and (4-11-06)

**f.** Complaint investigations and inspection procedures. (4-11-06)

**07. Effect of Previous Revocation or Denial of Certificate or License**. The Department is not required to consider the application of any applicant who has had a health care certificate or license denied or revoked until five (5) years have elapsed from the date of denial or revocation according to Section 39-3525, Idaho Code. (4-11-06)

**_(BREAK IN CONTINUITY OF SECTIONS)_**

## 140. EXCEPTION TO THE TWO RESIDENT LIMIT.

**01. Application for Exception**. A home may apply to the Department for an exception to the two (2) resident limit to care for three (3) or four (4) residents. (4-11-06)

**02. Criteria for Determination**. The Department will determine if safe and appropriate care can be provided based on resident needs. The Department will consider, at a minimum, the following factors in making its determination: (4-11-06)

**a.** Each current or prospective resident's physical, mental and behavioral status and history; (4-11-06)

**b.** The household composition including the number of adults, children and other family members requiring care from the provider; (4-11-06)

**c.** The training, education, and experience of the provider to meet each resident's needs; (4-11-06)

**d.** Potential barriers that might limit resident safe access to and exit from the rooms in the home; (4-11-06)

**e.** The number and qualifications of care givers in the home; (4-11-06)

**f.** The desires of the prospective and current residents; (4-11-06)

**g.** The individual and collective hours of care needed by the residents; (4-11-06)

**h.** The physical layout of the home and the square footage available to meet the needs of all persons living in the home; and (4-11-06)

**i.** If an exception to the two (2) resident limit would result in two (2) or more residents who require nursing facility level of care living in the home, then the application must also include the information required in Section 130 of these rules. (4-11-06)

**03. Other Employment**. Providers of three (3) or four (4) bed homes must not have other gainful employment unless: (4-11-06)

**a.** The total direct care time for all residents, as reflected by the plan of service and assessments, does not exceed eight (8) hours per day; (4-11-06)

**b.** The provider is immediately available to meet resident needs as they arise; and (4-11-06)

**c.** Each resident is supervised at all times unless the assessment or plan of service indicates the resident may be left unattended for designated periods of time. (4-11-06)

**04. Additional Training**. Providers of three (3) or four (4) bed homes must obtain additional training to meet the needs of the residents as determined necessary by the Department. (4-11-06)

~~***05.*** ***Guardianship****. A provider applying to care for three (3) or four (4) residents may not be the guardian of any resident unless either of the following applies:* *(4-11-06)*~~

~~***a.*** *The guardianship was established prior to July 1, 2001; or* *(4-11-06)*~~

~~***b.*** *The proposed guardian is a parent, child, sibling, or grandparent of the resident.* *(4-11-06)*~~

**0~~6~~5.** **Exception Nontransferable**. An exception to care for more than two (2) residents will not be transferable to another provider, address, or resident. (4-11-06)

**0~~7~~6.** **Reassessment of Exception**. An exception to care for more than two (2) residents must be reassessed at least annually and when either of the following occurs: (4-11-06)

**a.** Each time a new admission is considered; or (4-11-06)

**b.** When there is a significant change in any of the factors specified in Subsection 140.02 of these rules. (4-11-06)

**0~~8~~7.** **Annual Home Inspection**. A home with an exception to care for more than two (2) residents must have a home inspection at least annually. (4-11-06)

**0~~9~~8.** **Shared Sleeping Rooms**. In addition to the requirements in Section 700 of these rules, no more than two (2) residents will be housed in any multi-bed sleeping room. (4-11-06)

***(BREAK IN CONTINUITY OF SECTIONS)***

**500. ENVIRONMENTAL SANITATION STANDARDS.**
The home is responsible for disease prevention and maintenance of sanitary conditions. (4-11-06)

**01.** **Water Supply**. The water supply for the home must be adequate, safe, and sanitary. (4-11-06)

**a.** The home must use a public or municipal water supply or a Department-approved private water supply; (4-11-06)

**b.** If water is from a private supply, water samples must be submitted to a private accredited laboratory or the District Public Health Laboratory for bacteriological examination at least annually or more frequently if deemed necessary by the Department. Copies of the laboratory reports must be kept on file at the home; and (4-11-06)

**c.** There must be enough water pressure to meet the sanitary requirements at all times. (4-11-06)

**02. Sewage Disposal**. The sewage disposal system must be in good working order. All sewage and liquid wastes must be discharged, collected, treated, and disposed of in a manner approved by the Department. (4-11-06)

**03. Nonmunicipal Sewage Disposal**. For homes with nonmunicipal sewage disposal, at the time of the initial certification and at least every ~~*three*~~ five (~~*3*~~5) years thereafter the home must provide proof that the septic tank has been pumped or that pumping was not necessary. In addition, at the time of initial certification: ~~*(4-11-06)*~~(   )

**a.** The home must obtain a statement from the local health district indicating that the sewage disposal system meets local requirements. The statement must be kept on file at the home; or (4-11-06)

**b.** If the local health district does not issue these statements, the home must obtain a statement to that effect from the health district. The statement must be kept on file at the home. (4-11-06)

**04. Garbage and Refuse Disposal**. Garbage and refuse disposal must be provided by the home. (4-11-06)

**a.** Garbage containers outside the home used for storage of garbage and refuse must be constructed of durable, nonabsorbent materials and must not leak or absorb liquids. Containers must be provided with tight-fitting lids. (4-11-06)

**b.** Garbage containers must be maintained in good repair. Sufficient containers must be available to hold all garbage and refuse which accumulates between periods of removal from the premises. Storage areas must be kept clean and sanitary. (4-11-06)

**05. Insect and Rodent Control**. The home must be maintained free from infestations of insects, rodents and other pests. Chemicals (pesticides) used in the control program must be selected, stored, and used safely. (4-11-06)

**a.** The chemical must be selected on the basis of the pest involved and used only in the manner prescribed by the manufacturer; (4-11-06)

**b.** The home must take the necessary precautions to protect residents from obtaining toxic chemicals. (4-11-06)

**06. Yard**. The yard surrounding the home must be safe and maintained. (4-11-06)

**07. Linen-Laundry Facilities and Services**. A washing machine and dryer must be provided for the proper and sanitary washing of linen and other washable goods. (4-11-06)

**08. Housekeeping and Maintenance**. Sufficient housekeeping and maintenance must be provided to maintain the interior and exterior of the home in a clean, safe, and orderly manner. (4-11-06)

**a.** A sleeping room must be thoroughly cleaned including the bed, bedding, and

furnishings before it is occupied by a new resident; and (4-11-06)

**b.** Deodorizers must not be used to cover odors caused by poor housekeeping or unsanitary conditions. (4-11-06)

***(BREAK IN CONTINUITY OF SECTIONS)***

**701. MANUFACTURED HOMES AND MODULAR BUILDINGS.**

**01. Use of Manufactured Homes and Modular Buildings**. ~~*A late-model manufactured home*~~ Idaho Division of Building Safety (BDS) approved modular buildings or U.S. Department of Housing and Urban Development (HUD) approved buildings may be approved for use as a certified family home when the home meets the following requirements. ~~*(4-11-06)*~~(    )

**a.** The manufactured or modular home meets the requirements of HUD or BDS requirements in accordance with state and federal regulations as of the date ~~*the home was*~~ of manufacture~~*d is within eighteen (18) years of the date of initial certification*~~. ~~*(4-11-06)*~~(    )

**b.** The home meets the adopted standards and requirements of the local jurisdiction in which the home is located. ~~*If no local standard has been established, the home must be installed according to the Idaho Manufactured Home Installation standard.*~~ ~~*(4-11-06)*~~(    )

**c.** Recreational vehicles, commercial coaches, unregulated or unapproved modifications or additions to approved manufactured housing or modular buildings; and manufactured housing constructed prior to June 15, 1976, are prohibited for use as a certified family home without DHW assessment and approval. (    )

**02. Previously Certified**. A manufactured home approved for use as a certified family home before July 1, 200~~5~~1, may continue to be certified when evaluated on a case-by-case basis. ~~*(4-11-06)*~~(    )

# IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

## 16.03.21 - DEVELOPMENTAL DISABILITIES AGENCIES (DDA)

## DOCKET NO. 16-0321-1001 (NEW CHAPTER)

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 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. **The effective date for this chapter of rules is July 1, 2011.**

**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 Department is amending the proposed rule to address concerns received during the public comment period. The following terms were added for clarification to the rules: clinical supervision, plan of service, and program implementation plan. These terms were deleted: comprehensive assessment, substantial compliance and supervision. Several changes have been made for clarification around the DDA services, types of certificates, qualifications of those providing services, and national accreditation. 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 1, 2010, Idaho Administrative Bulletin, Vol. 10-09, pages 298 through 320**.**

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

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning the pending rule, contact Randy May (208) 334-5747.

DATED this 4th day of November, 2010.

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:** Three public hearings concerning this rulemaking will be held as follows:

| Wednesday, September 15, 2010<br>6:00 p.m. PDT | Wednesday, September 15, 2010<br>6:00 p.m. MDT | Wednesday, September 15, 2010<br>6:00 p.m. MDT |
|---|---|---|
| Dept. of Health & Welfare-Reg. 1<br>1120 Ironwood Drive, Suite 102<br>Lower Level Large Conf. Rm.<br>Coeur d'Alene, ID | Dept. of Health & Welfare-Reg. 4<br>1720 Westgate Drive<br>Suite A, Room 131<br>Boise, ID | Dept. Health & Welfare-Reg. 7<br>150 Shoup Avenue<br>2nd Floor, Large Conf. Rm.<br>Idaho Falls, 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:

**This chapter of rules replaces the existing licensing and certification requirements under IDAPA 16.04.11, "Developmental Disabilities Agencies (DDAs)." This rewritten DDA chapter is needed to provide the necessary certification requirements for providers, and the qualifications necessary to meet those requirements. The existing chapter for Developmental Disabilities Agencies (IDAPA 16.04.11) is being repealed in this Bulletin under Docket 16-0411-1001, and rewritten as a Division of Medicaid, Licensing and Certification chapter of rule, under IDAPA 16.03.21, "Developmental Disabilities Agencies."**

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

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

This rulemaking has no anticipated fiscal impact to state general funds.

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(2), Idaho Code, informal negotiated rulemaking was conducted with stakeholders in a meeting held on Wednesday, July 14, 2010.

**The notice for this negotiated rulemaking published in the** July 7, 2010, Idaho Administrative Bulletin, Vol. 10-7, p. 35**, under Docket No. 16-0411-1001.**

**INCORPORATION BY REFERENCE:** No materials are being incorporated by reference into these rules under this docket.

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the proposed rule, contact Randy May (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 22, 2010.

DATED this 19th day of August, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0321-1001***

**IDAPA 16, TITLE 03, CHAPTER 21**

**16.03.21 - DEVELOPMENTAL DISABILITIES AGENCIES (DDA)**

**000. LEGAL AUTHORITY.**
The Idaho Board of Health and Welfare is authorized under the "Idaho Developmental Disabilities Services and Facilities Act," Section 39-4605, Idaho Code, to adopt rules governing Developmental Disabilities Agencies in Idaho. ( )

**001. TITLE AND SCOPE.**

**01. Title**. The title of these rules is IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." ( )

**02. Scope**. These rules govern: ( )

**a.** The certification of Developmental Disabilities Agencies that provide services to persons with developmental disabilities; and ( )

**b.** The provision for services to individuals who meet minimum eligibility criteria under Section 66-402, Idaho Code. ( )

**c.** All agencies that meet the definition of a Developmental Disabilities Agency

(DDA) in Section 010 of these rules must be certified by the Department in accordance with the requirements in this chapter of rules. ( )

**002. WRITTEN INTERPRETATIONS.**
There are no written interpretations for this chapter of 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.**
There are no documents that have been incorporated by reference into this chapter of rules.( )

**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. ( )

**06. Licensing and Certification Unit**. The Department's Licensing and Certification Unit, 3232 Elder Street, Boise, ID 83705; Phone: 208 334-6626. ( )

**07. Licensing and Certification Unit Website**. http://www.healthandwelfare.idaho.gov/Medical/LicensingCertification/tabid/124/Default.aspx. ( )

**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.**

**01. Verification of Compliance**. The agency must verify that all employees, subcontractors, agents of the agency, and volunteers delivering DDA services have complied with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

**0*2*. Requirement to Report Additional Criminal Convictions, Pending Investigations, or Pending Charges**. Once an employee, subcontractor, agent of the agency, or volunteer delivering DDA services has received a criminal history clearance, any additional criminal convictions, pending investigations, or pending charges must be reported to the Department or its designee when the agency learns of the convictions, investigations, or charges. ( )

**010. DEFINITIONS -- A THROUGH Z.**

For the purposes of this chapter of rules, the following terms apply. ( )

**01. ADA**. The "Americans with Disabilities Act Accessibility Guidelines," under 28 CFR Part 36, Appendix A. ( )

**02. Adult**. A person who is eighteen (18) years of age or older. ( )

**03. Agency**. A developmental disabilities agency (DDA) as defined in Section 010 of this rule. ( )

**04. Board**. The Idaho State Board of Health and Welfare. ( )

***05. Clinical Supervision****. Initial direction and procedural guidance by a professional and periodic inspection of the actual work performed at the service delivery site. ( )*

**0*6*. 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. ( )

**07. Deficiency**. A determination of non-compliance with a specific rule or part of rule. ( )

**08. Department**. The Idaho Department of Health and Welfare. ( )

**09. Developmental Disabilities Agency (DDA)**. A DDA is an agency that is: ( )

**a.** A type of developmental disabilities facility, defined in Section 39-4604, Idaho Code, that is non-residential and provides services on an outpatient basis; ( )

**b.** Certified by the Department to provide services to people with developmental disabilities, according to this chapter of rules; and ( )

**c.** A business entity, open for business to the general public. ( )

**10.** **Developmental Disability**. A developmental disability, 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: ( )

**a.** Is attributable to an impairment, such as intellectual disability, cerebral palsy, epilepsy, autism, or other condition found to be closely related to or similar to one (1) of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments; and ( )

**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 ( )

**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. ( )

***11.*** ***Human Services Field****. A particular area of academic study in health care, social services, education, behavioral science or counseling.* *( )*

**1*2*.** **Measurable Objective**. A statement in specific and concrete terms that describes the observable results of the skill to be acquired. ( )

**1*3*.** **Paraprofessional**. A person delivering support services who meets the qualifications required in Section 400 of these rules. ( )

**1*4*.** **Participant**. A person who has been identified as having a developmental disability defined in Section 010 of this rule, and who is receiving services through a DDA. ( )

***15.*** ***Plan of Service****. An initial or annual plan that identifies all services and supports.* *( )*

**1*6*.** **Practitioner of the Healing Arts, Licensed**. A licensed physician, physician assistant, or nurse practitioner. ( )

**1*7*.** **Professional**. A professional delivering services within the scope of his practice and who meets the qualifications required in Section 400 of these rules. ( )

***18.*** ***Program Implementation Plan****. A plan that details how intervention goals from the plan of service will be accomplished.* *( )*

**1*9*.** **Provider**. An agency, or an individual working for an agency, that furnishes DDA services under the provisions of these rules. ( )

***20*.** **Provisional Certificate**. A certificate issued by the Department to a DDA with

deficiencies that do not adversely affect the health or safety of participants. A provisional certificate is issued contingent upon the correction of deficiencies in accordance with an agreed-upon plan. A provisional certificate is issued for a specific period of time, up to, but not to exceed, six (6) months. ( )

***21*.** **Repeat Deficiency**. A violation or deficiency found on a resurvey or revisit to a DDA that was also found during the previous survey or visit. ( )

***22*.** **Staff**. Employees or contractors of an agency who deliver services. ( )

**2*3*.** **Survey**. A review conducted by the Department to determine compliance with statutes and rules. ( )

**011. -- 074. (RESERVED).**

***SERVICES PROVIDED BY DEVELOPMENTAL DISABILITIES AGENCIES***
***(Sections 075 Through 099)***

**075. DDA SERVICES.**

A DDA provides services that include evaluation, diagnostic, training, treatment, and support 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. A DDA may provide the following services as specified on its certificate under Section 120 of these rules. ( )

**01.** **Support Services**. Support services may include supervision for a participant, as well as assisting and facilitating the participant's integration into the community. *( )*

**02.** **Intervention Services**. Intervention services *include* outcome-based therapeutic services*, professional consultation services, as well as education and training for families caring for participants with developmental disabilities*. *( )*

**076. -- 099. (RESERVED).**

***CERTIFICATION REQUIREMENTS FOR DEVELOPMENTAL DISABILITIES AGENCIES***
***(Sections 100 Through 199)***

**100. DDA CERTIFICATION.**

**01.** **Certification Required**. Before any agency can operate as a DDA, it must obtain DDA certification from the Department. No agency may provide services until the Department has approved the application for certification. No agency may provide services without a current certificate. ( )

**02.** **Application for Certification**. All DDAs must apply for certification under

Section 101 of these rules. ( )

**03. Restriction on Certification**. A business entity established by a parent for the sole purpose of providing DDA services to his own child cannot be certified as a DDA. ( )

**04. Effect of Previous Revocation or Denial of a Certificate or License**. The Department is not required to consider the application of any operator, administrator, or owner of an agency who has had his license or certification denied or revoked until five (5) years have lapsed from the date of denial or revocation. ( )

## 101. APPLICATION FOR INITIAL CERTIFICATION.

**01. Open Application**. An application for certification from new agencies will be accepted on an open and continuous basis. ( )

**0*2*. Content of Application for Certification**. Application for certification must be made on the Department-approved form available by contacting the Department as described in Subsection 005.06 of these rules. The application and supporting documents must be received by the Department at least sixty (60) days prior to the planned opening date. The application must include all of the following: ( )

**a.** Name, address, and telephone number of the agency; ( )

**b.** Types of services to be provided by the agency and the anticipated capacity of each service; ( )

**c.** The geographic service area of the agency as indicated by counties that will be served; ( )

**d.** The anticipated date for the initiation of services; ( )

**e.** An accurate and complete statement of all business names of the agency as filed with the Secretary of State, whether an assumed business name, partnership, corporation, limited liability company or other entity, that identifies each owner with more than five percent (5%) interest in the agency, and the management structure of the agency; ( )

**f.** A statement that the agency is in compliance with these rules and all other applicable local, state and federal requirements, including an assurance that the agency complies with pertinent state and federal requirements governing equal opportunity and nondiscrimination; ( )

**g.** A written code of ethics policy *adopting a code of ethics relevant to professional activities with participants and colleagues, in practice settings. The policy* must articulate basic values, ethical principles and standards for confidentiality, conflict of interest, exploitation, and inappropriate boundaries in an agency's relationship with participants, relatives, or with other agencies. This code of ethics must reflect nationally-recognized standards of practice; *( )*

**h.** A copy of the proposed organizational chart or plan for staffing of the agency;

( )

**i.** Staff qualifications including resumes, job descriptions, evidence of compliance with criminal history and background check requirements in Section 009.01 through 009.03 of these rules, and copies of state licenses and certificates for staff when applicable; *( )*

***j.*** *Written policies and procedures that address professionals entering the field are being provided, or have completed, increased supervision for a period of six (6) months; ( )*

***k*.** Written transportation safety policies and procedures required in Section 501 of these rules; ( )

***l*.** Staff and participant illness policy, communicable disease policy, and other health-related policies and procedures required in Section 510 of these rules; ( )

***m*.** Written policies and procedures that address special medical or health care needs of participants required in Section 510 of these rules; ( )

***n*.** Written medication policies and procedures to meet requirements in Section 511 of these rules; ( )

***o*.** Written admission, transfer, and transition policies and procedures; ( )

***p*.** Written description of the agency's quality assurance program developed to meet requirements in Section 900 of these rules; ( )

***q*.** Written participant grievance policies and procedures to meet requirements in Section 905 of these rules; ( )

***r*.** Written policies and procedures for reporting incidents to the adult or child protection authority and to the Department to meet requirements in Section 910 of these rules; ( )

***s*.** Written policies and procedures that address the development of participants' social skills and the management of participants' inappropriate behavior to meet requirements in Section 915 of these rules; ( )

***t*.** Written description of the program records system including a completed sample of a plan of service for participants, program implementation plan, and a monitoring record; ( )

***u*.** Written description of the fiscal record system including a sample of program billing; and ( )

***v*.** Any other information requested by the Department for determining the agency's compliance with these rules or the agency's ability to provide the services for which certification is requested. ( )

***w*.** When center-based services are to be provided, the following are also required for each service location: ( )

i. A site review must be completed by the Department prior to the initiation of center based services; ( )

ii. Address and telephone number for each service location; ( )

iii. A checklist that verifies compliance with the ADA requirements under Section 500 of these rules; ( )

iv. Evidence of a local fire safety inspection; ( )

v. Evidence of compliance with local building and zoning codes, including occupancy permit; ( )

vi. Written policies and procedures covering the protection of all persons in the event of fire and other emergencies under Section 500 of these rules; and ( )

vii. Written policies and procedures regarding emergency evacuation procedures. ( )

**102. -- 109. (RESERVED).**

**110. DEPARTMENT REVIEW OF APPLICATION FOR CERTIFICATION.**
Upon receipt of the application form and initial application materials, the Department will review the materials to determine if the agency has systems in place, that if properly implemented, would result in regulatory compliance. ( )

**111. DEPARTMENT'S WRITTEN DECISION REGARDING APPLICATION FOR CERTIFICATION.**
The Department will provide to the agency, within thirty (30) days of the date the completed application packet is received, a written decision regarding certification. An application is considered completed when all required documents are received and in compliance with these rules. ( )

**112. -- 114. (RESERVED).**

**115. CHANGES EACH DDA IS REQUIRED TO REPORT.**

**01. Change of Ownership or Physical Location**. ( )

**a.** The DDA must notify the Department at least thirty (30) days prior to any anticipated change in ownership or physical location. In order to continue operation after any such anticipated change, the DDA must receive an updated certificate from the Department that reflects the change. An agency that fails to notify the Department of such changes is operating without a certificate. ( )

**b.** When an agency plans to provide center-based services in a new physical location, on a temporary or permanent basis, the Department will conduct a site review within thirty (30) days after the agency has relocated. Included with the notification required under Subsection 115.01.a. of this rule, the agency must provide: ( )

i. Evidence of review and approval by the local fire and building authorities, including issuance of occupancy permit; and ( )

ii. A checklist that verifies compliance with the ADA requirements under Section 500 of these rules. ( )

**02. Change in Geographic Service Area**. The DDA must notify the Department at least thirty (30) days prior to any anticipated change(s) in the geographic service area including counties served. In order to continue operation after any such anticipated change, the DDA must receive an updated certificate from the Department that reflects the change(s). An agency that fails to notify the Department of such changes is operating without a certificate. ( )

**116. -- 119. (RESERVED).**

**120. INITIAL ISSUANCE OF CERTIFICATE.**

**01. Initial Certification**. When the Department determines that all application requirements have been met, a certificate is issued for a period of up to six (6) months from the initiation of services. During this period, the Department evaluates the agency's ongoing capability to provide services and to comply with these rules. The Department will resurvey the agency prior to the end of the initial certification period. ( )

**02. Return of Certificate**. The certificate is the property of the state and must be returned to the state if it is revoked or suspended. ( )

**03. Certificate Not Transferable**. The certificate is issued only to the agency named thereon, only for the period specified on the certificate, and only to the owners and operators as expressed on the application submitted to the Department, and may not be transferred or assigned to any other person or entity. ( )

**04. Availability of Certificate**. The certificate must be posted in a conspicuous location in the DDA where it may be seen readily by the participants and members of the public. ( )

**05. Service Specific Certification**. The certificate must indicate the type of service the agency is qualified to provide prior to the delivery of service. *Types of* certificate*s* include: *( )*

**a.** Support Services; ( )

**b.** Intervention Services; or ( )

**c.** Intervention and Support Services. ( )

**121. -- 124. (RESERVED).**

**125. RENEWAL AND EXPIRATION OF THE CERTIFICATE.**
An agency must request renewal of its certificate no less than ninety (90) days before the expiration date of the certificate, to ensure there is no lapse in certification. The request must contain any changes in optional services provided and outcomes of the internal quality assurance processes required under Section 900 of these rules. ( )

**01. Issuance of Certificate**. The Department issues certificates that are in effect for a period of no longer than three (3) years. ( )

**a.** The Department will survey each agency seeking renewal of its certificate. ( )

**b.** The Department will renew the certificate of an agency it finds to be in substantial compliance with statutes and these rules. ( )

**02. Renewal of Certificate**. A certificate may be renewed by the Department when it determines the agency requesting recertification is in substantial compliance with the provisions of this chapter of rules. A certificate issued on the basis of substantial compliance is contingent upon the correction of deficiencies in accordance with a plan developed by the agency and approved by the Department. ( )

**03. Expiration Without Timely Request for Renewal**. Expiration of a certificate without a timely request for renewal automatically rescinds the agency's certificate to deliver services under these rules. ( )

***04. National Accreditation****. The Department may accept national accreditation in lieu of state certification for developmental disabilities agencies. ( )*

***05. DDA Enrolled Prior to July 1, 2011****. Agencies certified prior to July 1, 2011, are qualified to provide DDA services under the Intervention and Support Services Certification. Developmental Therapy and Intensive Behavioral Intervention services delivered by an agency are not subject to the requirements listed in Subsection 400.06 of these rules. ( )*

**126. TYPES OF CERTIFICATES ISSUED.**

**01. Provisional Certificate**. When a DDA is found to be out of substantial compliance with these rules but does not have deficiencies that jeopardize the health or safety of participants, a provisional certificate may be issued by the Department for up to a six- (6) month period. A provisional certificate is issued contingent upon the correction of deficiencies in accordance with a plan developed by the agency and approved by the Department. Before the end of the provisional certification period, the Department will determine whether areas of concern have been corrected and whether the agency is in substantial compliance with these rules. If so, then certification will be granted. If not, the certificate will be denied or revoked. ( )

**02. One-Year Certificate.** A one- (1) year certificate is issued by the Department when it determines the agency is in substantial compliance with these rules, but there may be

areas of deficient practice which would impact the agency's ability to provide effective care. An agency is prohibited from receiving consecutive one- (1) year certificates. ( )

**03. Three-Year Certificate.** A three- (3) year certificate is issued by the Department when it determines the agency requesting certification is in substantial compliance with these rules and has no areas of deficient practice that would impact safe and effective care. ( )

**127. -- 299. (RESERVED).**

### *RULE ENFORCEMENT PROCESS AND REMEDIES*
### *(Sections 300 Through 399)*

**300. ENFORCEMENT PROCESS.**

The Department may impose a remedy or remedies, when it determines a DDA has not met the requirements in this chapter of rules. ( )

**01. Determination of Remedy**. In determining which remedy or remedies to impose, the Department will consider the DDA's compliance history, change of ownership, the number of deficiencies, the scope and severity of the deficiencies, and the potential risk to participants. Subject to these considerations, any of the following remedies, independently or in conjunction with others, subject to the provisions of these rules for notice and appeal: ( )

**a.** Require the DDA to submit a plan of correction that must be approved in writing by the Department; ( )

**b.** Issue a provisional certificate with a specific date for correcting deficient practices; ( )

**c.** Ban enrollment of all participants with specified diagnoses; ( )

**d.** Ban any new enrollment of participants; ( )

**e.** Summarily suspend the certificate and transfer participants; or ( )

**f.** Revoke the DDA's certificate. ( )

**02. Immediate Jeopardy**. If the Department finds a DDA's deficiency or deficiencies immediately jeopardize the health or safety of its participants, the Department may summarily suspend the DDA's certificate. ( )

**03. Repeat Deficiencies**. If the Department finds a repeat deficiency in a DDA, it may impose any of the remedies listed in Subsection 300.01 of this rule,. The Department may monitor the DDA on an "as needed" basis, until the DDA has demonstrated to the Department's satisfaction that it is in compliance with these rules. If so, then certification will be granted. If not, the certificate will be denied or revoked. ( )

**04. Failure to Comply**. If after three (3) months from the date of survey, the DDA has

not implemented the Plan of Correction *as approved by the Department* and remains out of compliance with the identified rule, the Department may impose one (1) or more of the remedies specified in Subsection 300.01 of this rule. *( )*

**301. REVOCATION OF CERTIFICATE.**

**01. Revocation of the DDA's Certificate**. The Department may revoke a DDA's certificate when persuaded by the preponderance of the evidence that the DDA is not in substantial compliance with the requirements in this chapter of rules. ( )

**02. Causes for Revocation of the Certificate**. The Department may revoke any DDA's certificate for any of the following causes: ( )

**a.** The certificate holder has willfully misrepresented or omitted information on the application for certification or other documents pertinent to obtaining a certificate; ( )

**b.** When persuaded by existing conditions in the agency that endanger the health or safety of any participant; ( )

**c.** Any act adversely affecting the welfare of participants is being permitted, performed, or aided and abetted by the person or persons supervising the provision of services in the agency. Such acts include neglect, physical abuse, mental abuse, emotional abuse, violation of civil rights, or exploitation; ( )

**d.** The provider has demonstrated or exhibited a lack of sound judgment that jeopardizes the health, safety, or well-being of participants; ( )

**e.** The agency has failed to comply with any of the conditions of a provisional certificate; ( )

**f.** The agency has one (1) or more major deficiencies. A major deficiency is a deficiency that endangers the health, safety, or welfare of any participant; ( )

**g.** An accumulation of minor deficiencies that, when considered as a whole, indicate the agency is not in substantial compliance with these rules; ( )

**h.** Repeat deficiencies by the agency of any requirement of these rules or of the Idaho Code; ( )

**i.** The agency lacks adequate personnel, as required by these rules or as directed by the Department, to properly care for the number and type of participants served at the agency; ( )

**j.** The agency is not in substantial compliance with the provisions for services required in these rules or with the participants' rights under Section 905 of these rules; ( )

**k.** The agency is delivering services outside the scope of its certificate; or ( )

**l.** The certificate holder refuses to allow the Department or protection and advocacy agencies full access to the agency environment, agency records, or the participants. ( )

**302. -- 309. (RESERVED).**

**310. NOTICE OF ENFORCEMENT REMEDY.**
The Department will notify the following of the imposition of any enforcement remedy on a DDA: ( )

**01. Notice to DDA**. The Department will notify the DDA in writing, transmitted in a manner that will reasonably ensure timely receipt. ( )

**02. Notice to Public**. The Department will notify the public by sending the DDA printed notices to post. The DDA must post all the notices on the premises of the DDA in plain sight in public areas where they will readily be seen by participants and their representatives, including exits and common areas. The notices must remain in place until all enforcement remedies have been officially removed by the Department. ( )

**03. Notice to the Professional Licensing Boards**. The Department will notify professional licensing boards, as appropriate. ( )

**311. HEARING RIGHTS.**
A DDA may request a hearing following any enforcement action taken by the Department, under Section 003 of these rules. ( )

**312. -- 399. (RESERVED).**

***STAFFING REQUIREMENTS AND PROVIDER QUALIFICATIONS***
***(Sections 400 Through 499)***

**400. GENERAL STAFFING REQUIREMENTS FOR AGENCIES.**
Each DDA is accountable for all operations, policy, procedures, and service elements of the agency. ( )

**01. Agency Administrator Duties**. The agency administrator is accountable for the overall operations of the agency including ensuring compliance with this chapter of rules, overseeing and managing staff, developing and implementing written policies and procedures, and overseeing the agency's quality assurance program. ( )

**02. Agency Administrator Qualifications**. An agency administrator must have two (2) years of supervisory or management experience in a developmental disabilities services setting. ( )

**03. Clinical Supervisor Duties**. A clinical supervisor must be employed by the DDA on a continuous and regularly scheduled basis and *be readily available on-site to provide* for:
*( )*

**a.** The supervision of service elements of the agency, including face to face supervision of agency staff providing direct care services*; and* *( )*

**b.** The observation and review of the direct services performed by all paraprofessional and professional staff on at least a monthly basis, or more often as necessary, to ensure staff demonstrate the necessary skills to correctly provide the *DDA* service*s*. *( )*

**04. Clinical Supervisor Qualifications**. A person qualified to act as clinical supervisor of a DDA must meet the following requirements: ( )

**a.** Must hold at least a bachelor's degree in a human services field from a nationally accredited university or college; and *( )*

**b.** Must provide documentation of one (1) year's supervised experience working with *the population served*; and *( )*

**c.** Must demonstrate competencies related to the requirements to provide intervention services as required by the Department; and ( )

**d.** Must complete a additional coursework as required by the Department*; or* *( )*

***e.*** *Individuals working as Developmental Specialists or as Intensive Behavioral Interventionists prior to July 1, 2011, are qualified to provide clinical supervision until June 30, 2013. The individual must meet the requirements of the Department-approved competency coursework by June 30, 2013, to maintain their certification.* *( )*

***f.*** The agency administrator and clinical supervisor can be the same individual. ( )

**05. Limitations**. *If a*n agency administrator or a clinical supervisor *also works as a professional delivering* direct services*, the agency must have policies and procedures demonstrating how the agency will continue to meet agency staffing requirements in Subsections 400.01 through 400.04 of this rule*. *( )*

**06. Professionals**. The agency must ensure that staff providing intervention services have the appropriate licensure or certification required to provide services. A person qualified to provide intervention services must also meet the following minimum requirements: ( )

**a.** Must hold at least a bachelor's degree in a human services field from a nationally accredited university or college; *( )*

**b.** Must provide documentation of one (1) year's supervised experience working with participants with developmental disabilities; ( )

**c.** Must demonstrate competencies related to the requirements to provide intervention services as required by the Department; and ( )

**d.** Must complete a supervised practicum *and* additional coursework as required by

the Department*; or* *( )*

*e. Individuals working as Developmental Specialists or as Intensive Behavioral Interventionists prior to July 1, 2011, are qualified to provide intervention services until June 30, 2013. The individual must meet the requirements of the Department-approved competency coursework by June 30, 2013, to maintain their certification.* *( )*

**07. Paraprofessionals**. A person qualified to provide support services must meet the following minimum requirements: ( )

**a.** Meet the qualifications prescribed for the type of services to be rendered; ( )

**b.** Have received instructions in the needs of the participant who will be provided the service; *and* *( )*

**c.** Demonstrate the ability to provide services according to a plan of service*.* *( )*

**08. Records of Licenses or Certifications**. The agency must maintain documentation of the staff qualifications, including copies of applicable licenses and certificates. ( )

**09. Parent or Legal Guardian of Participant**. A DDA may not hire the parent or legal guardian of a participant to provide services to the parent's *or legal guardian's* child. *( )*

**401. -- 409. (RESERVED).**

**410. GENERAL TRAINING REQUIREMENTS FOR DDA STAFF.**

Each DDA must ensure that all training of staff specific to service delivery to the participant *is* completed *as follows:* *( )*

**01. Yearly Training**. The DDA must ensure that staff or volunteers who provide DDA services complete a minimum of twelve (12) hours of formal training each calendar year. Each agency staff providing services to participants must: ( )

**a.** Participate in fire and safety training upon employment and annually thereafter; and ( )

**b.** Be certified in CPR and first aid within ninety (90) days of hire and maintain current certification thereafter; and ( )

i. The agency must ensure that CPR and first-aid trained staff are present or accompany participants when services or DDA-sponsored activities are being provided. ( )

ii. Each agency staff person must have age appropriate CPR and first aid certification for the participants he serves. ( )

**c.** Be trained to meet any special health or medical requirements of the participants they serve. ( )

**02. Sufficient Training**. Training of all staff must include the following as applicable to their work assignments and responsibilities: ( )

**a.** Optimal independence of all participants is encouraged, supported, and reinforced through appropriate activities, opportunities, and training; ( )

**b.** Correct and appropriate use of assistive technology used by participants; ( )

**c.** Accurate record keeping and data collection procedures; ( )

**d.** Adequate observation, review, and monitoring of staff, volunteer, and participant performance to promote the achievement of participant goals and objectives; ( )

**e.** Participant's rights, advocacy resources, confidentiality, safety, and welfare; and ( )

**f.** The proper implementation of all policies and procedures developed by the agency. ( )

**03. Additional Training for Professionals**. Training of all professional staff must include the following as applicable to their work assignments and responsibilities: ( )

**a.** Correct and consistent implementation of all participants' individual program plans and implementation plans, to achieve individual objectives; ( )

**b.** Consistent use of behavioral and developmental programming principles and the use of positive behavioral intervention techniques. ( )

**411. -- 419. (RESERVED).**

**420. VOLUNTEER WORKERS IN A DDA.**

If volunteers are utilized by a DDA, the agency must establish written policies and procedures governing the screening, training, and utilization of volunteer workers. ( )

**421. -- 499. (RESERVED).**

## *FACILITY, SAFETY, AND HEALTH STANDARDS*
## *(Sections 500 Through 599)*

**500. FACILITY STANDARDS FOR AGENCIES PROVIDING CENTER-BASED SERVICES.**

The requirements in Section 500 of this rule, apply when an agency is providing center-based services. ( )

**01. Accessibility**. Agencies designated under these rules must be responsive to the needs of persons receiving services and accessible to persons with disabilities as defined in Section 504 of the federal Rehabilitation Act, the Americans with Disabilities Act (ADA)

Accessibility Guidelines, and the uniform federal accessibility standard. The DDA must submit a completed checklist to the Department to verify compliance with the ADA requirements. This checklist must be provided to the Department with the application for certification. ( )

**02. Environment**. The facilities of the agency must be designed and equipped to meet the needs of each participant including factors such as sufficient space, equipment, lighting, and noise control. ( )

**03. Fire and Safety Standards**. ( )

**a.** Buildings on the premises must meet all local and state codes concerning fire and life safety that are applicable to a DDA. The owner or operator of a DDA must have the center inspected at least annually by the local fire authority and as required by local city or county ordinances. In the absence of a local fire authority, such inspections must be obtained from the Idaho State Fire Marshall's office. A copy of the inspection must be made available to the Department upon request and must include documentation of any necessary corrective action taken on violations cited; ( )

**b.** There must be written policies and procedures covering the protection of all persons in the event of fire and other emergencies; ( )

**c.** On the premises where natural or man-made hazards are present, suitable fences, guards, or railings must be provided to protect participants; ( )

**d.** The premises must be kept free from the accumulation of weeds, trash, and rubbish; and ( )

**e.** Portable heating devices are prohibited except those units that have heating elements that are limited to not more than two hundred twelve degrees Fahrenheit (212°F). The use of unvented, fuel-fired heating devices of any kind is prohibited. All portable space heaters must be approved by Underwriters Laboratories as well as approved by the local fire or building authority and covered in the local fire or building inspections; and ( )

**f.** All hazardous or toxic substances must be properly labeled and stored under lock and key; and ( )

**g.** Water temperatures in areas accessed by participants must not exceed one hundred twenty degrees Fahrenheit (120°F); and ( )

**h.** There must be a telephone available on the premises for use in the event of an emergency. Emergency telephone numbers must be posted near the telephone. ( )

**04. Evacuation Plans**. Evacuation plans must be posted throughout the center. Plans must indicate point of orientation, location of all fire extinguishers, location of all fire exits, and designated meeting area outside of the building. ( )

**a.** The DDA must conduct quarterly fire drills. At least two (2) times each year these fire drills must include complete evacuation of the building. The DDA must document the amount

of time it took to evacuate the building; and ( )

**b.** A brief summary of each fire drill conducted must be written and maintained on file. The summary must indicate the date and time the drill occurred, participants and staff participating, problems encountered, and corrective action(s) taken. ( )

**05. Food Safety and Storage**. ( )

**a.** When the agency provides food service for participants and meets the definition of a "food establishment," in Section 39-1602, Idaho Code, the agency must comply with IDAPA 16.02.19, "Food Safety and Sanitation Standards for Food Establishments." Compliance is verified through inspection by the local District Health Department. ( )

**b.** When the agency does not provide food service for participants, it must keep refrigerators and freezers used to store participant lunches and other perishable foods in good repair and equipped with an easily readable thermometer. Refrigerators must be maintained at forty-one degrees Fahrenheit (41°F) or below. Freezers must be maintained at ten degrees Fahrenheit (10°F) or below. ( )

**c.** When medicines requiring refrigeration are stored in a food refrigerator, medicines must be stored in a package and kept inside a covered, leak-proof container that is clearly identified as a container for the storage of medicines. ( )

**06. Housekeeping and Maintenance Services**. ( )

**a.** The interior and exterior of the center must be maintained in a clean, safe, and orderly manner and must be kept in good repair; ( )

**b.** Deodorizers cannot be used to cover odors caused by poor housekeeping or unsanitary conditions; ( )

**c.** The center must be maintained free from infestations of insects, rodents, and other pests; and ( )

**d.** The center must maintain the temperature and humidity within a normal comfort range by heating, air conditioning, or other means. ( )

**501. VEHICLE SAFETY REQUIREMENTS.**

Each DDA that transports participants must: ( )

**01. Preventative Maintenance Program**. Establish a preventive maintenance program for each agency-owned or leased vehicle, including vehicle inspections and other regular maintenance to ensure participant safety. ( )

**02. Transportation Safety Policy**. Develop and implement a written transportation safety policy. ( )

**03. Licenses and Certifications for Drivers and Vehicles**. Obtain and maintain

licenses and certifications for drivers and vehicles required by public transportation laws, regulations, and ordinances that apply to the agency to conduct business and to operate the types of vehicles used to transport participants. Agencies must maintain documentation of appropriate licensure for all employees who operate vehicles. ( )

**04. Applicable Laws, Rules, and Regulations**. Adhere to all laws, rules, and regulations applicable to drivers and vehicles of the type used. ( )

**05. Liability Insurance**. Continuously maintain liability insurance that covers all passengers and meets the minimum liability insurance requirements under Idaho law. If an agency employee transports participants in the employee's personal vehicle, the agency must ensure that adequate liability insurance coverage is carried to cover those circumstances. ( )

**502. -- 509. (RESERVED).**

**510. HEALTH REQUIREMENTS.**

**01. Required Health Policies and Procedures**. Each DDA must develop policies and procedures that: ( )

**a.** Describe how the agency will ensure that each staff person is free from communicable disease; ( )

**b.** Describe how the agency will protect participants from exposure to individuals exhibiting symptoms of illness. ( )

**c.** Address any special medical or health care needs of particular participants being served by the agency. ( )

**02. Services that Require Licensed Professionals**. Some services are of such a technical nature that they must always be performed by, or under the supervision of, a licensed nurse or other licensed health professional. The agency must ensure all such care is provided within the scope of the care provider's training and expertise. These limitations are outlined in IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." ( )

**03. Employees**. Each employee who has direct contact with participants must be free of communicable disease and infected skin lesions while on duty. ( )

**04. Incident Reports**. Each DDA must complete incident reports for all accidents, injuries, or other events that endanger a participant or require the participant to be hospitalized. Each report must document the adult participant's legal guardian, if he has one, or, in the case of a minor, the minor's parent or legal guardian, has been notified or that the participant's care provider has been notified if the participant or the participant's parent or legal guardian has given the agency permission to do so. A documented review by the agency of all incident reports must be completed at least annually with written recommendations. These reports must be retained by the agency for five (5) years. ( )

**05. Reporting Incidents as Mandatory Reporters**. DDA's must notify appropriate

authorities of any health- and safety-related incident they are obligated to report to adult or child protection authorities, or law enforcement as mandatory reporters as required in Section 910 of these rules. ( )

**06. Reporting Incidents to the Department**. If a DDA reports a health- and safety-related incident to protective or legal authorities, they must also notify the Department of this incident within twenty-four (24) hours. ( )

**511. MEDICATION STANDARDS AND REQUIREMENTS.**

**01. Medication Policy**. Each DDA must develop written medication policies and procedures that outline in detail how the agency will ensure appropriate handling and safeguarding of medications. An agency that chooses to assist participants with medications must also develop specific policies and procedures to ensure this assistance is safe and is delivered by qualified, fully-trained staff. Documentation of training must be maintained in the staff personnel file. ( )

**02. Handling of Participant's Medication**. ( )

**a.** The medication must be in the original pharmacy-dispensed container, or in an original over-the-counter container, or placed in a unit container by a licensed nurse and be appropriately labeled with the name of the medication, dosage, time to be taken, route of administration, and any special instructions. Each medication must be packaged separately, unless in a Mediset, blister pack, or similar system. ( )

**b.** Evidence of the written or verbal order for the medication from the physician or other practitioner of the healing arts must be maintained in the participant's record. Medisets filled and labeled by a pharmacist or licensed nurse can serve as written evidence of the order. An original prescription bottle labeled by a pharmacist describing the order and instructions for use can also serve as written evidence of an order from the physician or other practitioner of the healing arts. ( )

**c.** The agency is responsible to safeguard the participant's medications while the participant is at the agency or in the community. ( )

**d.** Medications that are no longer used by the participant must not be retained by the agency or agency staff for longer than thirty (30) calendar days. ( )

**03. Self-Administration of Medication**. When the participant is responsible for administering his own medication without assistance, a written approval stating that the participant is capable of self-administration must be obtained from the participant's primary physician or other practitioner of the healing arts. The participant's record must also include documentation that a physician or other practitioner of the healing arts, or a licensed nurse has evaluated the participant's ability to self-administer medication and has found that the participant: ( )

**a.** Understands the purpose of the medication; ( )

**b.** Knows the appropriate dosage and times to take the medication; ( )

**c.** Understands expected effects, adverse reactions or side effects, and action to take in an emergency; and ( )

**d.** Is able to take the medication without assistance. ( )

**04. Assistance with Medication**. An agency may choose to assist participants with medications; however, only a licensed nurse or other licensed health professional may administer medications. Prior to unlicensed agency staff assisting participants with medication, the following conditions must be in place: ( )

**a.** 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, a course approved by the Idaho State Board of Nursing, or other Department-approved training; ( )

**b.** The participant's health condition is stable; ( )

**c.** The participant's health status does not require nursing assessment, as outlined in IDAPA 23.01.01, "Rules for the Idaho Board of Nursing," before receiving the medication or nursing assessment of the therapeutic or side effects after the medication is taken; ( )

**d.** The medication is in the original pharmacy-dispensed container with proper label and directions, or in an original over-the-counter container, or the medication has been placed in a unit container by a licensed nurse. Proper measuring devices must be available for liquid medication that is poured from a pharmacy-dispensed container; ( )

**e.** Written and oral instructions from a licensed physician or other practitioner of the healing arts, pharmacist, or nurse concerning the reason(s) for the medication, the dosage, expected effects, adverse reactions or side effects, and action to take in an emergency have been reviewed by the staff person; ( )

**f.** Written instructions are in place that outline required documentation of assistance and who to call if any doses are not taken, overdoses occur, or actual or potential side effects are observed; ( )

**g.** Procedures for disposal or destruction of medications must be documented and consistent with procedures outlined in the "Assistance with Medications" course. ( )

**05. Administration of Medications**. Only a licensed nurse or another licensed health professional working within the scope of his license may administer medications. Administration of medications must comply with the Administrative Rules of the Board of Nursing, IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." ( )

**512. -- 519. (RESERVED).**

**520. SETTING REQUIREMENTS FOR AGENCIES DELIVERING COMMUNITY-BASED SERVICES.**
The requirements in Section 520 of these rules apply when a DDA is providing community-based services. ( )

**01. Accessibility**. The community-based setting must be accessible, safe, and appropriate for each participant. ( )

**02. Environment**. The community-based setting must be designed and equipped to meet the needs of each participant including factors such as sufficient space, equipment, lighting, and noise control. ( )

**03.** ***Service*** **Group Size**. The community-based services must occur in integrated, inclusive settings and with no more than three (3) participants per *qualified staff* at each session. *( )*

**04. Image Enhancement**. The community-based services must enhance each participant's social image and personal competencies. ( )

**05. Promote Inclusion.** The community-based services must promote the participant's inclusion in the natural community. ( )

**06. Natural Environment**. The environment where an activity or behavior naturally occurs that is typical for peers of the participant's age, such as the *home and* community where the *participant* live*s or participates in activities,* and according to the service environment indicated. *( )*

**521. -- 599. (RESERVED).**

***PROGRAM REQUIREMENTS***
***(Sections 600 Through 699)***

**600. 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. ( )

**01. Requirements for Participants Seven Through Sixteen**. For participants ages seven (7) through sixteen (16), the DDA must document that the child has been referred to the local school district. ( )

**02. Requirements for Participants Three to Twenty-One**. For participants ages three (3) to twenty-one (21), the following applies: ( )

**a.** For participants who are children enrolled in school, the local school district is the lead agency as required under Individuals with Disabilities Education Act (IDEA), Part B. The DDA must inform the child's home school district if it is serving the child during the hours that

school is typically in session. ( )

i. The DDA participant's record must contain an Individualized Education Plan (IEP), including any recommendations for an extended school year. ( )

ii. The DDA must document that it has provided a current copy of the child's plan of service to the child's school. ( )

iii. The DDA may provide additional services beyond those the school is obligated to provide during regular school hours. ( )

**b.** For participants of mandatory school attendance age, seven (7) though sixteen (16), who are not enrolled in school, the DDA must document that it has referred the child to the local school district for enrollment in educational and related services under the provisions of the Individuals with Disabilities Education Act (IDEA). ( )

**601. RECORD REQUIREMENTS.**

Each DDA certified under these rules must maintain accurate, current, and complete participant and administrative records. These records must be maintained for at least five (5) years. Each participant record must support the individual's choices, interests, and needs that result in the type and amount of each service provided. Each participant record must clearly document the date, time, duration, and type of service, and include the signature of the individual providing the service, for each service provided. Each signature must be accompanied both by credentials and the date signed. Each agency must have an integrated participant records system to provide past and current information and to safeguard participant confidentiality under these rules. ( )

**01. General Records Requirements.** Each participant record must contain the following information: ( )

***a*.** Authorized plan of service as required for the participant. ( )

***b*.** Program implementation plans that include participant's name, baseline statement, measurable objectives, written instructions to staff, service environments, target date, and corresponding program documentation and monitoring records when intervention services are delivered to the participant. ( )

***c*.** When a participant has had a psychological or psychiatric assessment, the results of the assessment must be maintained in the participant's record. ( )

***d*.** *P*rofile sheet containing the identifying information *reflecting the current status of* the participant, including residence and living arrangement, contact information, emergency contacts, physician, current medications, allergies, special dietary or medical needs, and any other information required to provide safe and effective care; *( )*

***e*.** *M*edical, social, and developmental information and assessments that *reflect the current status of the participant*; and *( )*

***f*.** Intervention evaluation. An evaluation must be completed or obtained by the

agency prior to the delivery of the intervention service. The evaluation must include the results, test scores, and narrative reports signed with credentials and dated by the respective evaluators. ( )

**02. Status Review**. Written documentation that identifies the participant's progress toward goals defined on his plan, and includes why the participant continues to need the service. ( )

**03. Case Record Organization**. The case record must be divided into program and discipline areas identified by tabs, including plan of service, medical, social, psychological, speech, and developmental, as applicable. ( )

**602. -- 609. (RESERVED).**

**610. ACCESSIBILITY OF AGENCY RECORDS.**

The DDA and records required under these rules must be accessible to the Department during normal operations of the agency for the purpose of inspection and copying, with or without prior notification, under Section 39-4605(4), Idaho Code. ( )

**611. -- 899. (RESERVED).**

***QUALITY ASSURANCE, PARTICIPANT RIGHTS, REQUIRED POLICIES, ETC.***
***(Sections 900 Through 999)***

**900. REQUIREMENTS FOR AN AGENCY'S QUALITY ASSURANCE PROGRAM.**

Each DDA defined under these rules must develop and implement a quality assurance program. ( )

**01. Purpose of the Quality Assurance Program**. The quality assurance program is an ongoing, proactive, internal review of the DDA designed to ensure: ( )

**a.** Services provided to participants produce measurable outcomes, are high quality, and are consistent with individual choices, interests, needs, and current standards of practice; ( )

**b.** Sufficient staff and material resources are available to meet the needs of each person served; ( )

**c.** The environment in which services are delivered is safe and conducive to learning; ( )

**d.** Skill training activities are conducted in the natural setting where a person would commonly learn and utilize the skill, whenever appropriate; and ( )

**e.** The rights of a person with disabilities are protected and each person is provided opportunities and training to make informed choices. ( )

**02. Quality Assurance Program Components**. Each DDA's written quality assurance program must include: ( )

**a.** Goals and procedures to be implemented to achieve the purpose of the quality assurance program as described in Subsection 900.01 of this rule; ( )

**b.** Person, discipline, or department responsible for each goal; ( )

**c.** A system to ensure the correction of problems identified within a specified period of time; ( )

**d.** A method for assessing participant satisfaction annually including minimum criteria for participant response and alternate methods to gather information if minimum criteria is not met; ( )

**e.** An annual review of the agency's code of ethics, identification of violations, and implementation of an internal plan of correction; ( )

**f.** An annual review of agency's policy and procedure manual to specify date and content of revisions made; and ( )

**g.** *Ongoing r*eview of participant progress *to ensure* revisions *to* daily activities or specific implementation procedures are *made when progress, regression, or inability to maintain independence is identified*. *( )*

**03. Additional Requirements**. The quality assurance program must ensure that DDA services provided to participants: ( )

**a.** Are developed with each participant, parent, or legal guardian, where applicable, and actively promote the participation, personal choice, and preference of the participant; ( )

**b.** Are age appropriate; ( )

**c.** Promote integration; ( )

**d.** Provide opportunities for community participation and inclusion; ( )

**e.** Offer opportunities for participants to exercise their rights; and ( )

**f.** Are observable in practice. ( )

**901. -- 904. (RESERVED).**

**905. PARTICIPANT RIGHTS.**

Each DDA must ensure the rights provided under Sections 66-412 and 66-413, Idaho Code, as well as the additional rights listed in Subsection 905.02 of this rule, for each participant receiving DDA services. ( )

**01. Participant Rights Provided Under Idaho Code**. Section 66-412, Idaho Code, provide the following rights for participants: ( )

**a.** Humane care and treatment; ( )

**b.** Not be put in isolation; ( )

**c.** Be free of mechanical restraints, unless necessary for the safety of that person or for the safety of others; ( )

**d.** Be free of mental and physical abuse; ( )

**e.** Voice grievances and recommend changes in policies or services being offered; ( )

**f.** Practice his own religion; ( )

**g.** Wear his own clothing and retain and use personal possessions; ( )

**h.** Be informed of his medical and habilitative condition, of services available at the agency, and the charges for the services; ( )

**i.** Reasonable access to all records concerning himself; ( )

**j.** Refuse services; and ( )

**k.** Exercise all civil rights, unless limited by prior court order. ( )

**02. Additional Participant Rights**. The agency must also ensure the following rights for each participant: ( )

**a.** Privacy and confidentiality; ( )

**b.** Receive courteous treatment; ( )

**c.** Receive a response from the agency to any request made within a reasonable time frame; ( )

**d.** Receive services that enhance the participant's social image and personal competencies and, whenever possible, promote inclusion in the community; ( )

**e.** Refuse to perform services for the agency. If the participant is hired to perform services for the agency the wage paid must be consistent with state and federal law; ( )

**f.** Review the results of the most recent survey conducted by the Department and the accompanying plan of correction; ( )

**g.** All other rights established by law; and ( )

**h.** Be protected from harm. ( )

**03. Method of Informing Participants of Their Rights**. Each DDA must ensure and document that each person receiving services is informed of his rights in the following manner: ( )

**a.** Upon initiation of services, the DDA must provide each participant and his parent or guardian, where applicable, with a packet of information which outlines rights, access to grievance procedures, and the names, addresses, and telephone numbers of protection and advocacy services. This packet must be written in easily understood terms. ( )

**b.** When providing center-based services, a DDA must prominently post a list of the rights contained in this chapter. ( )

**c.** The DDA must provide each participant and his parent or guardian, where applicable, with a verbal explanation of their rights in a manner that will best promote individual understanding of these rights. ( )

**d.** Parents of infants and toddlers under three (3) years of age must be provided with a copy of their parental rights consistent with the requirements of 34 CFR 303.400 through 303.460, and 303.510 through 303.512. ( )

**906. -- 909. (RESERVED).**

**910. OBLIGATION TO REPORT ABUSE, NEGLECT, EXPLOITATION, AND INJURIES.**

Each agency must report all confirmed or suspected incidents of mistreatment, neglect, exploitation, or abuse of participants to the adult or child protection authority in accordance with the "Child Protective Act," Section 16-1619, Idaho Code, and the "Adult Abuse, Neglect and Exploitation Act," Section 39-5303, Idaho Code, or law enforcement as mandatory reporters. ( )

**911. -- 914. (RESERVED).**

**915. POLICIES AND PROCEDURES REGARDING DEVELOPMENT OF SOCIAL SKILLS AND MANAGEMENT OF *MALADAPTIVE* BEHAVIOR.**

Each DDA must develop and implement written policies and procedures that address the development of participants' social skills and management of *maladaptive* behavior. These policies and procedures must include statements that *address*: *( )*

**01. Adaptive and Maladaptive Behaviors**. *For intervention services, e*nsure *an evaluation* of participants' *adaptive and maladaptive* behaviors *is completed*. *( )*

**02. Social Skills *Development***. Focus on developing or increasing participants' social skills. *( )*

**03. Prevention Strategies**. Ensure and document the use of positive approaches to

increase social skills and decrease *maladaptive* behavior while using least restrictive alternatives and consistent, proactive responses to behaviors. *( )*

**04. Function of Behavior**. Address the possible underlying causes or function of a behavior and identify what participants may be attempting to communicate by the behavior. ( )

**05. Behavior Replacement**. For intervention services, ensure that programs to assist participants with managing *maladaptive* behavior include teaching of alternative adaptive skills to replace the *maladaptive* behavior. *( )*

**06. Protected Rights**. Ensure the safety, welfare, and human and civil rights of participants are adequately protected. ( )

**07. Objectives and Plans**. For intervention services, ensure that objectives and intervention techniques are developed or obtained and implemented to address self-injurious behavior, aggressive behavior, inappropriate sexual behavior, and any other behaviors which significantly interfere with participants' independence or ability to participate in the community. Ensure that reinforcement selection is individualized and appropriate to the task and not contraindicated for medical reasons. ( )

**08. Participant Involvement**. Ensure plans developed by the DDA involve the participants, whenever possible, in developing the plan to increase social skills and to manage *maladaptive* behavior. *( )*

**09. Written Informed Consent**. Ensure programs developed by an agency to assist participants with managing *maladaptive* behavior are conducted only with the written informed consent of a participant, parent, or legal guardian, where applicable. When programs used by the agency are developed by another service provider the agency must obtain a copy of the informed consent. *( )*

**10. Review and Approval**. Ensure programs developed by an agency to manage *maladaptive* behavior are only implemented after the review and written approval of the professional. If the program contains restrictive or aversive components, a licensed individual working within the scope of their license, must also review and approve, in writing, the plan prior to implementation. When programs implemented by the agency are developed by another service provider, the agency must obtain a copy of these reviews and approvals. *( )*

**11. Appropriate Use of Interventions**. Ensure interventions used to manage participants' *maladaptive* behavior are never used: *( )*

**a.** For disciplinary purposes; ( )

**b.** For the convenience of staff; ( )

**c.** As a substitute for a needed training program; or ( )

**d.** By untrained or unqualified staff. ( )

**916. -- 919. (RESERVED).**

**920. ANNUAL PLAN.**

Each agency is required, as needed, to participate in the development of the state developmental disabilities plan by completing an annual needs assessment survey regarding services for Idahoans with developmental disabilities. ( )

**921. -- 999. (RESERVED).**

# IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

## 16.04.11 - DEVELOPMENTAL DISABILITIES AGENCIES

## DOCKET NO. 16-0411-1001 - (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 2011 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. The effective date for this rule is **July 1, 2011**.

**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 Title 39, Chapter 46, 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 pending rule is being adopted as proposed. The notice of the proposed rule repealing this chapter was published in the** September 1, 2010, Idaho Administrative Bulletin, Vol. 10-9, page 321**.**

**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 fund.

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning this pending rule, contact Randy May at (208) 334-5747.

DATED this 12th day of November, 2010.

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 Title 39, Chapter 48, Idaho Code.

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

| Wednesday, September 15, 2010<br>6:00 p.m. PDT | Wednesday, September 15, 2010<br>6:00 p.m. MDT | Wednesday, September 15, 2010<br>6:00 p.m. MDT |
|---|---|---|
| Dept. of Health & Welfare-Reg. 1<br>1120 Ironwood Drive, Suite 102<br>Lower Level Large Conf. Rm.<br>Coeur d'Alene, ID | Dept. of Health & Welfare-Reg. 4<br>1720 Westgate Drive<br>Suite A, Room 131<br>Boise, ID | Dept. Health & Welfare-Reg. 7<br>150 Shoup Avenue<br>2nd Floor, Large Conf. Rm.<br>Idaho Falls, 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:

**This chapter is being repealed under this docket and rewritten under IDAPA 16.03.21, "Developmental Disabilities Agencies," Docket 16-0321-1001 in this bulletin. This rewritten chapter will contain the Licensing and Certification requirements for developmental disabilities agencies. With this repeal, the benefits and services have been moved into Department rules under Docket 16-0310-1002, "Medicaid Enhanced Plan Benefits," and Docket 16-0313-1002, "Consumer-Directed Services," in this bulletin.**

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

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

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220, Idaho Code, informal negotiated rulemaking was conducted with stakeholders in a meeting held on Wednesday, July 14, 2010.

**The notice for this negotiated rulemaking published in the July 7, 2010, Idaho Administrative Bulletin, Vol. 10-7, page 35.**

**INCORPORATION BY REFERENCE:** No materials are being incorporated by reference under this docket.

**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 22, 2010.

DATED this 11th day of August, 2010.

**IDAPA 16.04.11 IS BEING REPEALED IN ITS ENTIRETY**

# IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

## 16.05.06 - CRIMINAL HISTORY AND BACKGROUND CHECKS

## DOCKET NO. 16-0506-1001

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** The effective date of the amendment to the temporary rule is September 1, 2010. This pending rule has been adopted by the agency and is now pending review by the 2011 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 Section 56-1004A, 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.

**The Department implemented a selective contract for Non-Emergency Medical Transportation Services under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." These rules for criminal history checks have been amended to reflect that change.**

**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** July 7, 2010, Idaho Administrative Bulletin, Vol. 10-7, pages 36 through 44**.**

**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 and the amendment to temporary rule, contact Steve Bellomy (208) 334-0609.

DATED this 12th day of November, 2010.

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

***THIS NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE***

**EFFECTIVE DATES:** The effective dates of these temporary rules are **May 1, 2010, and July 1, 2010.**

**AUTHORITY:** In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 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 July 21, 2010.

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 criminal history and background check (CHC) rules provide a list of individuals and providers required to have a CHC. The CHC rules reference other Department rules and statutes requiring certain individuals to meet the CHC requirements. Currently, some of the individuals and providers listed in this chapter are not consistent with the Department rules that require the background check. In order to clarify the distinction between the Department's program rules and the Department's CHC rules, these CHC rules are being amended to reference only those Department rules that require an individual to have a criminal history and background check.**

**The Department's list of disqualifying crimes, and unconditional denials that prevent a person from receiving a CHC clearance is being updated. The Department is changing these rules to state that an individual listed on the Nurse Aide and Child Protection Central registries will receive unconditional denials. The 5-year disqualifying crimes list is amended to encompass additional crimes to better protect children and vulnerable adults.**

**TEMPORARY RULE JUSTIFICATION:** Pursuant to Sections 67-5226(1)(a), Idaho Code, the Governor has found that temporary adoption of these rules are appropriate for the following reason:

**To protect the safety of children and vulnerable adults from individuals who may harm them.**

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

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

There is no anticipated fiscal impact to the state general fund due to this rule change.

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because this rule change is necessary to protect the public health, safety, or welfare.

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

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the temporary and proposed rule, contact Steve Bellomy (208) 334-0609.

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 28, 2010.

DATED this 27th day of May, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0506-1001***

## 010. DEFINITIONS AND ABBREVIATIONS.

**01. Application**. An individual's request for a criminal history and background check in which the individual discloses any convictions, pending charges, or child or adult protection findings, and authorizes the Department to obtain information from available databases and sources relating to the individual. (3-26-08)

**02. Clearance**. A clearance issued by the Department once the criminal history and background check is completed and no disqualifying crimes or relevant records are found.

(3-26-08)

**03. Conviction**. An individual is considered to have been convicted of a criminal offense as defined in Subsections 010.03.a. through 010.03.d. of this rule: (3-26-08)

**a.** When a judgment of conviction, or an adjudication, has been entered against the individual by any federal, state, military, or local court; (3-26-08)

**b.** When there has been a finding of guilt against the individual by any federal, state, military, or local court; (3-26-08)

**c.** When a plea of guilty or nolo contendere by the individual has been accepted by any federal, state, military, or local court; (3-26-08)

**d.** When the individual has entered into or participated in first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld. This includes: (3-26-08)

i. When the individual has entered into participation in a drug court; or (3-26-08)

ii. When the individual has entered into participation in a mental health court. (3-26-08)

**04. Criminal History and Background Check**. A criminal history and background check is a fingerprint-based check of an individual's criminal record and other relevant records ~~*to determine the suitability of the individual to provide care or services to vulnerable adults or children*~~. ~~*(3-26-08)*~~(    )

**05. Criminal History Unit**. The Department's Unit responsible for processing fingerprint-based criminal history and background checks, conducting exemption reviews, and issuing clearances or denials according to these rules. (3-26-08)

**06. Denial**. A denial is issued by the Department when an individual has a relevant record or disqualifying crime. There are two (2) types of denials: (3-26-08)

**a.** Conditional Denial. A denial of an applicant because of a relevant record found in Section 230 of these rules. (3-26-08)

**b.** Unconditional Denial. A denial of an applicant because of a conviction for a disqualifying crime or a relevant record found in Sections 200 and 210 of these rules. ~~*(3-26-08)*~~(    )

**07. Department**. The Idaho Department of Health and Welfare or its designee. (3-26-08)

**08. Disqualifying Crime**. A disqualifying crime is a designated crime listed in Section 210 of these rules that results in the unconditional denial of an applicant. (3-26-08)

**09. Exemption Review**. A review by the Department at the request of the applicant when a conditional denial has been issued. (3-26-08)

**10. Federal Bureau of Investigation (FBI)**. The federal agency where fingerprint-based criminal history and background checks are processed. (3-26-08)

**11. Good Cause**. ~~*The facts and circumstances that would compel a reasonably prudent person to act in the same or similar manner under the same or similar circumstances*~~ Substantial reason, one that affords a legal excuse. ~~*(3-26-08)*~~(    )

**12. Idaho State Police Bureau of Criminal Identification**. The state agency where fingerprint-based criminal history and background checks are processed. (3-26-08)

**13. Relevant Record**. A relevant record is a record that is from criminal records or from registries checked by the Department as provided in Section 56-1004A, Idaho Code~~*, that may result in a conditional denial*~~. ~~*(3-26-08)*~~(    )

## *(BREAK IN CONTINUITY OF SECTIONS)*

### 061. EMPLOYER RESPONSIBILITIES.

The criminal history and background check clearance is not a determination of suitability for employment. The Department's criminal history and background check clearance means that an individual was found to have no disqualifying crime or relevant record. Employers are responsible for determining the individual's suitability for employment as described in Subsections 061.01 through 061.03 of these rules. (3-26-08)

**01. Screen Applicants**. The employer should screen applicants prior to initiating a criminal history and background check in determining the suitability of the applicant for employment. If an applicant discloses a disqualifying crime or offense, or discloses other information that would indicate a risk to the health and safety of children and vulnerable adults, a determination of suitability for employment should be made during the initial application screening. (3-26-08)

**02. Ensure Time Frames Are Met**. The employer is responsible to ensure that the required time frames are met for completion and submission of the application and fingerprints to the Department as required in Section 150 of these rules. (3-26-08)

**03. Employment Determination**. The employer is responsible for reviewing the results of the criminal history and background check even if a clearance that resulted in no disqualifying crimes or offenses found is issued by the Department. The employer must then make a determination as to the ability or risk of the individual to provide care or services to children or vulnerable adults. ~~*(3-26-08)*~~(    )

***(BREAK IN CONTINUITY OF SECTIONS)***

**100. INDIVIDUALS SUBJECT TO A CRIMINAL HISTORY AND BACKGROUND CHECK.**
Individuals subject to a Department criminal history and background check are those persons or classes of individuals who are required by statute, or ~~*program*~~ Department rules to complete a criminal history and background check. ~~*(3-26-08)*~~(____)

**01. Adoptive Parent Applicants**. ~~*All persons applying to the Department or petitioning the court to be an adoptive parent and all adults in the home, except stepparents applying for adoption of a stepchild, as described in*~~ Individuals who must comply with IDAPA 16.06.01, "~~*Rules Governing*~~ Child and Family ~~*and Children's*~~ Services," and IDAPA 16.06.02, "Rules Governing Standards for Child Care Licensing." ~~*(3-29-10)*~~(____)

**02. Alcohol or Substance Use Disorders Treatment Facilities and Programs**. ~~*Staff, contractors, volunteers, student interns, and others assigned to programs who have direct contact with children and vulnerable adults, as defined in Section 39-5302, Idaho Code, and as required by IDAPA 16.06.03, "Rules and Minimum Standards Governing Alcohol/Drug Abuse Prevention and Treatment Programs," or*~~ Individuals who must comply with IDAPA 16.07.20, "Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs~~.~~," and IDAPA 16.03.09, "Medicaid Basic Plan Benefits." ~~*(3-29-10)*~~(____)

**03. Certified Family Homes**. ~~*Certified family home providers, all adults in the home, and substitute caregivers, as required in*~~ Individuals who must comply with Section 39-3520, Idaho Code, ~~*and*~~ IDAPA 16.03.19, "Rules Governing Certified Family Homes," and IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ~~*(3-29-10)*~~(____)

**04. Children's Residential Care Facilities**. ~~*Owners, operators, and employees of all children's residential care facilities, as required in*~~ Individuals who must comply with Section 39-1210, Idaho Code, and IDAPA 16.06.02, "Rules Governing Standards for Child Care Licensing." ~~*(3-29-10)*~~(____)

**05. Children's Therapeutic Outdoor Programs**. ~~*Staff, volunteers, and interns working in Children's Therapeutic Outdoor Programs, as defined in*~~ Individuals who must comply with Section 39-1208, Idaho Code, and IDAPA 16.06.02, "Rules Governing Standards for Child Care Licensing." ~~*(3-29-10)*~~(____)

**06. ~~*Commercial*~~ *Contracted* Non-Emergency *Medical* Transportation Providers**. ~~*Staff of commercial non-emergency transportation providers who have contact with participants, as required in*~~ Individuals who must comply with IDAPA 16.03.09, "Medicaid Basic Plan Benefits." ~~*(3-29-10)*~~*(____)*

**07. Designated Examiners and Designated Dispositioners**. Individuals ~~*seeking appointment as a designated examiner or designated dispositioner, or both, as required in*~~ who must comply with IDAPA 16.07.39, "Appointment of Designated Examiners and Designated Dispositioners." ~~*(3-29-10)*~~(____)

**08. Developmental Disabilities Agencies**. ~~*Employees, subcontractors, agents, and volunteers of developmental disabilities agencies, as required in*~~ Individuals who must comply with IDAPA 16.04.11, "Rules Governing Developmental Disabilities Agencies," and IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ~~*(3-29-10)*~~(____)

**09. Emergency Medical Services (EMS)**. ~~*Applicants for EMS certification, as required in*~~ Individuals who must comply with IDAPA 16.02.03, "Rules Governing Emergency Medical Services." ~~*(3-29-10)*~~(____)

**10. Home and Community-Based Services (HCBS)**. ~~*Providers, employees, and contractors for home and community-based services, as required in*~~ Individuals who must comply with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ~~*(3-29-10)*~~(____)

**11. Home Health Agencies**. ~~*Employees and contractors of home health agencies, as required in*~~ Individuals who must comply with IDAPA 16.03.07, "Home Health Agencies." ~~*(3-29-10)*~~(____)

**12. Idaho Child Care Program (ICCP)**. ~~*ICCP applicants, providers, employees, volunteers, including those in group child care, family child care, relative child care, in-home child care, and individuals age thirteen (13) or older living in the home, who have direct contact with children, as required in*~~ Individuals who must comply with IDAPA 16.06.12, "Rules Governing the Idaho Child Care Program." ~~*(3-29-10)*~~(____)

**13. Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID)**. ~~*Employees and contractors of intermediate care facilities for the mentally retarded, as required in*~~ Individuals who must comply with IDAPA 16.03.11, "Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID)." ~~*(3-29-10)*~~(____)

**14. Licensed Foster Care**. ~~*All foster care applicants and other adult members of the household, as required in*~~ Individuals who must comply with Section 39-1211, Idaho Code, and IDAPA 16.06.02, "Rules Governing Standards for Child Care Licensing." ~~*(3-29-10)*~~(____)

**15. Licensed Day Care**. ~~*Applicants, owners, operators, employees, volunteers, and those over twelve (12) years of age who have unsupervised direct contact with the children of day care centers, group day care facilities and family day care homes, as required in*~~ Individuals who must comply with Sections 39-1105, 39-1113, and 39-1114, Idaho Code, and IDAPA 16.06.02, "Rules Governing Standards for Child Care Licensing." ~~*(3-29-10)*~~(____)

**16. Mental Health Clinics**. ~~*Mental health clinic's direct care staff, as required in*~~ Individuals who must comply with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," and IDAPA 16.03.09, "Medicaid Basic Plan Benefits." ~~*(3-29-10)*~~(____)

**17. Nonhospital, Medically-Monitored Detoxification/Mental Health Diversion Units**. ~~*Owners, operators, and all employees, transfers, reinstated former employees, student interns, contractors, and volunteers who provide care or services or have access to clients, as required in*~~ Individuals who must comply with IDAPA 16.07.50, "Minimum Standards for Nonhospital, Medically-Monitored Detoxification/Mental Health Diversion Units." ~~*(3-29-10)*~~(____)

**18. Personal Assistance Agencies**. ~~*Staff of personal assistance agencies acting as fiscal intermediaries, as required in*~~ Individuals who must comply with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ~~*(3-29-10)*~~(____)

**19. Personal Care Service Providers**. ~~*Providers of personal care services, as required in*~~ Individuals who must comply with Section 39-5604, Idaho Code, and IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ~~*(3-29-10)*~~(____)

**20. Psychosocial Rehabilitation Providers**. Individuals ~~*providing psychosocial rehabilitation services, as required in*~~ who must comply with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ~~*(3-29-10)*~~(____)

**21. Residential Care or Assisted Living Facilities in Idaho**. ~~*Employees and contractors of residential care or assisted living facilities, as required in*~~ Individuals who must comply with IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." ~~*(3-29-10)*~~(____)

**22. Semi-Independent Group Residential Care Facilities for the Developmentally Disabled or Mentally Ill**. ~~*Employees and contractors of semi-independent group residential care facilities for the developmentally disabled or mentally ill, as required in*~~ Individuals who must comply with IDAPA 16.03.15, "Rules and Minimum Standards for Semi-Independent Group Residential Care Facilities for the Developmentally Disabled or Mentally Ill." ~~*(3-29-10)*~~(____)

**23. Service Coordinators and Paraprofessional Providers**. ~~*Service coordinators and paraprofessionals working for an agency, as required in*~~ Individuals who must comply with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ~~*(3-29-10)*~~(____)

**24. Skilled Nursing and Intermediate Care Facilities**. ~~*Employees and contractors of skilled nursing and intermediate care facilities, as required in*~~ Individuals who must comply with IDAPA 16.03.02, "Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities." ~~*(3-29-10)*~~(____)

**25. Support Brokers and Community Support Workers**. ~~*Support brokers and community support workers, as required in*~~ Individuals who must comply with IDAPA 16.03.13, "Consumer-Directed Services." ~~*(3-29-10)*~~(____)

### *(BREAK IN CONTINUITY OF SECTIONS)*

## 200. UNCONDITIONAL DENIAL.

An individual who receives an unconditional denial is not available to provide services, have access, or to be licensed or certified by the Department. (3-26-08)

**01. Reasons for an Unconditional Denial~~*Issuance*~~**. Unconditional denials are issued for: (____)

**a.** ~~d~~Disqualifying crimes described in Section 210 of these rules~~.~~; ~~(3-26-08)~~(    )

**b.** A relevant record on the Idaho Child Abuse Central Registry with a Level 1 or Level 2 finding; or (    )

**c.** A relevant record on the Nurse Aide Registry. (    )

**02. Issuance of an Unconditional Denial**. The Department will issue an unconditional denial within fourteen (14) days of completion of a criminal history and background check. (3-26-08)

**03. Challenge of Department's Unconditional Denial**. An individual has thirty (30) days from the date the unconditional denial is issued to challenge the Department's unconditional denial. The individual must submit the challenge in writing and provide court records or other information which demonstrates the Department's unconditional denial is incorrect. These documents must be filed with~~:~~ ~~T~~the Criminal History Unit~~, 3268 Elder Street, Boise, ID 83705~~ described in Section 005 of these rules. ~~(3-26-08)~~(    )

**a.** If the individual challenges the Department's unconditional denial, the Department will review the court records, documents and other information filed by the individual. The Department will issue a decision within thirty (30) days of the receipt of the challenge. The Department's decision will be a final order under IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings," Section 152. (3-26-08)

**b.** If the individual does not challenge the Department's unconditional denial within thirty (30) days, it becomes a final order of the Department under IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings," Section 152. (3-26-08)

**04. No Exemption Review**. No exemption review, as described in Section 250 of these rules, is allowed for an unconditional denial. (3-26-08)

**05. Final Order**. The Department's final order under IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings," Section 152, may be appealed in District Court. (3-26-08)

**201. -- 209. (RESERVED).**

**210. DISQUALIFYING CRIMES RESULTING IN AN UNCONDITIONAL DENIAL.**

An individual is not available to provide direct care or services when the individual discloses or the criminal history and background check reveals a conviction for a disqualifying crime on his record as described in Subsections 210.01 and 210.02 of this rule. (3-26-08)

**01. Disqualifying Crimes**. The disqualifying crimes described in Subsections 210.01.a through 210.01.v. of these rules will result in an unconditional denial being issued. (3-26-08)

**a.** Abuse, neglect, or exploitation of a vulnerable adult, as defined in Section 18-

1505, Idaho Code; (3-26-08)

**b.** Aggravated, first-degree and second-degree arson, as defined in Sections 18-801 through 18-803, and 18-805, Idaho Code; (3-26-08)

**c.** Crimes against nature, as defined in Section 18-6605, Idaho Code; (3-26-08)

**d.** Forcible sexual penetration by use of a foreign object, as defined in Section 18-6608, Idaho Code; (3-26-08)

**e.** Incest, as defined in Section 18-6602, Idaho Code; (3-26-08)

**f.** Injury to a child, felony or misdemeanor, as defined in Section 18-1501, Idaho Code; (3-26-08)

**g.** Kidnapping, as defined in Sections 18-4501 through 18-4503, Idaho Code; (3-26-08)

**h.** Lewd conduct with a minor, as defined in Section 18-1508, Idaho Code; (3-26-08)

**i.** Mayhem, as defined in Section 18-5001, Idaho Code; (3-26-08)

**j.** Murder in any degree, ~~*voluntary*~~ manslaughter, assault, or battery with intent to commit a serious felony, as defined in Sections 18-909, 18-911, 18-4001, 18-4003, 18-4006, and 18-4015, Idaho Code; ~~*(3-26-08)*~~(_____)

**k.** Poisoning, as defined in Sections 18-4014 and 18-5501, Idaho Code; (3-26-08)

**l.** Possession of sexually exploitative material, as defined in Section 18-1507A, Idaho Code; (3-26-08)

**m.** Rape, as defined in Section 18-6101, Idaho Code; (3-26-08)

**n.** Robbery, as defined in Section 18-6501, Idaho Code; (3-26-08)

**o.** Felony stalking, as defined in Section 18-7905, Idaho Code; (3-26-08)

**p.** Sale or barter of a child, as defined in Section 18-1511, Idaho Code; (3-26-08)

**q.** Sexual abuse or exploitation of a child, as defined in Sections 18-1506 and 18-1507, Idaho Code; (3-26-08)

**r.** Video voyeurism, as defined in Section 18-6609, Idaho Code; (3-26-08)

**s.** Enticing of children, as defined in Sections 18-1509 and 18-1509A, Idaho Code; (3-26-08)

**t.** Inducing individuals under eighteen (18) years of age into prostitution or

patronizing a prostitute, as defined in Sections 18-5609 and 18-5611, Idaho Code; (3-26-08)

**u.** Any felony punishable by death or life imprisonment; or (3-26-08)

**v.** Attempt, conspiracy, accessory after the fact, or aiding and abetting, as defined in Sections 18-205, 18-306, 18-1701, and 19-1430, Idaho Code, to commit any of the disqualifying designated crimes. (3-29-10)

**02. Disqualifying Five-Year Crimes**. The Department will issue an unconditional denial for an individual who has been convicted of the following described crimes for five (5) years from the date of the conviction for the crimes listed in Subsections 210.02.a. through 210.02.~~q~~h. of this rule: ~~(3-29-10)~~(    )

**a.** ~~*Aggravated assault, as defined in Section 18-905, Idaho Code*~~ Any felony not described in Subsection 210.01, of this rule; ~~(3-26-08)~~(    )

~~***b.*** *Aggravated battery, as defined in Section 18-907(1), Idaho Code;* (3-26-08)~~

~~***c.*** *Arson in the third degree, as defined in Section 18-804, Idaho Code;* (3-26-08)~~

~~***d.*** *Burglary, as defined in Section 18-1401, Idaho Code;* (3-26-08)~~

~~***e.*** *Felony computer crimes, as defined in Section 18-2202, Idaho Code;* (3-29-10)~~

~~***f.*** *A felony involving a controlled substance;* (3-26-08)~~

~~***g.*** *Felony domestic violence, as defined in Section 18-918, Idaho Code;* (3-29-10)~~

~~***h.*** *Any felony lottery crime as defined in Section 67-7448, Idaho Code;* (3-29-10)~~

~~***i.*** *Felony theft, as defined in Section 18-2403, Idaho Code;* (3-26-08)~~

~~***j***~~**b.** Misdemeanor ~~*F*~~forgery of and fraudulent use of a financial transaction card, as defined in Sections 18-3123 through 18-3128, Idaho Code; ~~(3-29-10)~~(    )

~~***k***~~**c.** Misdemeanor ~~*F*~~forgery and counterfeiting, as defined in Sections 18-3601 through 18-3620, Idaho Code; ~~(3-26-08)~~(    )

~~***l.*** *Grand theft, as defined in Section 18-2407(1), Idaho Code;* (3-26-08)~~

~~***m***~~**d.** Misdemeanor ~~*I*~~identity theft, as defined in Section 18-3126, Idaho Code; ~~(4-9-09)~~(    )

~~***n***~~**e.** Misdemeanor ~~*I*~~insurance fraud, as defined in Sections 41-293 and 41-294, Idaho Code; ~~(3-26-08)~~(    )

~~***o***~~**f.** Misdemeanor ~~*P*~~public assistance fraud, as defined in Sections 56-227 and 56-227A, Idaho Code; or ~~(4-9-09)~~(    )

~~*p.*~~ ~~*Attempted strangulation, as defined in Section 18-923, Idaho Code; or*~~ ~~*(4-9-09)*~~

**g.** Stalking in the second degree, as defined in Section 18-7906, Idaho Code. (____)

~~*q*~~**h.** Attempt, conspiracy, accessory after the fact, or aiding and abetting, as defined in Sections 18-205, 18-306, 18-1701, and 19-1430, Idaho Code, to commit any of the disqualifying five (5) year crimes. (3-29-10)

**03. Underlying Facts and Circumstances**. The Department may consider the underlying facts and circumstances of felony or misdemeanor conduct including a guilty plea or admission in determining whether or not to issue a clearance, regardless of whether or not the individual received one (1) of the following: (3-26-08)

**a.** A withheld judgment; (3-26-08)

**b.** A dismissal, suspension, deferral, commutation, or a plea agreement where probation or restitution was or was not required; (3-26-08)

**c.** An order according to Section 19-2604, Idaho Code, or other equivalent state law; or (3-26-08)

**d.** A sealed record. (3-26-08)

***(BREAK IN CONTINUITY OF SECTIONS)***

**230. RELEVANT RECORDS RESULTING IN A ~~*CONDITIONAL*~~ DENIAL.**
An individual is not available to provide direct care or services when the individual discloses or the criminal history and background check reveals a relevant record on his record as described Subsections 230.01 and 230.02 of this rule. (3-26-08)

**01. Individuals Licensed or Certified by the Department or a Department Employee**. A ~~*conditional*~~ denial may be issued when an individual who is licensed or certified by the Department, or who is a Department employee discloses, or the criminal history and background check reveals, a relevant record as defined in Subsections 230.01.a. through 230.01.f. of this rule: ~~*(3-26-08)*~~(____)

**a.** A plea, finding, or adjudication of guilt to any felony or misdemeanor, or any crime other than a traffic violation, that does not result in a suspension of the individual's driver's license; (3-26-08)

**b.** A substantiated child protection complaint or a substantiated adult protection complaint; (3-26-08)

**c.** The Department determines there is a potential health and safety risk to vulnerable

adults or children; (3-26-08)

**d.** The individual has falsified or omitted information on the application form; (3-26-08)

**e.** The individual is ~~*listed with a finding*~~ on the Nurse Aide Registry with a negative finding; or ~~*(3-26-08)*~~( )

**f.** The Department determines additional information is required. (3-26-08)

**02.** **Employees of Providers or Contractors**. A ~~*conditional*~~ denial may be issued when an individual who is employed by a provider or contractor discloses, or the criminal history and background check reveals, a relevant record as defined in Subsections 230.02.a. through 230.0~~*1*~~2.c. of this rule. ~~*(3-26-08)*~~( )

**a.** A substantiated child protection complaint or a substantiated adult protection complaint; (3-26-08)

**b.** The individual is ~~*listed with a finding*~~ on the Nurse Aide Registry with a negative finding; or ~~*(3-26-08)*~~( )

**c.** The Department determines additional information is required. (3-26-08)

**03.** **Underlying Facts and Circumstances**. The Department may consider the underlying facts and circumstances of felony or misdemeanor conduct including a guilty plea or admission in determining whether or not to issue a clearance, regardless of whether or not the individual received one (1) of the following: (3-26-08)

**a.** A withheld judgment; (3-26-08)

**b.** A dismissal, suspension, deferral, commutation, or a plea agreement where probation or restitution was or was not required; (3-26-08)

**c.** An order according to Section 19-2604, Idaho Code, or other equivalent state law; or (3-26-08)

**d.** A sealed record. (3-26-08)

# IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

## 16.07.37 - CHILDREN'S MENTAL HEALTH SERVICES

## DOCKET NO. 16-0737-1001

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 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; and H0715 (2010) - DHW Children's Mental Health budget holdbacks for SFY 2010 and appropriations for SFY 2011.

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

**These rule changes allow the Department to limit and prioritize Children's Mental Health Services, including eligibility. This is necessary due to the reductions in appropriations. These changes give the Department the ability to focus the available resources on those who have the greatest clinical and financial needs.**

**In addition, these rule changes align the Children's Mental Health Services rules with the corresponding rules in IDAPA 16.07.33, "Adult Mental Health Services."**

**The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the** June, 2 2010, Idaho Administrative Bulletin, Vol. 10-6, pages 45 through 47**.**

**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 fiscal impact of the holdback on funds for SFY 2010 and the appropriations for SFY 2011 (both in H0715) reduces the appropriation for SFY 2010 by $566,000 and by an additional $190,500 for SFY 2011, for a total reduction of $756,500. The rule changes will align the rules with the intent language found in H0715 (2010).**

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning this pending rule, contact Chuck Halligan at (208) 334-6559.

DATED this 1st day of October, 2010.

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

***THIS NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE***

**EFFECTIVE DATE:** The effective date of the temporary rule is **May 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 regular rulemaking procedures have been initiated. 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; and H0715 (2010) - DHW Children's Mental Health budget holdbacks for SFY 2010 and appropriations for SFY 2011.

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

| Thursday, June 17, 2010<br>5:00 p.m. PDT | Tuesday, June 29, 2010<br>5:00 p.m. MDT | Wednesday, June 30, 2010<br>5:00 p.m. MDT |
|---|---|---|
| Dept. of Health & Welfare-Reg. 2<br>State Office Building<br>1118 F Street<br>3rd Floor Conf. Rm.<br>Lewiston, ID | Dept. of Health & Welfare-Reg.7<br>State Office Building<br>150 Shoup Ave<br>2nd Floor Conf. Rm.<br>Idaho Falls, ID | Dept. Health & Welfare-Reg. 4<br>J.R. Williams Building<br>700 West State Street<br>East Conf. Rm.<br>Boise, ID |

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

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

**The proposed rule changes will allow the Department to limit and prioritize Children's Mental Health Services, including eligibility. This is necessary due to the reductions in appropriations. These changes will give the Department the ability to focus the available resources on those who have the greatest clinical and financial needs.**

**In addition, these rule changes will more closely align the Children's Mental Health Services rules with the corresponding rules in IDAPA 16.07.33, "Adult Mental Health Services."**

**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 in order to protect public health, safety, or welfare, and to comply with deadlines in amendments to governing law or federal programs (in this case, H0715 (2010)).**

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

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

**The fiscal impact of the holdback on funds for SFY 2010 and the appropriations for SFY 2011 (both in H0715) reduces the appropriation for SFY 2010 by $566,000 and by an additional $190,500 for SFY 2011, for a total reduction of $756,500. The rule changes will align the rules with the intent language found in H0715.**

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because this rulemaking is being done to meet budget appropriations approved by the legislature under H0715 (2010).

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the temporary and 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 June 30, 2010.

DATED this 28th day of April, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0737-1001***

**407. ELIGIBILITY DETERMINATION.**

**01. The Department Determines Eligibility for Mental Health Services**. The total number of children who are eligible for mental health services through the Department will be established by the Department. The Department may, in its sole discretion, limit or prioritize mental health services, define eligibility criteria, or establish the number of persons eligible based upon such factors as court-ordered services, availability of funding, the degree of financial need, the degree of clinical need, or other factors. ( )

**0~~1~~2. Eligibility Requirements**. To be eligible for children's mental health services through a voluntary application to the Department, the applicant must: (5-8-09)

**a.** Be under eighteen (18) years of age; (5-8-09)

**b.** Reside within the state of Idaho; (5-8-09)

**c.** Have a DSM-IV-TR Axis I diagnosis. A substance use disorder alone, or developmental disorder alone, does not constitute an eligible Axis I diagnosis, although one (1) or more of these conditions may co-exist with an eligible Axis I diagnosis; and (5-8-09)

**d.** Have a substantial functional impairment as assessed by using the Child and Adolescent Functional Assessment Scale (CAFAS) or the Preschool and Early Childhood Functional Assessment Scale (PECFAS). Substantial functional impairment requires a full eight (8) (CAFAS) or seven (7) (PECFAS) scale score of eighty (80) or higher with "moderate" impairment in at least one (1) of the following three (3) scales: ~~(5-8-09)~~(____)

i. Self-harmful behavior; (5-8-09)

ii. Moods/emotions; or (5-8-09)

iii. Thinking. (5-8-09)

**0~~2~~3. Court-Ordered Assessment, Treatment, and Services**. The court may order the Department to provide assessment, treatment, and services under the Children's Mental Health Services Act, Title 16, Chapter 24, Idaho Code and the Juvenile Corrections Act, Title 20, Chapter 5, Idaho Code. Subject to court approval, the Department will make efforts to include parents and guardians in the assessment, treatment, and service planning process. (5-8-09)

**0~~3~~4. Ineligible Conditions**. A child who does not meet the requirements under Subsections 407.0~~1~~2 or 407.0~~2~~3 of this rule is not eligible for children's mental health services, other than crisis response. A child with a diagnosis of substance use disorder alone, or developmental disorder alone, may be eligible for Department services under IDAPA 16.07.17, "Alcohol and Substance Use Disorders Services" or IDAPA 16.04.11, "Developmental Disabilities Agencies," for substance use or developmental disability services. ~~(5-8-09)~~(____)

# IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

## 16.07.50 - RULES AND MINIMUM STANDARDS GOVERNING NONHOSPITAL, MEDICALLY-MONITORED DETOXIFICATION/MENTAL HEALTH DIVERSION UNITS

## DOCKET NO. 16-0750-1001

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 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 39-305, 39-311, and 56-1003, 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 pending rule is being adopted as proposed. The proposed rules updated testing requirements for blood alcohol and tuberculosis and published in the October 6, 2010, Idaho Administrative Bulletin, Vol. 10-10, pages 287 through 289.**

**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 Ross Edmunds at (208) 334-5726.

DATED this 12th day of November, 2010.

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

***THIS NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE***

**EFFECTIVE DATE:** The effective date for these temporary rules is **October 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 39-305, 39-311, and 56-1003, Idaho Code.

**PUBLIC HEARING SCHEDULE:** Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 20, 2010.

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 Nonhospital, Medically-Monitored Detoxification/Mental Health Diversion Units rules are being updated to allow for a breath alcohol test to be performed on individuals being brought in for treatment in addition to the blood draw alcohol test. Also, the Tuberculin skin testing requirements for clients is being amended, as many clients may not stay in the unit long enough to have the skin test read.**

**TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(a), Idaho Code, the Governor has found that temporary adoption of these rules are necessary for protection of public health and safety.**

**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 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, informal negotiated rulemaking was conducted with stakeholders of non-hospital, medically-monitored, detoxification and mental health diversion units.**

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

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the temporary and proposed rule, contact Kathleen Allyn at (208) 334-0997.

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 27, 2010.

DATED this 19th day of August, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0750-1001***

**246. CONTROL OF TUBERCULOSIS.**

In order to assure the control of tuberculosis in the facility, there must be a planned, organized program of prevention through written and implemented procedures that are consistent with current accepted practices and include the following in Subsections 246.01 through 246.0~~3~~5 of this rule. ~~(3-29-10)~~(    )

**01. Tuberculin Skin Tests**. The results of a tuberculin skin test, taken immediately prior to admission or within six (6) months prior to admission, must be established for each client. If the status is not known upon admission, a tuberculin skin test must be done as soon as possible. (3-29-10)

**a.** If the tuberculin skin test is negative, the test does not have to be repeated prior to discharge. (3-29-10)

**b.** If the tuberculin skin test is positive, the client must have a chest x-ray to rule out the presence of infectious pulmonary tuberculosis. (3-29-10)

**02. Protective Infection Control Techniques**. If any x-ray is suggestive of infectious pulmonary tuberculosis, the facility is required to implement protective infection control techniques in accordance with these rules and as required by the facility's governing body through its CEO or administrator. (3-29-10)

**03. Transfer of Client Suspected or Diagnosed**. Arrangements for transfer to an appropriate facility must be made for any client suspected or diagnosed with infectious pulmonary tuberculosis. These arrangements must be made in accordance with these rules and as required by the facility's governing body through its CEO or administrator. (3-29-10)

**04. Discharge Prior to Availability of Test Result**. A client, discharged prior to sufficient time elapsing for the tuberculin skin test to be read, will be instructed regarding the appropriate time frame and protocol for return to the facility to have the tuberculin skin test read. ( )

**05. Sobering Station Exclusion**. The tuberculin skin tests required in Subsection 246.01 of this rule, is not required for clients receiving services from a sobering station. ( )

### *(BREAK IN CONTINUITY OF SECTIONS)*

**320. REQUIRED MINIMUM ADMISSION CRITERIA TO DETOXIFICATION UNITS.**

According to physician-approved written admission criteria, policies, and procedures, each detoxification unit must develop and implement written admission criteria that are uniformly applied to all clients. (3-29-10)

**01. Admission to Detoxification Unit**. A prospective client will be admitted or retained only if he meets the following admission criteria: (3-29-10)

**a.** Must be eighteen (18) years of age or older; (3-29-10)

**b.** Demonstrates a need for detoxification services; (3-29-10)

**c.** Has alcohol or other addictive controlled substance intake of sufficient amount and duration to create a reasonable expectation of withdrawal upon cessation of use; (3-29-10)

**d.** Is medically stable prior to admission and if seeking detoxification from alcohol has a blood alcohol level no greater than ~~200mg/100cc~~ point twenty-four (.24) as measured by an accurately calibrated Breathalyzer or as determined by another equivalent laboratory test. A client who has a blood alcohol content in excess of point twenty-four (.24) may be admitted with approval granted by the medical director or his designee; ~~(3-29-10)~~( )

**e.** Meets admission criteria specifications that do not exceed ASAM Level III.7-D; and (3-29-10)

**f.** Demonstrates the capacity to benefit from short-term stabilization and the services available at the facility may reduce the prospective client's acute symptoms and may prevent the client from detoxification hospitalization. (3-29-10)

**02. Detoxification Unit Able to Provide Services**. The detoxification unit must have the capability, capacity, personnel, and services to provide appropriate care to the prospective client. The client cannot require a type of service for which the detoxification unit is not approved to provide. (3-29-10)

**03. Monitoring Clients in Detoxification Unit**. The level of monitoring in the

detoxification unit of the client or the physical restrictions of the environment must be adequate to prevent the client from causing serious harm to self or others. (3-29-10)

**04. Notification of Admission of Opiate/Methadone Client**. The lead nurse must be notified that an opiate/methadone client was admitted to the detoxification unit. The name of the clinic where the client received the methadone must be documented in the client's record. (3-29-10)

# IDAPA 19 - IDAHO STATE BOARD OF DENTISTRY

## 19.01.01 - RULES OF THE STATE BOARD OF DENTISTRY

## DOCKET NO. 19-0101-1001

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is accepted, 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:

**The pending rules provide for updates to documents which are incorporated by reference into the rules of the Board relative to the use of sedation and general anesthesia by dentists, and codes of ethics of the practice of dentistry and dental hygiene. New documents incorporated by reference include standards for clinical dental hygiene practice and standards for dental patient records.**

**The text of the pending rule (19.01.01.060.03.a) has been amended to add reference to an incorporated document in Section 19.01.01.004.**

**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** October 6, 2010 Idaho Administrative Bulletin, Vol. 10-10, pages 337 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: N/A

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning the pending rule, contact Susan Miller, 208-577-2638.

DATED this 5th day of November, 2010.

Susan D. Miller
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: 208-577-2638
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(s) 54-912.

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

| Thursday, October 21, 2010 at 10:00 a.m. |
|---|
| Office of the Idaho Board of Dentistry<br>350 North 9th Street, Suite M-100<br>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 004: The proposed rule change provides for Rule 004 updates and changes to conform to new editions of documents which are incorporated by reference into the rules of the Board. Certain reference documents have been updated by their writers to reflect new nomenclature and procedures in the fields of administration of anesthesia, as well as including new standards for practice of dentistry and dental hygiene.**

**Rule 012: The proposed rule change provides for change in nomenclature in anesthesia permits.**

**Rule 030: The proposed rule change provides for change in nomenclature for administration of nitrous oxide/oxygen.**

**Rule 031: The proposed rule change provides for a change in the nomenclature for the**

**administration of anesthesia, etc.**

**Rule 035: The proposed rule change provides for a change in nomenclature for administration of nitrous oxide/oxygen.**

**Rule 054: The proposed rule change provides for changes to reflect new nomenclature and procedures involved in the methods of anxiety and pain control, sedation terms, and routes of administration.**

**Rule 055: The proposed rule change provides for changes to reflect new nomenclature and procedures for minimal sedation.**

**Rule 057: The proposed rule change provides for changes to reflect new nomenclature and procedures for the administration of Nitrous oxide/oxygen.**

**Rule 060: The proposed rule change provides for changes in the nomenclature and the procedures in the administration of moderate sedation**

**Rule 061: The proposed rules changes provide for changes in the nomenclature and the procedures of the administration of general anesthesia and deep sedation.**

**Rule 063: The proposed rule changes provide for changes in nomenclature regarding incident reporting.**

**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 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.

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

**Certain reference documents have been updated by their writers to reflect new nomenclature and procedures in the fields of administration of anesthesia, as well as including new standards for practice of dentistry and dental hygiene.**

**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 27,

2010.

DATED this 26th day of August, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 19-0101-1001***

**004. INCORPORATION BY REFERENCE (RULE 4).**
Pursuant to Section 67-5229, Idaho Code, this chapter incorporates by reference the following documents: (7-1-93)

**01. Documents.** (7-1-93)

**a.** American Association of Oral and Maxillofacial Surgeons, Office Anesthesia Evaluation Manual, ~~*6*~~7th Edition, 200~~*0*~~6. ~~*(3-15-02)*~~(____)

**b.** American Dental Association, ~~*Council on Dental Education,*~~ Guidelines for Teaching ~~*the Comprehensive Control of Pain and Anxiety in Dentistry*~~ Pain Control and Sedation to Dentists and Dental Students, October 200~~*3*~~7. ~~*(4-11-06)*~~(____)

**c.** American Dental Association, ~~*Council on Dental Education,*~~ Guidelines for the Use of ~~*Conscious Sedation, Deep*~~ Sedation and General Anesthesia ~~*for*~~ by Dentists, October 200~~*3*~~7. ~~*(4-11-06)*~~(____)

**d.** American Dental Association Policy Statement: The Use of Sedation and General Anesthesia by Dentists, October 2007. (____)

**~~*d*~~e.** Centers for Disease Control and Prevention, DHHS, Guidelines for Infection Control in Dental Health-Care Settings, 2003. (4-6-05)

**~~*e*~~f.** American Dental Association, Principles of Ethics, Code of Professional Conduct and Advisory Opinions (ADA Code), January 200~~*3*~~9 ~~*(as amended)*~~. ~~*(3-20-04)*~~(____)

**~~*f*~~g.** American Dental Hygienists' Association, Code of Ethics for Dental Hygienists (ADHA Code), ~~*1995*~~ June 2009. ~~*(4-6-05)*~~(____)

**h.** American Dental Hygienists' Association, Standards for Clinical Dental Hygiene Practice, March 10, 2008. (____)

**i.** American Association of Dental Boards, the Dental Patient Record, June 12, 2009. (____)

**02. Availability**. These documents are available for public review at the Idaho State Board of Dentistry, 350 North 9th Street, Suite M-100, Boise, Idaho 83720, or the Idaho State Law Library, Supreme Court Building, 451 W. State Street, Boise, Idaho 83720. (3-15-02)

***(BREAK IN CONTINUITY OF SECTIONS)***

**012. LICENSE AND APPLICATION FEES (RULE 12).**
The license fees and application fees shall be as follows: (3-30-07)

**01. Application Fees for Dentists**: (7-1-91)

**a.** General: (3-18-99)

i. By examination -- three hundred dollars ($300). (3-26-08)

ii. By credentials -- six hundred dollars ($600). (3-18-99)

**b.** Specialty: (7-1-91)

i. By examination -- three hundred dollars ($300). (3-26-08)

ii. By credentials -- six hundred dollars ($600). (3-18-99)

**02. Application Fees for Dental Hygienists:** (7-1-91)

**a.** By examination -- one hundred fifty dollars ($150). (3-26-08)

**b.** By credentials -- one hundred fifty dollars ($150). (3-26-08)

**03. Biennial License Fees for Dentists**: (3-30-07)

**a.** Active -- three hundred seventy-five dollars ($375). (3-26-08)

**b.** Inactive -- one hundred sixty dollars ($160). (3-26-08)

**c.** Specialty -- three hundred seventy-five dollars ($375). (3-26-08)

**04. Biennial License Fees for Hygienists**: (3-30-07)

**a.** Active -- one hundred seventy-five dollars ($175). (3-26-08)

**b.** Inactive -- eighty-five dollars ($85). (3-26-08)

**05. Application Fees for General Anesthesia and ~~*Conscious*~~ Moderate Sedation Permits**: ~~*(4-2-03)*~~( )

**a.** Initial Application -- three hundred dollars ($300). (4-2-03)

**b.** Renewal Application -- three hundred dollars ($300). (4-2-03)

**c.** Reinstatement Application -- three hundred dollars ($300). (4-2-03)

***(BREAK IN CONTINUITY OF SECTIONS)***

**030. DENTAL HYGIENISTS - PRACTICE (RULE 30).**
Subject to the provisions of the Dental Practice Act, Chapter 9, Title 54, Idaho Code, dental hygienists are hereby authorized to perform the activities specified below: (4-6-05)

**01. General Supervision**. A dental hygienist may perform specified duties under general supervision as follows: (4-6-05)

**a.** Oral prophylaxis (including removal of supragingival and subgingival calculus, stains and plaque biofilm from teeth); (4-11-06)

**b**. Medical history assessments and intra-oral and extra-oral assessments (including charting of the oral cavity and surrounding structures, taking case histories and periodontal assessment); (4-11-06)

**c.** Developing patient care plans for prophylaxis, non-surgical periodontal therapy and supportive and evaluative care in accordance with the treatment parameters set by supervising dentist; (4-11-06)

**d.** Root planing; (4-11-06)

**e.** Non-surgical periodontal therapy; (4-11-06)

**f.** Closed subgingival curettage; (4-11-06)

**g.** Administration of local anesthesia; (4-6-05)

**h.** Removal of marginal overhangs (use of high speed handpieces or surgical instruments is prohibited); (4-6-05)

**i.** Application of topical antibiotics or antimicrobials (used in non-surgical periodontal therapy); (4-6-05)

**j.** Instructing patients in techniques of oral hygiene and preventive procedures; (4-6-05)

**k.** Placement of antibiotic treated materials pursuant to written order and site specific; (4-6-05)

**l.** All duties which may be performed by a dental assistant; and (4-11-06)

**m.** Such other duties as approved by the Board. (4-11-06)

**02. Indirect Supervision**. A dental hygienist may perform specified duties under indirect supervision as follows: (4-6-05)

**a.** Administration and monitoring of nitrous oxide/oxygen; ~~(4-6-05)~~(____)

**b.** All dental hygienist duties specified under general supervision; and (4-6-05)

**c.** Such other duties as approved by the Board. (4-11-06)

**03. Direct Supervision**. A dental hygienist may perform specified duties under direct supervision as follows: (4-6-05)

**a.** Use of a laser restricted to gingival curettage and bleaching; (4-6-05)

**b.** All dental hygienist duties specified under general and indirect supervision; and (4-6-05)

**c.** Such other duties as approved by the Board. (4-11-06)

**031. DENTAL HYGIENISTS - PROHIBITED PRACTICE (RULE 31).**
Subject to the provisions of the Dental Practice Act, Chapter 9, Title 54, Idaho Code, and these rules, a dental hygienist may not perform certain specified duties. (4-6-05)

**01. Prohibited Duties**. A dental hygienist is prohibited from performing the duties specified below: (4-6-05)

**a.** Definitive diagnosis and dental treatment planning; (4-6-05)

**b.** The operative preparation of teeth for the placement of restorative materials; (4-6-05)

**c.** The placement or carving of restorative materials; (4-6-05)

**d.** Administration of any general anesthesia, ~~*or conscious*~~ minimal sedation, or moderate sedation; ~~(4-6-05)~~(____)

**e.** Final placement of any fixed or removable appliances; (4-6-05)

**f.** Final removal of any fixed appliance; (4-6-05)

**g.** Cutting procedures utilized in the preparation of the coronal or root portion of the tooth; (4-6-05)

**h.** Cutting procedures involving the supportive structures of the tooth; (4-6-05)

**i.** Placement of the final root canal filling; (4-6-05)

**j.** Final impressions of any tissue-bearing area, whether hard or soft tissue; (4-6-05)

**k.** Occlusal equilibration procedures for any prosthetic restoration, whether fixed or removable; (4-6-05)

**l.** Final placement of prefabricated or cast restorations or crowns; and (4-6-05)

**m.** Such other duties as specifically prohibited by the Board. (4-6-05)

**032. -- 034. (RESERVED).**

**035. DENTAL ASSISTANTS - PRACTICE (RULE 35).**

**01. Direct Supervision**. A dental assistant may perform specified activities under direct supervision as follows: (4-6-05)

**a.** Recording the oral cavity (existing restorations, missing and decayed teeth); (4-6-05)

**b.** Placement of topical anesthetic agents (prior to administration of a local anesthetic by a dentist or dental hygienist); (4-6-05)

**c.** Removal of excess bonding material from temporary and permanent restorations and orthodontic appliances (using hand instruments or contra-angle handpieces with disks or polishing wheels only); (4-6-05)

**d.** Expose and process radiographs; (4-6-05)

**e.** Take impressions for preparation of diagnostic models, bleach trays, fabrication of night guards, temporary appliances, temporary crowns or bridges; (4-6-05)

**f.** Record diagnostic bite registration; (4-6-05)

**g.** Record bite registration for fabrication of restorations; (4-6-05)

**h.** Provide patient education and instruction in oral hygiene and preventive services; (4-6-05)

**i.** Placement of cotton pellets and temporary restorative materials into endodontic access openings; (4-6-05)

**j.** Placement and removal of arch wire; (4-6-05)

**k.** Placement and removal of orthodontic separators; (4-6-05)

**l.** Placement and removal of ligature ties; (4-6-05)

**m.** Cutting arch wires; (4-6-05)

**n.** Removal of loose orthodontic brackets and bands to provide palliative treatment; (4-6-05)

**o.** Adjust arch wires; (4-6-05)

**p.** Etching of teeth prior to placement of restorative materials; (4-6-05)

**q.** Etching of enamel prior to placement of orthodontic brackets or appliances by a Dentist; (4-6-05)

**r.** Placement and removal of rubber dam; (4-6-05)

**s.** Placement and removal of matrices; (4-6-05)

**t.** Placement and removal of periodontal pack; (4-6-05)

**u.** Removal of sutures; (4-6-05)

**v.** Application of cavity liners and bases; (4-6-05)

**w.** Placement and removal of gingival retraction cord; (4-6-05)

**x.** Application of topical fluoride agents; and (4-6-05)

**y.** Performing such other duties as approved by the Board. (4-6-05)

**02. Prohibited Duties**. Subject to other applicable provisions of these rules and of the Act, dental assistants are hereby prohibited from performing any of the activities specified below: (7-1-93)

**a**. Definitive diagnosis and treatment planning. (4-6-05)

**b.** The placement or carving of permanent restorative materials in any manner. (7-1-93)

**c.** Any procedure using lasers. (4-6-05)

**d.** The administration of any general anesthetic, infiltration anesthetic or any injectable nerve block procedure. (4-6-05)

**e.** Any oral prophylaxis. Oral prophylaxis is defined as the removal of plaque, calculus, and stains from the exposed and unexposed surfaces of the teeth by scaling and polishing. (7-1-93)

**f.** Any intra-oral procedure using a high-speed handpiece, except to the extent authorized by a Certificate of Registration or certificate or diploma of course completion issued

by an approved teaching entity. (4-6-05)

**g.** The following expanded functions, unless authorized by a Certificate of Registration or certificate or diploma of course completion issued by an approved teaching entity and performed under direct supervision: (4-6-05)

i. Fabrication and placement of temporary crowns; (4-6-05)

ii. Perform the mechanical polishing of restorations; (7-1-93)

iii. Initiating, regulating and monitoring the administration of nitrous oxide/oxygen ~~analgesia~~ to a patient; ~~(4-11-06)~~(____)

iv. Application of pit and fissure sealants; (7-1-93)

v. Coronal polishing, unless authorized by a Certificate of Registration; this refers to the technique of removing soft substances from the teeth with pumice or other such abrasive substances with a rubber cup or brush. This in no way authorizes the mechanical removal of calculus nor is it to be considered a complete oral prophylaxis. This technique (coronal polishing) would be applicable only after examination by a dentist and removal of calculus by a dentist or dental hygienist. (7-1-93)

vi. Use of a high-speed handpiece restricted to the removal of orthodontic cement or resin. (4-6-05)

**03. Expanded Functions Qualifications**. A dental assistant may be considered Board qualified in expanded functions, authorizing the assistant to perform any or all of the expanded functions described in Subsection 035.02.g. upon satisfactory completion of the following requirements: (4-6-05)

**a.** Completion of Board-approved training in each of the expanded functions with verification of completion of the training to be provided to the Board upon request by means of a Certificate of Registration or other certificate evidencing completion of approved training. The required training shall include adequate training in the fundamentals of dental assisting, which may be evidenced by: (4-6-05)

i. Current certification by the Dental Assisting National Board; or (7-1-93)

ii. Successful completion of a Board-approved course in the fundamentals of dental assisting; or (3-18-99)

iii. Successfully challenging the fundamentals course. (7-1-93)

**b.** Successful completion of a Board-approved competency examination in each of the expanded functions. There are no challenges for expanded functions. (3-18-99)

**04. Course Approval**. Any school, college, institution, university or other teaching entity may apply to the Board to obtain approval of its courses of instruction in expanded

functions. Before approving such course, the Board may require satisfactory evidence of the content of the instruction, hours of instruction, content of examinations or faculty credentials. (3-18-99)

**05. Other Credentials**. Assistants, who have completed courses or study programs in expanded functions that have not been previously approved by the Board, may submit evidence of the extent and nature of the training completed, and, if in the opinion of the Board the same is at least equivalent to other Board-approved courses, and demonstrates the applicant's fitness and ability to perform the expanded functions, the Board may consider the assistant qualified to perform any expanded function(s). (3-18-99)

### *(BREAK IN CONTINUITY OF SECTIONS)*

### 054. DEFINITIONS (RULE 54).

For the purposes of these anesthesia rules, the following terms will be used, as defined below: (4-11-06)

**01. Methods of Anxiety and Pain Control**. (4-11-06)

**a.** ~~*Anxiolysis*~~ Analgesia shall mean ~~*the process of*~~ the diminution or elimination of ~~*the patient's anxiety, apprehension or fear by the administration of a pharmacological agent that renders the patient relaxed but does not impair the patient's ability to maintain normal mental abilities and vital functions. An oral sedative agent can be administered in the treatment setting or prescribed for patient dosage prior to the appointment*~~ pain. ~~*(4-11-06)*~~(____)

**b.** Local anesthesia shall mean the elimination of sensation, especially pain, in one (1) part of the body by the topical application or regional injection of a drug. (____)

**~~*b*~~c.** ~~*Conscious*~~ Minimal sedation shall mean a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond ~~*appropriately*~~ normally to ~~*physical*~~ tactile stimulation ~~*or*~~ and verbal command~~*, and that is produced through the enteral or parenteral administration of a pharmacological or non-pharmacological method or a combination thereof*~~. Although cognitive function and coordination may be modestly impaired, ventilator and cardiovascular functions are unaffected. In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness~~*unlikely*~~. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of ~~*conscious*~~ minimal sedation. ~~*Oral sedative agents can be administered in the treatment setting or prescribed for patient dosage prior to the appointment.*~~ ~~*(4-11-06)*~~(____)

**d.** Moderate sedation shall mean a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. (____)

**~~*c*~~e.** Deep sedation shall mean a~~*n*~~ drug-induced ~~*state of depressed*~~ depression of consciousness ~~*accompanied by partial loss of protective reflexes, including the inability to continually maintain an airway independently and/or to respond purposefully to physical stimulation or verbal command, and that is produced by a pharmacological or non-pharmacological method or a combination thereof*~~ during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilator function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. ~~*(4-11-06)*~~(____)

**~~*d*~~f.** General anesthesia shall mean a~~*n*~~ drug-induced ~~*state*~~ loss of ~~*un*~~consciousness ~~*accompanied by a partial or complete loss of protective reflexes, including the inability to continually maintain an airway independently and respond purposefully to physical stimulation or verbal command, and that is produced by a pharmacological or non-pharmacological method or a combination thereof*~~ during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilator function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired. ~~*(4-11-06)*~~(____)

~~***e.** Local anesthesia shall mean the elimination of sensation, especially pain, in one (1) part of the body by the topical application or regional injection of a drug. (4-11-06)*~~

~~***f.** Nitrous oxide inhalation analgesia shall mean an induced controlled state of minimally depressed consciousness, produced solely by the inhalation of a combination of nitrous oxide and oxygen, in which the patient retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command. (4-11-06)*~~

**02. Sedation Terms.** (4-11-06)

**a.** Advanced Cardiac Life Support (ACLS) shall mean an advanced cardiac life support course offered by a recognized accrediting organization. (4-11-06)

**b.** Monitor or monitoring shall mean the direct clinical observation of a patient during the administration of anesthesia by a person trained to observe the physical condition of the patient and capable of assisting with emergency or other procedures. (4-11-06)

**c.** Operator shall mean the supervising dentist or another person who is authorized by these rules or holds a permit to induce and administer the proper level of anesthesia/sedation. (4-11-06)

**d.** Titration shall mean the administration of ~~*small*~~ incremental doses of a drug until a desired ~~*clinical*~~ effect is ~~*observed*~~ reached. Knowledge of each drug's time of onset, peak response and duration of action is essential to avoid over sedation. Although the concept of titration of a drug to effect is critical for patient safety, when the intent is moderate sedation one must know whether the previous dose has taken full effect before administering an additional drug

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

**e.** Maximum recommended (MRD) shall mean maximum FDA-recommended dose of a drug, as printed in FDA-approved labeling for unmonitored home use. ( )

**f.** Incremental dosing shall mean administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD). ( )

**g.** Supplemental dosing during minimal sedation shall mean a single additional dose of the initial drug that may be necessary for prolonged procedures. The supplemental dose should not exceed one-half of the initial dose and should not be administered until the dentist has determined the clinical half-life of the initial dosing has passed. The total aggregate dose must not exceed one and one-half times (1.5x) MRD on the day of treatment. ( )

**03. Routes of Administration**. (4-11-06)

**a.** Enteral. Any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa (i.e., oral, rectal, sublingual). (4-11-06)

**b.** Inhalation. A technique of administration in which a gaseous or volatile agent is introduced into the ~~*pulmonary tree*~~ lungs and whose primary effect is due to absorption through the ~~*pulmonary bed*~~ gas/blood interface. ~~*(4-11-06)*~~( )

**c.** Parenteral. A technique of administration in which the drug bypasses the gastrointestinal (GI) tract ~~(~~[i.e., intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), ~~*intraocular*~~ intraosseous (IO~~)~~]. ~~*(4-11-06)*~~( )

**d.** Transdermal~~*/transmucosal*~~. A technique of administration in which the drug is administered by patch or iontophoresis through skin. ~~*(4-11-06)*~~( )

**e.** Transmucosal. A technique of administration in which the drug is administered across mucosa such as intranasal, sublingual, or rectal. ( )

**055. ~~*ANXIOLYSIS*~~ MINIMAL SEDATION (RULE 55).**
Persons licensed to practice dentistry in accordance with the Idaho Dental Practice Act and these rules ~~*may*~~ are not required to obtain a permit to administer ~~*medication to patients for the purpose of relieving anxiety so long as the medication is given in a dosage that is within the current guidelines set forth for anxiolytic dosage on the manufacturer's package insert or other recognized drug reference and does not induce a state of depressed consciousness to the level of general anesthesia, deep sedation, or conscious sedation in the patient*~~ minimal sedation to adult patients. When the intent is minimal sedation for adults, the appropriate initial dosing of a single enteral drug is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use. ~~*(4-11-06)*~~( )

**01. Patient Safety**. The administration of ~~*anxiolytics by means of titration or in combination with nitrous oxide inhalation analgesia*~~ minimal sedation is permissible so long as it does not produce an alteration of the state of consciousness in a patient to the level of ~~*conscious*~~ moderate sedation, deep sedation or general anesthesia. A dentist must first qualify for and obtain

the appropriate permit from the Board of Dentistry to be authorized to sedate patients to the level of ~~*conscious*~~ moderate sedation, deep sedation or general anesthesia. Nitrous oxide/oxygen ~~*inhalation analgesia shall not*~~ may be used in combination with ~~*anxiolytic medication except during the limited period of time required to administer a local anesthetic*~~ a single enteral drug in minimal sedation. Notwithstanding any other provision in these rules, a dentist shall initiate and regulate the administration of nitrous oxide/oxygen ~~*inhalation analgesia*~~ when used in combination with ~~*anxiolysis*~~ minimal sedation. ~~*(4-11-06)*~~( )

**02. Personnel**. ~~*A patient sedated for anxiolytic purposes in the dental office shall be monitored by an assistant trained in basic life support to observe appropriate physiologic parameters and assist in any support or resuscitation measures required.*~~ At least one (1) additional person currently certified in Basic Life Support for Healthcare Providers must be present in addition to the dentist. ~~*(4-11-06)*~~( )

### *(BREAK IN CONTINUITY OF SECTIONS)*

### 057. NITROUS OXIDE/OXYGEN ~~*INHALATION ANALGESIA*~~ (RULE 57).

Persons licensed to practice dentistry and dental hygiene and dental assistants certified in accordance with the Idaho Dental Practice Act and these rules are not required to obtain a permit to administer nitrous oxide/oxygen ~~*inhalation analgesia*~~ to patients. Nitrous oxide/oxygen ~~*inhalation analgesia*~~ when used in combination with other sedative agents may produce an alteration of the state of consciousness in a patient to the level of ~~*conscious*~~ moderate sedation, deep sedation or general anesthesia. A dentist must first qualify for and obtain the appropriate permit from the Board of Dentistry to be authorized to sedate patients to the level of ~~*conscious*~~ moderate sedation, deep sedation or general anesthesia. ~~*(4-11-06)*~~( )

**01. Patient Safety**. In connection with the administration of nitrous oxide/oxygen ~~*inhalation analgesia*~~, a dentist shall: ~~*(4-11-06)*~~( )

**a.** Evaluate the patient to insure that the patient is an appropriate candidate for nitrous/oxygen ~~*inhalation analgesia*~~; and ~~*(4-11-06)*~~( )

**b.** Insure that any patient under nitrous/oxygen ~~*inhalation analgesia*~~ shall be continually monitored~~*for such matters as response to verbal stimulation, oral mucosal color and vital signs*~~; and ~~*(4-11-06)*~~( )

**c.** Insure that a second person shall be on the office premises who can immediately respond to any request from the person administering the nitrous/oxygen ~~*inhalation analgesia; and*~~. ~~*(4-11-06)*~~( )

~~***d.*** *Insure that a qualified person is continuously monitoring the patient. (4-11-06)*~~

**02. Required Facilities and Equipment**. Dental offices in which nitrous oxide/oxygen ~~*sedation*~~ is administered to patients shall, at a minimum and in addition to emergency medications, maintain appropriate facilities and have equipment on site for immediate use as

follows: ~~(4-11-06)~~( )

**a.** A nitrous oxide delivery system with a fail-safe ~~*mechanism*~~ system that ~~*will insure appropriate continuous oxygen delivery and a scavenger system*~~ is appropriately checked and calibrated. The equipment must also have either: ( )

i. A functioning device that prohibits the delivery of less than thirty percent (30%) oxygen; or ( )

ii. An appropriately calibrated and functioning in-line oxygen analyzer with audible alarm; and ~~(4-11-06)~~( )

**b.** An ~~*operating room sufficiently large to accommodate the patient and allow for delivery of appropriate care in an emergency situation*~~ appropriate scavenging system must be available; and ~~(4-11-06)~~( )

~~**c.**~~ ~~*Suction equipment capable of aspirating gastric contents from the mouth and pharynx;*~~ ~~(4-11-06)~~

~~**d**~~**c.** A ~~*portable*~~ positive-pressure oxygen delivery system ~~*including full face masks and a bag-valve mask device capable of delivering positive pressure, oxygen-enriched ventilation to the patient; and*~~ suitable for the patient being treated. ~~(4-11-06)~~( )

~~**e.**~~ ~~*An appropriately sized measuring device for taking a patient's blood pressure.*~~ ~~(4-11-06)~~

**03.** **Personnel**. For nitrous oxide/oxygen administration, personnel shall include: ~~(4-11-06)~~( )

**a.** An operator; and (4-11-06)

**b.** An assistant ~~*trained*~~ currently certified in ~~*basic life support to monitor appropriate physiologic parameters and assist in any support or resuscitation measures required (the operator and the assistant may be the same person)*~~ Basic Life Support for Healthcare Providers. ~~(4-11-06)~~( )

**c.** Auxiliary personnel must have documented training in Basic Life Support for Healthcare Providers, shall have specific assignments, and shall have current knowledge of the emergency cart inventory. The ~~*practitioner*~~ dentist and all office personnel must participate in periodic reviews of office emergency protocol. ~~(4-11-06)~~( )

**058. -- 059. (RESERVED).**

**060. ~~*ADMINISTRATION OF CONSCIOUS*~~ MODERATE SEDATION (RULE 60).**
Dentists licensed in the state of Idaho cannot ~~*use conscious*~~ administer moderate sedation in the practice of dentistry unless they have obtained the proper ~~*conscious*~~ moderate sedation permit from the Idaho State Board of Dentistry. A ~~*conscious*~~ moderate sedation permit may be either ~~*limited*~~ enteral or ~~*comprehensive*~~ parenteral. A ~~*limited conscious*~~ moderate enteral sedation permit

authorizes dentists to administer ~~*conscious*~~ moderate sedation by either enteral or combination inhalation-enteral routes of administration. A ~~*comprehensive conscious*~~ moderate parenteral sedation permit authorizes a dentist to administer ~~*conscious*~~ moderate sedation by ~~*enteral, combination inhalation-enteral or parenteral*~~ any route~~*s*~~ of administration. A dentist shall not administer ~~*conscious*~~ moderate sedation to children under eighteen (18) years of age unless they have qualified for and been issued a ~~*comprehensive conscious*~~ moderate parenteral sedation permit. ~~*(4-11-06)*~~(    )

**01. Requirements for a ~~*Limited Conscious*~~ Moderate Enteral Sedation Permit**. To qualify for a ~~*limited conscious*~~ moderate enteral sedation permit, a dentist applying for a permit ~~*must*~~ shall provide proof that the dentist has complete**d** training in the ~~*use and*~~ administration of ~~*conscious*~~ moderate sedation ~~*drugs*~~ to a level consistent with that prescribed in ~~*Part I and Part III of*~~ the American Dental Association's "~~*ADA*~~ Guidelines for Teaching ~~*the Comprehensive Control of*~~ Pain Control and ~~*Anxiety in Dentistry*~~ Sedation to Dentists and Dental Students," as incorporated in Section 004 in these rules. The five (5) year requirement regarding the required training for a ~~*limited conscious*~~ moderate enteral sedation permit shall not be applicable to applicants who hold an equivalent permit in another state which has been in effect for the twelve (12) month period immediately prior to the application date. To obtain a ~~*limited conscious*~~ moderate enteral sedation permit, a dentist must provide certification of the following: ~~*(4-11-06)*~~(    )

**a.** Completion of an American Dental Association accredited or Board of Dentistry approved post-doctoral training program within five (5) years of the date of application for a ~~*limited conscious*~~ moderate enteral sedation permit that included documented training of a minimum of ~~*eighteen*~~ twenty-four (~~*18*~~24) hours of ~~*didactic education*~~ instruction plus management of at least ~~*twenty*~~ ten (~~*2*~~10) ~~*clinically-oriented*~~ adult case experiences ~~*which provided competency in enteral and combination inhalation-enteral conscious sedation. Clinically-oriented experiences may include either supervised administration or group observations on patients undergoing enteral or combination inhalation-enteral conscious sedation*~~ by the enteral and/or enteral-nitrous oxide/oxygen route. These ten (10) cases must include at least three live clinical dental experiences managed by participants in groups no larger than five (5). The remaining cases may include simulations and/or video presentations, but must include one experience in returning a patient from deep to moderate sedation; ~~*or*~~ and ~~*(4-11-06)*~~(    )

~~***b.*** *Completion of a Board of Dentistry approved course of instruction within five (5) years of the date of application for a limited conscious sedation permit that included documented training of a minimum of eighteen (18) hours of didactic education plus twenty (20) clinically-oriented experiences which provided competency in enteral and combination inhalation-enteral conscious sedation. Clinically-oriented experiences may include either supervised administration or group observations on patients undergoing enteral or combination inhalation-enteral conscious sedation; and* *(4-11-06)*~~

**~~*c*~~b.** Proof of ~~*completion and*~~ current certification of Advanced Cardiac Life Support ~~*training*~~ or its equivalent. ~~*(4-11-06)*~~(    )

**02. Requirements for a ~~*Comprehensive Conscious*~~ Moderate Parenteral Sedation Permit**. ~~*A*~~ To qualify for a moderate parenteral sedation permit, a dentist applying for a permit ~~*to administer comprehensive conscious sedation*~~ shall provide proof that the dentist has ~~*received*~~

~~*formal*~~ completed training ~~*and certification*~~ in the ~~*use*~~ administration of ~~*conscious*~~ moderate parenteral sedation ~~*drugs*~~ as ~~*described*~~ prescribed in the American Dental Association's "Guidelines for Teaching ~~*the Comprehensive*~~ Pain Control ~~*of Pain and Anxiety in Dentistry*~~ and Sedation to Dentists and Dental Students," ~~*published by the American Dental Association and*~~ as incorporated ~~*by reference*~~ in~~*to*~~ Section 004 of these rules within the five (5) year period immediately prior to the date of application for a ~~*comprehensive conscious*~~ moderate parenteral sedation permit. The five (5) year requirement shall not be applicable to applicants who hold an equivalent permit in another state which has been in effect for the twelve (12) month period immediately prior to the date of application. The ~~*formal*~~ training program shall: ~~*(4-11-06)*~~(____)

**a.** Be sponsored by or affiliated with a dental school accredited by the Commission on Dental Accreditation of the American Dental Association or a teaching hospital or facility approved by the Board of Dentistry; and (4-5-00)

**b.** Consist of a minimum of sixty (60) hours ~~*didactic education and*~~ of instruction, plus management of at least twenty (20) ~~*hours*~~ patients ~~*contact*~~ by the intravenous route~~*. Patient contact includes the administration of the intravenous (IV) sedation and management by the participant from induction through emergence.*~~; and ~~*(3-18-99)*~~(____)

**c.** Include the issuance of a certificate of successful completion that indicates the type, number of hours, and length of training received. (3-18-99)

**d.** In addition, the dentist must ~~*show proof of*~~ maintain current certification ~~*of*~~ in Advanced Cardiac Life Support ~~*training*~~ or its equivalent. ~~*(3-15-02)*~~(____)

**03. General Requirements for ~~*Limited*~~ Moderate Enteral and ~~*Comprehensive Conscious*~~ Moderate Parenteral Sedation Permits.** ~~*(4-11-06)*~~(____)

**a. Facility Requirements**. The dentist must have a properly equipped facility for the administration of ~~*conscious*~~ moderate sedation~~*staffed with a dentist-supervised team of auxiliary personnel capable of reasonably handling procedures, problems, and emergencies incident thereto*~~. The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation and providing the equipment, drugs and protocol for patient rescue. ~~*Adequacy of the facility and competence of the anesthesia team will be determined by e*~~Evaluators appointed by the Idaho State Board of Dentistry will periodically assess the adequacy of the facility and competence of the anesthesia team. *The Board adopts the standards incorporated by reference in Section 004.01.c. and Section 004.01.d. of these rules as set forth by the American Dental Association.* ~~*(3-18-99)*~~(____)

**b. Personnel**. For ~~*conscious*~~ moderate sedation, the minimum number of personnel shall be two (2) including: ~~*(10-1-87)*~~(____)

i. The operator; and (10-1-87)

ii. An assistant ~~*trained to monitor appropriate physiologic parameters and assist in any support or resuscitation measures required*~~ currently certified in Basic Life Support for Healthcare Providers. ~~*(10-1-87)*~~(____)

iii. Auxiliary personnel must have documented training in basic life support for healthcare providers, shall have specific assignments, and shall have current knowledge of the emergency cart inventory. The practitioner and all office personnel must participate in documented periodic reviews of office emergency protocol, including simulated exercises, to assure proper equipment function and staff interaction. ~~*(3-18-99)*~~(        )

**c. Permit Renewal**. Renewal of the permit will be required every five (5) years~~*in conjunction with the routine dental licensure renewal*~~. Proof of a minimum of twenty-five (25) credit hours continuing education in ~~*conscious*~~ moderate sedation which may include training in medical/office emergencies will be required to renew a permit. A fee shall be assessed to cover administrative costs. ~~*(4-2-03)*~~(        )

**d. Reinstatement**. A dentist may make application for the reinstatement of an expired or surrendered permit issued by the Board under this rule within five (5) years of the date of the permit's expiration or surrender. Applicants for reinstatement of a permit shall satisfy the facility and personnel requirements of this rule and shall be required to verify that they have obtained an average of five (5) credit hours of continuing education in ~~*conscious*~~ moderate sedation ~~*techniques*~~ for each year subsequent to the date upon which the permit expired or was surrendered. A fee for reinstatement shall be assessed to cover administrative costs. ~~*(4-2-03)*~~(        )

**061. GENERAL ANESTHESIA AND DEEP SEDATION (RULE 61).**

Dentists licensed in the state of Idaho cannot use general anesthesia or deep sedation ~~*techniques*~~ in the practice of dentistry unless they have obtained the proper permit from the Idaho State Board of Dentistry by conforming with the following conditions: ~~*(10-1-87)*~~(        )

**01. General Requirements**. A dentist applying for a permit to administer general anesthesia ~~*and*~~ or deep sedation shall provide proof that the dentist: ~~*(10-1-87)*~~(        )

**a.** Has completed an ~~*minimum of one (1) year of advance training in anesthesiology and related academic subjects beyond the undergraduate dental school level*~~ advanced education program accredited by the ADA Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage deep sedation or general anesthesia, commensurate with Part IV.C of the American Dental Association's "Guidelines for the Use of Sedation and General Anesthesia by Dentists" within the five (5) year period immediately prior to the date of application for a permit. The five (5) year requirement shall not be applicable to applicants who hold an equivalent permit in another state which has been in effect for the twelve (12) month period immediately prior to the date of application~~*. This training is described in Part II of the "Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry," as incorporated by reference in Section 004 of these rules*~~; ~~*or*~~ and ~~*(4-11-06)*~~(        )

~~***b.*** *Is a diplomate of the American Board of Oral and Maxillofacial Surgery; or* *(10-1-87)*~~

~~***c.*** *Is a member of the American Association of Oral and Maxillofacial Surgeons; or* *(10-1-87)*~~

**d.** *Is a Fellow of the American Dental Society of Anesthesiology; and* *(4-5-00)*

**eb.** *Has c*Current Certification *of* in Advanced Cardiac Life Support *Training* or its equivalent; and *(3-15-02)*( )

**fc.** Has an established protocol or admission to a recognized hospital. (3-18-99)

**02. Facility Requirements**. The dentist must have a properly equipped facility for the administration of general anesthesia*, staffed with a dentist-supervised team of auxiliary personnel capable of reasonably handling procedures, problems, and emergencies incident thereto* or deep sedation. The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of general anesthesia or deep sedation and providing the equipment, drugs and protocol for patient rescue. *Adequacy of the facility and competence of the anesthesia team will be determined by e*Evaluators appointed by the Idaho State Board of Dentistry will periodically assess the adequacy of the facility and competence of the anesthesia team. The Board adopts the standards incorporated by reference in Section 004 of these rules, *regarding approval of equipment within the facility* as set forth by the American Association of Oral and Maxillofacial Surgeons in their office anesthesia evaluation manual. *(4-11-06)*( )

**03. Personnel**. For general anesthesia *and* or deep sedation *techniques*, the minimum number of personnel shall be three (3) including: *(10-1-87)*( )

**a.** A qualified *person* operator to direct the sedation as specified in Section 061 of this rule; and *(4-11-06)*( )

**b.** *A qualified person whose primary responsibilities are observation and monitoring of the patient and who has documented current CPR certification; and* Two (2) additional individuals who have current certification in Basic Life Support for the Healthcare Provider. *(3-18-99)*( )

**c.** *An assistant for the operator who has documented current CPR certification.* When the same individual administering the deep sedation or general anesthesia is performing the dental procedure, one (1) of the additional appropriately trained team members must be designated for patient monitoring. *(3-18-99)*( )

**04. *Conscious* Moderate Sedation**. A dentist holding a permit to administer general anesthesia or deep sedation under this rule may also administer *conscious* moderate sedation. *(3-18-99)*( )

**05. Permit Renewal**. Renewal of the permit will be required every five (5) years *in conjunction with the routine dental licensure renewal*. Proof of a minimum of twenty-five (25) credit hours of continuing education in general anesthesia *and* or deep sedation *techniques* and proof of current certification in Advance Cardiac Life Support will be required to renew a permit. A fee shall be assessed to cover administrative costs. *(4-2-03)*( )

**06. Reinstatement**. A dentist may make application for the reinstatement of an expired or surrendered permit issued by the Board under this rule within five (5) years of the date

of the permit's expiration or surrender. Applicants for reinstatement of a permit shall satisfy the facility and personnel requirements of this rule and shall be required to verify that they have obtained an average of five (5) credit hours of continuing education in general anesthesia ~~*and*~~ or deep sedation ~~*techniques*~~ for each year subsequent to the date upon which the permit expired or was surrendered. A fee for reinstatement shall be assessed to cover administrative costs. ~~*(4-2-03)*~~(____)

***(BREAK IN CONTINUITY OF SECTIONS)***

**063. INCIDENT REPORTING (RULE 63).**

~~*Any anesthesia permit holder*~~ Dentists shall report to the Board, in writing, within seven (7) days after the death or transport to a hospital or emergency center for medical treatment for a period exceeding twenty-four (24) hours of any patient to whom ~~*conscious*~~ sedation ~~*or general anesthesia*~~ was administered. ~~*(3-18-99)*~~(____)

# IDAPA 23 - IDAHO BOARD OF NURSING

## 23.01.01 - RULES OF THE IDAHO BOARD OF NURSING

## DOCKET NO. 23-0101-1001

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 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 54-1404(11), 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 6, 2010 Idaho Administrative Bulletin, Vol. 10-10, pages 365 through 374**.**

**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 28th day of October, 2010.

Sandra Evans, M.A.Ed., R.N.
Executive Director
Board of Nursing
280 N. 8th St. (8th & Bannock), Ste. 210
P. O. Box 83720, Boise, ID 83720-0061
Phone: (208) 334-3110, Ext. 26
Fax: (208) 334-3262

***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 54-1404(11), 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 20, 2010.

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:

**A current definition addressing who is allowed to administer medications is too restrictive and inadvertently fails to include certified medication assistants. A rule amendment is necessary to more accurately reflect license renewal procedures. Existing provisions regarding license reinstatement are not located together, have unnecessary redundancies, and contain a grammatical error. There is confusion and lack of clarity over the term "family member" for purposes of prescribing medications and a definition is required. A provision regarding nursing school administrators is misplaced and the Board will no longer be issuing wallet certificates and duplicate licenses so provisions addressing these matters need to be deleted. The proposed amendments will: (1) clarify that persons specifically authorized by Board statute or rule may administer medications; (2) reflect the fact that the Board no longer mails license renewal applications, but only sends notice of renewal to licensees; (3) add a provision to inform licensees where they can obtain license applications; (4) reorganize provisions regarding license reinstatement in a more convenient, understandable format and accessible location, and eliminate redundancies; (5) define the term "family member" in connection with the prescriptive authority of an advanced practice nurse; (6) move a provision on school administrators to a more appropriate location in rule; and (7) delete outdated references to wallet certificates and duplicate licenses.**

**FEE SUMMARY:** The following is a specific description of the fee or charge imposed or increased: None.

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

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(2), Idaho Code, negotiated

rulemaking was not conducted because virtually all of the rulemaking consists of “housekeeping” matters such as reorganizing, renumbering and re-titling sections to create a more logical, coherent, procedural framework, and to correct an obvious misstatement in one provision and an obvious misplacement of another provision. The remaining rulemaking simply provides clarity to an existing definition of a term and established a necessary definition in connection with another term, neither of which should be controversial.

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

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the proposed rule, contact Sandra Evans, M.A.Ed., R.N., Executive Director, at (208) 334-3110 Ext. 26.

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 27, 2010.

DATED this 20th day of August, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 23-0101-1001***

**010. DEFINITIONS.**

**01. Abandonment**. The termination of a nurse/patient relationship without first making appropriate arrangements for continuation of required nursing care. The nurse/patient relationship begins when responsibility for nursing care of a patient is accepted by the nurse. Refusal to accept an employment assignment or refusal to accept or begin a nurse/patient relationship is not abandonment. Reasonable notification, or a timely request for alternative care for a patient, directed to an attending physician or to a staff supervisor, prior to leaving the assignment, constitutes termination of the nurse/patient relationship. (3-30-07)

**02. Accreditation**. The official authorization or status granted by a recognized accrediting entity or agency other than a state board of nursing. (7-1-93)

**03. Administration of Medications**. The process whereby a prescribed medication is given to a patient by one (1) of several routes. Administration of medication is a complex nursing responsibility which requires a knowledge of anatomy, physiology, pathophysiology, and pharmacology. ~~*Licensed nurses*~~ Only persons authorized under Board statutes and these rules may administer medications and treatments as prescribed by health care providers authorized to prescribe medications. ~~*(5-3-03)*~~(____)

**04. Approval**. The process by which the Board evaluates and grants official recognition to education programs that meet standards established by the Board. (5-3-03)

**05. Assist**. To aid or help in the accomplishment of a prescribed set of actions. (7-1-93)

**06. Assistance With Medications**. The process whereby a non-licensed care provider is delegated tasks by a licensed nurse to aid a patient who cannot independently self-administer medications. (5-3-03)

**07. Board**. The Idaho Board of Nursing. (7-1-93)

**08. Board Staff**. The executive director and other such personnel as are needed to implement the Nursing Practice Act and these rules. (7-1-93)

**09. Charge Nurse**. A licensed nurse who bears primary responsibility for assessing, planning, prioritizing and evaluating care for the patients on a unit, as well as the overall supervision of the licensed and unlicensed staff delivering the nursing care. (5-3-03)

**10. Clinical Preceptor**. A licensed professional nurse who acts to facilitate student training in a manner prescribed by a written agreement between the preceptor's employer and an educational institution. (5-3-03)

**11. Competence**. Safely performing those functions within the role of the licensee in a manner that demonstrates essential knowledge, judgment and skills. (5-3-03)

**12. Curriculum**. The systematic arrangement of learning experiences including didactic courses, practical experiences, and other activities needed to meet the requirements of the nursing program and of the certificate or degree conferred by the parent institution. (5-3-03)

**13. Delegation**. The process by which a licensed nurse assigns tasks to be performed by others. (5-3-03)

**14. Disability**. Any physical, mental, or emotional condition that interferes with the nurse's ability to practice nursing safely and competently. (5-3-03)

**15. Emeritus License**. A license issued to a nurse who desires to retire from active practice for any length of time. (5-3-03)

**16. Licensing Examination**. A licensing examination that is acceptable to the Board. (5-3-03)

**17. License in Good Standing**. A license not subject to current disciplinary action, restriction, probation or investigation in any jurisdiction. (5-3-03)

**18. Limited License**. A nursing license subject to specific restrictions, terms, and conditions. (5-3-03)

**19. Nursing Assessment**. The systematic collection of data related to the patient's health care needs. (5-3-03)

**20. Nursing Diagnosis**. The clinical judgment or conclusion regarding patient/client/ family/ community response to actual or potential health problems made as a result of the nursing assessment. (7-1-93)

**21. Nursing Intervention**. An action deliberately selected and performed to support the plan of care. (5-3-03)

**22. Nursing Service Administrator**. A licensed professional nurse who has administrative responsibility for the nursing services provided in a health care setting. (7-1-93)

**23. Organized Program of Study**. A written plan of instruction to include course objectives and content, teaching strategies, provisions for supervised clinical practice, evaluation methods, length and hours of course, and faculty qualifications. (7-1-93)

**24. Patient**. An individual or a group of individuals who are the beneficiaries of nursing services in any setting and may include client, resident, family, community. (5-3-03)

**25. Patient Education**. The act of teaching patients and their families, for the purpose of improving or maintaining an individual's health status. (5-3-03)

**26. Plan of Care**. The goal-oriented strategy developed to assist individuals or groups to achieve optimal health potential. (5-3-03)

**27. Practice Standards**. General guidelines that identify roles and responsibilities for a particular category of licensure and, used in conjunction with the decision-making model, define a nurse's relationship with other care providers. (5-3-03)

**28. Probation**. A period of time set forth in an order in which certain restrictions, conditions or limitations are imposed on a licensee. (5-3-03)

**29. Protocols**. Written standards that define or specify performance expectations, objectives, and criteria. (5-3-03)

**30. Revocation**. Termination of the authorization to practice. (5-3-03)

**31. Scope of Practice**. The extent of treatment, activity, influence, or range of actions permitted or authorized for licensed nurses based on the nurse's education, preparation, and experience. (5-3-03)

**32. Supervision**. Designating or prescribing a course of action, or giving procedural guidance, direction, and periodic evaluation. Direct supervision requires the supervisor to be physically present and immediately accessible to designate or prescribe a course of action or to give procedural guidance, direction, and periodic evaluation. (4-6-05)

**33. Suspension**. An order temporarily withdrawing a nurse's right to practice nursing.

(5-3-03)

**34. Technician/Technologist**. These individuals are not credentialed by regulatory bodies in Idaho and may include, but are not limited to: surgical, dialysis and radiology technicians/technologists, monitor technicians and medical assistants. (3-30-07)

**35. Universal Standards**. The recommendations published by the Center for Disease Control, Atlanta, Georgia, for preventing transmission of infectious disease, also referred to as "Standard Precautions." (5-3-03)

### *(BREAK IN CONTINUITY OF SECTIONS)*

**060. LICENSE RENEWAL.**
All licenses must be renewed as prescribed in the Section 54-1411, Idaho Code. (3-30-01)

**01. Renewal ~~*Application*~~ Notice -- Licensed Professional Nurse**. A notice of renewal ~~*application*~~ will be mailed to every currently licensed professional nurse, at the address on record with the Board, on or before July 1 of every odd-numbered year. ~~*(3-30-01)*~~(    )

**02. Renewal ~~*Application*~~ Notice -- Licensed Practical Nurse**. A notice of renewal ~~*application*~~ will be mailed to every currently licensed practical nurse, at the address on record with the Board, on or before July 1 of every even-numbered year. ~~*(3-30-01)*~~(    )

**03. Renewal ~~*Application*~~ Notice -- Advanced Practice Professional Nurse**. A notice of renewal ~~*application*~~ will be mailed to every currently licensed advanced practice professional nurse, at the address on record with the Board, on or before July 1 of every odd-numbered year. ~~*(3-30-01)*~~(    )

**04. Renewal ~~*Application*~~ Notice -- Emeritus Licensure**. A notice of renewal ~~*application*~~ will be mailed to every holder of a current emeritus license, at the address on record with the Board, on or before July 1 of the renewal year that applied to the applicant's license at the time emeritus status was granted. If the applicant was an RN or APPN at the time emeritus status was granted, renewal will take place in odd numbered years. If the applicant was an LPN at the time emeritus status was granted, renewal will take place in even numbered years. ~~*(4-2-03)*~~(    )

**05. Renewal Applications**. Renewal applications may be obtained by contacting the Board. (    )

**0~~5~~6. Final Date to Renew**. The original ~~*signed*~~ completed renewal application and renewal fee as prescribed in Section 900 of these rules, must be submitted to the Board and post-marked or electronically dated not later than August 31 of the appropriate renewal year. ~~*(3-30-01)*~~(    )

**0~~6~~7. Date License Lapsed**. Licenses not renewed prior to September 1 of the appropriate year will be lapsed and therefore invalid. (11-28-84)

**0~~7~~8. Effective Period**. Renewed licenses shall be effective for a two (2) year period, from September 1 of the renewal year. (3-30-01)

**061. LICENSE REINSTATEMENT (NON-DISCIPLINE).**

**01. Within One Year**. A person whose license has lapsed for failure to pay the renewal fee by the specified date may apply for reinstatement within one (1) year by: (3-30-07)

**a.** Filing a completed renewal application; and (3-30-01)

**b.** Payment of the verification of records fee and the renewal fee as prescribed in Subsection 900.05 of these rules. (4-2-03)

**02. After One Year**. After one (1) year, but less than three (3) years, a person whose license has lapsed for failure to pay the renewal fee by the specified date may apply for reinstatement by: (3-30-07)

**a.** Filing a completed reinstatement application; and (3-30-01)

**b.** Payment of the fees prescribed in Subsection 900.05 of these rules; and (3-30-07)

**c.** Providing evidence satisfactory to the Board of the applicant's ability to practice safely and competently. (3-30-01)

**d.** Causing the submission of ~~A~~a current fingerprint-based criminal history check as set forth in Section 54-1401(3), Idaho Code. ~~*(3-30-07)*~~(____)

**03. After Three Years**. After three (3) years, a person whose license has lapsed for failure to timely pay the renewal fee may apply for reinstatement by: (3-30-07)

**a.** Filing a completed reinstatement application; and (3-30-07)

**b.** Payment of the fees prescribed in Subsection 900.05 of these rules; and (3-30-07)

**c.** Payment of the temporary license fee prescribed in Subsection 901.07 of these rules, if required; and (4-2-03)

**d.** Providing evidence, satisfactory to the Board, of the applicant's ability to practice safely and competently. (3-30-07)

**e.** Causing the submission of ~~A~~a current fingerprint-based criminal history check as set forth in Section 54-1401(3), Idaho Code. ~~*(3-30-07)*~~(____)

~~***04. After Discipline***. *A person whose license has been subject to disciplinary action by the Board may apply for reinstatement of the license to active and unrestricted status by:* *(3-30-07)*~~

~~**a.** *Submitting a completed application for reinstatement; and* *(4-2-03)*~~

~~**b.** *Payment of the fees prescribed in Subsection 900.05 of these rules; and* *(3-30-07)*~~

~~**c.** *Documenting compliance with any term and restrictions set forth in any order as a condition of reinstatement; and* *(3-30-07)*~~

~~**d.** *Providing evidence, satisfactory to the Board, of the applicant's ability to practice safely and competently.* *(3-30-07)*~~

~~**e.** *A current fingerprint-based criminal history check as set forth in Section 54-1401(3), Idaho Code.* *(3-30-07)*~~

~~**f.** *A person whose license has been revoked may not apply for reinstatement until two (2) years following the order of revocation.* *(3-30-07)*~~

**0~~5~~4. Reinstatement of Emeritus License to Current Status**. A person who holds a current emeritus license in good standing may apply for reinstatement of the license to active and unrestricted status by: (4-2-03)

**a.** Submitting a completed application for reinstatement; and (4-2-03)

**b.** Payment of the fees prescribed in Subsection 900.05 of these rules; and (3-30-07)

**c.** Providing evidence, satisfactory to the Board, of the applicant's current competency to practice. (3-30-07)

## *Codified Section 120 has been moved and renumbered to proposed Section 062*

### ~~12~~062. REINSTATEMENT AFTER DISCIPLINE.

~~**01.** ***Application**. Applicants for reinstatement of revoked licenses must apply on forms provided by the Board and must pay any required fees.* *(3-15-02)*~~

**01. Submission of Application Materials**. A person whose license has been subject to disciplinary action by the Board may apply for reinstatement of the license to active and unrestricted status by: ( )

**a.** Submitting a completed application for reinstatement; and ( )

**b.** Payment of the fees prescribed in Subsection 900.05 of these rules; and ( )

**c.** Documenting compliance with any term and restrictions set forth in any order as a condition of reinstatement; and ( )

**d.** Providing evidence, satisfactory to the Board, of the applicant's ability to practice

safely and competently. ( )

**e.** Causing the submission of a current fingerprint-based criminal history check as set forth in Section 54-1401(3), Idaho Code. ( )

**02. Appearance Before Board**. Applicants for reinstatement may be required to appear before the Board. (3-15-02)

**03. Evaluation of Applications**. In considering applications for reinstatement, the Board will evaluate: (3-15-02)

**a.** The nature and severity of the act which resulted in ~~*revocation of the license*~~ discipline; ~~*(7-1-91)*~~( )

**b.** The conduct of the applicant subsequent to the ~~*revocation of license*~~ discipline; ~~*(6-1-78)*~~( )

**c.** The lapse of time since ~~*revocation*~~ discipline; ~~*(6-1-78)*~~( )

**d.** The degree of compliance with all terms and conditions the Board may have set forth as a prerequisite for reinstatement; (3-15-02)

**e.** Any intervening circumstances that may have altered the need for compliance; (3-15-02)

**f.** The degree of rehabilitation attained by the applicant as evidenced by statements sent directly to the Board from qualified people who have professional knowledge of the applicant; (11-28-84)

**g.** The applicant's adherence to or violation of any applicable law or rule regulating the practice of nursing; and (4-6-05)

**h.** The applicant's criminal background information as evidenced by a current fingerprint based criminal history check as set forth in Section 54-1401(3), Idaho Code. (4-6-05)

**04. Board Action Possible**. After evaluation, the Board may deny a reinstatement, grant a reinstatement, or issue a license permitting the applicant to practice nursing under specified terms and conditions. (3-15-02)

**05. Assessment of Costs**. As a condition of withdrawing, reversing, modifying, or amending a ~~*suspension or revocation*~~ prior disciplinary order, the applicant may be required to pay all or any part of the costs incurred by the Board in the proceedings in which the order was entered. ~~*(3-15-02)*~~( )

**06. Application for Reinstatement After Revocation**. Unless otherwise provided in the order of revocation, applicants for reinstatement of revoked licenses may not apply for reinstatement for a period of two (2) years after entry of the order. (3-15-02)

**06~~2~~3. -- 075. (RESERVED).**

***(BREAK IN CONTINUITY OF SECTIONS)***

**102. -- 1~~19~~31. (RESERVED).**

***Codified Section 120 has been moved and renumbered to proposed Section 062***

~~***121. -- 131. (RESERVED).***~~

***(BREAK IN CONTINUITY OF SECTIONS)***

**316. GROUNDS FOR DISCIPLINE OF AN ADVANCED PRACTICE PROFESSIONAL NURSE LICENSE.**

In addition to the grounds set forth in Section 54-1413, Idaho Code, and Section 100 of these rules, an advanced practice professional nursing license may be suspended, revoked, placed upon probation, or other disciplinary sanctions imposed by the Board on the following grounds: (3-30-07)

**01. Prescribing or Dispensing Controlled Substances**. Prescribing, dispensing, or selling any drug classified as a controlled substance to a family member or to himself. For purposes of Section 316 of these rules, "family member" is defined as the licensee's spouse, child (biological, adopted, or foster), parent, sibling, grandparent, grandchild, or the same relation by marriage. ~~*(7-1-99)*~~( )

**02. Violating Governing Law**. Violating any state or federal law relating to controlled substances. (7-1-99)

**03. Outside Scope of Practice**. Prescribing or dispensing outside the scope of the advanced practice professional nurse's practice. (7-1-99)

**04. Other Than Therapeutic Purposes**. Prescribing or dispensing for other than therapeutic purposes. (7-1-99)

**05. Violation of Nursing Practice Act or Board Rules**. Violating the provisions of the Nursing Practice Act or the rules of the Board. (7-1-99)

***(BREAK IN CONTINUITY OF SECTIONS)***

**641. FACULTY ~~*RESPONSIBILITIES*~~.**

**01. Numbers Needed**. There shall be sufficient faculty with educational preparation and nursing expertise to meet the objectives and purposes of the nursing education program. (4-5-00)

**a.** Number of faculty shall be sufficient to design and implement the curriculum necessary to prepare students to function in a rapidly changing healthcare environment. (4-5-00)

**b.** Number of faculty in the clinical setting shall be sufficient in number to assure patient safety and meet student learning needs. (4-5-00)

**02. Faculty-Student Ratio**. There shall be no more than ten (10) students for every faculty person in the clinical agencies. Deviations may be presented for approval with the program's annual report to the Board with written justification assuring client safety and supporting accomplishment of learner objectives. (4-5-00)

~~***03. Numbers of Administrators Needed****. There shall be at least one (1) qualified nursing administrator for each nursing education department or division. In institutions that offer nursing education programs for more than one (1) level of preparation and where the scope of administrative responsibility so requires, there shall be an individual administrator for each nursing education program. (11-28-84)*~~

**642. (RESERVED).**

**643. ADMINISTRATOR RESPONSIBILITIES AND QUALIFICATIONS.**

**01. Administrator Responsibilities**. The administrator provides the leadership and is accountable for the administration, planning, implementation, and evaluation of the program. The administrator's responsibilities include, but are not limited to: (4-5-00)

**a.** Development and maintenance of an environment conducive to the teaching and learning processes; (4-5-00)

**b.** Liaison with and maintenance of the relationship with administrative and other units within the institution; (4-5-00)

**c.** Leadership within the faculty for the development and implementation of the curriculum; (4-5-00)

**d.** Preparation and administration of the program budget; (4-5-00)

**e.** Facilitation of faculty recruitment, development, performance review, promotion, and retention; (4-5-00)

**f.** Liaison with and maintenance of the relationship with the Board; and (4-5-00)

**g.** Facilitation of cooperative agreements with practice sites. (4-5-00)

**02. Administrator Qualifications**. The administrator of the program shall be a licensed professional nurse, with an unencumbered license in this state, and with the additional education and experience necessary to direct the program. (4-5-00)

**a.** Programs for Unlicensed Assistive Personnel. Meet institutional requirements. (4-5-00)

**b.** Practical Nurse Administrator. The administrator in a program preparing for practical nurse licensure shall: (4-5-00)

i. Hold a minimum of a master's degree with a major in nursing; and (4-5-00)

ii. Have evidence of experience in education, administration, and practice sufficient to administer the program. (4-5-00)

**c.** Professional Nurse Administrator. The administrator in a program preparing for professional nurse licensure shall: (4-5-00)

i. Hold a minimum of a master's degree with a major in nursing and meet institutional requirements; and (4-5-00)

ii. Have evidence of experience in education, administration, and practice sufficient to administer the program. (4-5-00)

**d.** Advanced Practice Professional Nurse Administrator. The administrator in a program preparing for advanced practice professional nursing shall: (4-5-00)

i. Hold a master's degree and an earned doctoral degree, one of which is in nursing; and (4-5-00)

ii. Have evidence of experience in education, administration, and practice sufficient to administer the program. (4-5-00)

**03. Numbers of Administrators Needed**. There shall be at least one (1) qualified nursing administrator for each nursing education department or division. In institutions that offer nursing education programs for more than one (1) level of preparation and where the scope of administrative responsibility so requires, there shall be an individual administrator for each nursing education program. (____)

## *(BREAK IN CONTINUITY OF SECTIONS)*

### 900. RENEWAL AND REINSTATEMENT FEES.

Fees will be assessed for renewal of licensure or for reinstatement of a lapsed, disciplined, limited, or emeritus license. Any person submitting the renewal application and fee post-marked or electronically dated later than August 31 shall be considered delinquent and the license lapsed

and therefore invalid: ~~*(3-30-07)*~~( )

**01. Licensed Professional Nurse Renewal Fee**. Licensed professional nurses will be assessed a renewal fee of ninety dollars ($90) due by August 31 of each odd-numbered year. (3-30-06)

**02. Licensed Practical Nurse Renewal Fee**. Licensed practical nurses will be assessed a renewal fee of ninety dollars ($90) due by August 31 of each even-numbered year. (3-30-06)

**03. Advanced Practice Professional Nurse**. Licensed advanced practice professional nurses will be assessed a renewal fee of ninety dollars ($90) due by August 31 of each odd-numbered year. (3-30-06)

**04. Emeritus License**. Emeritus status nurses will be assessed a renewal fee of twenty dollars ($20) due by August 31 of the renewal year. (4-2-03)

**05. Reinstatement Fee**. Nurses requesting reinstatement of a lapsed, disciplined, limited, or emeritus license, or reinstatement of an emeritus license to active status, will be assessed the records verification and renewal fees. (3-30-07)

**06. Delay in Processing**. Processing of renewal applications not accompanied by cash, cashier's check, a money order, or other guaranteed funds may be delayed in order to allow clearance of personal checks through the licensee's bank. (3-30-01)

***(BREAK IN CONTINUITY OF SECTIONS)***

**907. ~~*LICENSES AND WALLET CERTIFICATES*~~ (RESERVED).**

~~***01. Duplicate Wallet Certificates**. Duplicate wallet certificates will be issued where the original wallet certificate has been lost or destroyed. Applicants requesting a duplicate wallet certificate must pay a ten dollar ($10) application fee. (3-30-01)*~~

~~***02. Revised Wallet Certificates**. Revised wallet certificates will be issued to reflect a change in name. Applicants requesting a revised wallet certificate must pay a ten dollar ($10) application fee. (3-30-01)*~~

~~***03. Duplicate Licenses**. (3-30-01)*~~

~~*a. Duplicate licenses are reproductions of original licenses. (3-30-01)*~~

~~*b. Applicants requesting a duplicate license must pay a ten dollar ($10) application fee. (3-30-01)*~~

~~*c. Original licenses may not be revised. (3-30-01)*~~

# IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

## 24.03.01 - RULES OF THE STATE BOARD OF CHIROPRACTIC PHYSICIANS

## DOCKET NO. 24-0301-1001

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 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(s) 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 Board of Chiropractic Physicians would like to establish a code of ethics that will further protect the public. Changes from the published proposed rule are necessary due to comments received and considered by the Board. Appendix A number one (1) has been amended to clarify the duty to report and Appendix A number four (4) has been amended to exclude the Safekeeping Pre-paid Funds paragraph.**

**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 October 6, 2010 Idaho Administrative Bulletin, Vol. 10-10, pages 379 through 381.**

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

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning the pending rule, contact Cherie Simpson at 208 334-3233.

DATED this 18th day of November, 2010.

Tana Cory, Bureau Chief
Bureau of Occupational Licenses
700 W. State Street, 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 54-707, 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 20, 2010.

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 Chiropractic Physicians would like to establish a code of ethics that will further protect the public.**

**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:

There is no fiscal impact.

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because discussions were held in a noticed, open meeting of the Board.

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

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at (208) 334-3233.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 27,

2010.

DATED this 13th day of August, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-0301-1001***

**602. -- ~~999~~604.(RESERVED).**

**605. CODE OF ETHICS (RULE 605).**
Chiropractic physicians are responsible for maintaining and promoting ethical practice in accordance with the ethical principles set forth in Appendix A in these rules. ( )

**606. -- 999. (RESERVED).**

**Appendix A – Chiropractic Physicians Code of Ethics**

**Preamble**

This code of ethics set forth principles for the ethical practice of chiropractic. All chiropractic physicians are responsible for maintaining and promoting ethical practice and otherwise complying with the terms of this code of ethics. To this end, the chiropractic physician shall act in the best interest of the patient. This code of ethics shall be binding on all chiropractic physicians.

**1. Duty to Report**

A. Duty to Report. It shall be the duty of every licensee to notify the Board through the Bureau of Occupational Licenses of any violation of the Chiropractic Act or Board Rules, *if the licensee has personal knowledge of the conduct.*

B. Reporting of Certain Judgments to Board. If a judgment is entered against a licensee in any court, or a settlement is reached on a claim involving malpractice exceeding fifty thousand dollars ($50,000), a licensee shall report that fact to the Board within thirty (30) days. The licensee may satisfy the provision of this subsection if he/she provides the Board with a copy of the judgment or settlement.

If a licensee is convicted of a felony or a crime involving dishonesty, theft, violence, habitual use of drugs or alcohol, or sexual misconduct, he/she shall report that fact to the board within thirty (30) days following the conviction.

**2. Advertising of Research Projects**

Advertisement of Affiliation with Research Projects. If a licensee advertises any affiliation with a research project, he must make a written statement of the objectives, cost and budget of the project, and the person conducting the research. Such statements are to be made available at the request of the Board, to scientific organizations, and to the general public. The advertisement must indicate that it is supported by clinical research. Any willful failure to comply with these requirements will be deemed false and deceptive advertising under rule 450. Licensee must comply with all state and federal laws and regulations governing research projects on humans, and shall obtain "Institutional Review Board" (IRB) approval as established and set forth in the U.S. Code of Federal Regulations, Title 45, Part 46, Subpart A (45 CFR 46.101-46-505).

**3. Sexual Misconduct**

The doctor-patient relationship requires the chiropractic physician to exercise utmost care that he or she will do nothing to exploit the trust and dependency of the patient. Sexual misconduct is a form of behavior that adversely affects the public welfare and harms patients individually and collectively. Sexual misconduct exploits the doctor-patient relationship and is a violation of the public trust. This section of the Code of Ethics shall not apply between a chiropractor and their spouse.

For the purposes of this subsection, sexual misconduct is divided into sub-categories based upon the severity of the conduct:

A. Sexual Impropriety. Any behavior such as gestures, expressions, and statements which are sexually suggestive or demeaning to a patient, or which demonstrate a lack of respect for a patient's privacy.

B. Sexual Violation. Physician-patient contact of a sexual nature, whether initiated by the physician or the patient.

C. A chiropractic physician shall wait at least one (1) year ("waiting period") following the termination of a professional doctor-patient relationship, before beginning any type of sexual relationship with a former patient.

**4. Pre-Paid Funds**

A. A chiropractic physician shall promptly refund any unearned fees within thirty (30) days upon request and cancellation of the pre-paid contract. A full accounting of the patient account shall be provided to the patient at the time of the refund or upon request.

# IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

## 24.06.01 - RULES FOR THE LICENSURE OF OCCUPATIONAL THERAPISTS AND OCCUPATIONAL THERAPY ASSISTANTS

## DOCKET NO. 24-0601-1001

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 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(s) 54-3717, Idaho Code.

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

**The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 6, 2010 Idaho Administrative Bulletin, Vol. 10-10, pages 382 through 387.**

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

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning this pending rule, contact Cherie Simpson at 208 334-3233.

DATED this 17th day of November, 2010.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
1109 Main St., STE 220
Boise, ID 83702
(208) 334-3233 phone
(208) 334-3945 fax

***THIS NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE***

**EFFECTIVE DATE:** The effective date of the temporary rule is **July 28, 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 Section 54-3717, Idaho Code.

**PUBLIC HEARING SCHEDULE:** Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 20, 2010.

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 Board of Occupational Therapists and Occupational Therapy Assistants in this set of rules is updating previous rules under the Board of Medicine to clarify the inactive status and the requirements to reinstate. Further, the Board adopted a rule that has caused concern to licensees and providers and limited service to the public. In an effort to address this concern while still protecting the public and ensuring their health, safety, and welfare, the Board is clarifying the level of supervision for students, graduates, and assistants. It also clarifies the supervision needed for certain treatment modalities.**

**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 for the following reasons:

**The Board adopted a rule that has caused concern to licensees and providers and limited service to the public. In an effort to address this concern while still protecting the public and ensuring their health, safety, and welfare, the Board is clarifying the level of supervision for students, graduates, and assistants. It also clarifies the supervision needed for certain treatment modalities.**

**FEE SUMMARY:** The following is a specific description of the fee or charge imposed or increased: None.

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

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because discussions were held in a noticed open meeting.

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

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the temporary and proposed rule, contact Cherie Simpson at (208) 334-3233.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 27, 2010.

DATED this 18th day of August, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-0601-1001***

**011. SUPERVISION.**

An occupational therapist shall supervise and be responsible for the patient care given by occupational therapy assistants, graduate occupational therapists, graduate occupational therapy assistants, student occupational therapists, student occupational therapy assistants, and aides. (3-29-10)

**01. Skill Levels**. The following skill levels apply to occupational therapy assistants, graduate occupational therapists, graduate occupational therapy assistants, student occupational ~~therapy~~therapists, student occupational therapy assistants and aides: ~~(3-29-10)~~(____)

**a.** Entry Level - Working on initial skill development (zero to one (0-1) year experience) or working in a new area of practice; (3-29-10)

**b.** Intermediate Level - Increased independence and mastery of basic roles and functions. Demonstrates ability to respond to new situations based on previous experience (generally one to five (1-5) years' experience); (3-29-10)

**c.** Advanced Level - Refinement of skills with the ability to understand complex issues and respond accordingly. (3-29-10)

**02. Supervision Levels**. The following supervision levels apply to occupational therapy assistants, graduate occupational therapists, graduate occupational therapy assistants, student occupational ~~therapy~~therapists, student occupational therapy assistants and aides:

~~*(3-29-10)*~~(      )

**a.** Direct Line of Site Supervision - An occupational therapist or occupational therapy assistant must provide direct line of site supervision to an aide; (3-29-10)

**b.** Direct Supervision - Daily, direct contact at the site of work with the supervisor physically present at all times within the facility when the supervisee renders care and requires the supervisor to co-sign all documentation that is completed by the supervisee. This supervision is the minimal level of supervision required for students, ~~*and*~~ for entry or intermediate level occupational therapy assistants applying deep thermal and electrotherapeutic modalities, and for advanced level occupational therapy assistants who apply such modalities while lacking the education and training required in Subsection 012.01 of these rules; ~~*(3-29-10)*~~(      )

**c.** Close Supervision - Daily, direct contact at the site of work. The occupational therapist provides direction in developing the plan of treatment and periodically inspects the actual implementation of the plan. This supervision is the minimal level of supervision required for entry level occupational therapy assistants and graduate occupational therapy assistants ~~*who are working under a temporary license*~~; ~~*(3-29-10)*~~(      )

**d.** Routine Supervision - Requires direct contact at least every two (2) weeks at the site of work, with interim supervision occurring by other methods, such as by telephone or written communication. This supervision is the minimal level of supervision required for ~~*a temporary occupational therapist or for an*~~ graduate occupational therapists and intermediate level occupational therapy assistant. It also is the minimum level of supervision required for advanced level occupational therapy assistants applying deep thermal and electrotherapeutic modalities while possessing the education and training specified in Subsection 012.01 of these rules;
~~*(3-29-10)*~~(      )

**e.** General Supervision - Initial direction and periodic review of the following: service delivery, update of treatment plans, and treatment outcomes. The supervisor need not at all times be present at the premises where the occupational therapy assistant is performing the professional services. However, not less than monthly direct contact must be provided, with supervision available as needed by other methods. This supervision is the minimal level of supervision required for an intermediate to advanced occupational therapy assistant. (3-29-10)

**03. Supervision Ratios**. An occupational therapist may supervise up to three (3) full-time occupational therapy assistants, but never more than two (2) entry level occupational therapy assistants. The total number of supervised occupational therapy assistants, ~~*and*~~ non-licensed occupational therapy personnel (including any graduate occupational therapists, graduate occupational therapy assistants, student occupational therapy, student occupational therapy assistants, and aides), and occupational therapists in training to provide deep thermal, electrotherapeutic modalities and wound care may not exceed five (5) without prior Board approval. The Board may permit the supervision of a greater number by an occupational therapist if, in the Board's opinion, there would be adequate supervision and the public's health and safety would be served. It is the supervising occupational therapist's responsibility to notify the Board of any circumstances requiring approval of a greater number and to submit a written plan for resolution of the situation. ~~*(3-29-10)*~~(      )

**04. Record Keeping**. The occupational therapy assistant, graduate occupational therapist, and graduate occupational therapy assistant must maintain on file at the job site signed documentation reflecting supervision activities. This supervision documentation must contain the following: date of supervision, means of communication, and information discussed. Both the supervising occupational therapist and the ~~occupational therapy assistant /limited permit licensee~~ person being supervised must sign each entry. ~~(3-29-10)~~(        )

**05. Occupational Therapy Assistants**. Occupational Therapy Assistants may deliver occupational therapy services under the supervision of occupational therapists as follows. The occupational therapy assistant: (3-29-10)

**a.** May only select, implement, and modify therapeutic activities and interventions that are consistent with client goals, the requirements of the practice setting, and the occupational therapy assistant's demonstrated competency levels; (3-29-10)

**b.** Must not initiate a treatment program until the occupational therapist has evaluated the client and planned treatment for the client, or discharge the client from a treatment program without supervision from the occupational therapist; (3-29-10)

**c.** Must not perform an evaluation, but may contribute to the evaluation process with the supervision of the occupational therapist; (3-29-10)

**d.** May participate in the screening process by collecting data, such as records, by general observation and by conducting a general interview, and may communicate the information gathered to the occupational therapist; (3-29-10)

**e.** May track the need for reassessment, report changes in status that might warrant reassessment or referral, and administer the reassessment under the supervision of the occupational therapist; (3-29-10)

**f.** Must immediately discontinue any specific treatment procedure which appears harmful to the client, and so notify the occupational therapist; (3-29-10)

**g.** Is responsible for knowing about the client's targeted occupational therapy outcomes and for providing information and documentation related to outcome achievement; (3-29-10)

**h.** May implement outcome measurements and provide needed client discharge resources. (3-29-10)

**06. Aides**. Aides do not provide skilled occupational therapy services. An aide is trained by an occupational therapist or an occupational therapy assistant to perform specifically delegated tasks. The occupational therapist is responsible for the overall use and actions of the aide. An aide first must demonstrate competency to be able to perform the assigned, delegated client and non-client tasks. The occupational therapist must oversee the development, documentation, and implementation of a plan to supervise and routinely assess the ability of the occupational therapy aide to carry out non-client and client-related tasks. The occupational therapy assistant may contribute to the development and documentation of this plan. An aide shall

function only under the direct line of sight supervision of an occupational therapist or occupational therapy assistant. An aide may provide: (3-29-10)

**a.** Non-client-related tasks, including clerical and maintenance activities and preparation of the work area or equipment. (3-29-10)

**b.** Client-related, routine tasks during which the aide may interact with the client. The following conditions must exist when an occupational therapist or occupational therapy assistant delegates a selected client-related task to the aide: (3-29-10)

i. The outcome anticipated for the delegated task is predictable. (3-29-10)

ii. The client and environment are stable and will not require that judgment, interpretations, or adaptations be made by the aide. (3-29-10)

iii. The client has demonstrated some previous performance ability in executing the task. (3-29-10)

iv. The task routine and process have been clearly established. (3-29-10)

v. The aide has been trained and is able to demonstrate competency in carrying out the task and in using any necessary equipment. (3-29-10)

vi. The aide has been instructed on how to specifically carry out the delegated task with the specific client. (3-29-10)

vii. The aide knows the precautions, signs, and symptoms for the particular client that would indicate the need to seek assistance from the occupational therapist or occupational therapy assistant. (3-29-10)

**c.** The supervision of the aide needs to be documented for every client-related activity performed by an aide. Documentation must include information about frequency and methods of supervision used, the content of supervision, and the names and credentials of all persons participating in the supervisory process. (3-29-10)

**012. DEEP THERMAL AND ELECTROTHERAPEUTIC MODALITIES, AND WOUND CARE.**

**01. Qualifications**. Except as provided in ~~*Paragraph*~~ Subsection 012.0~~*1*~~2~~*.b. i.*~~ of these rules, a person may not utilize occupational therapy techniques involving deep thermal, electrotherapeutic modalities or perform wound care management unless the person is licensed by the Board as an occupational therapist and certified by the Hand Therapy Commission. In lieu of being certified by the Hand Therapy Commission, the person must have obtained education and training as described in Paragraphs 012.01.a. through 012.01.c. of this rule. ~~*(3-29-10)*~~

~~*a.*~~ ~~*Is licensed by the Board as an occupational therapist; and*~~ ~~*(3-29-10)*~~

~~*i.*~~ ~~*Is certified by the Hand Therapy Commission; or*~~ ~~*(3-29-10)*~~

~~ii~~**a.** ~~Has~~ If the person utilizes techniques involving deep thermal, electrotherapeutic modalities, the person must have successfully completed three (3) continuing education units in the application of deep thermal and electrotherapeutic modalities ~~and one and one half (1.5) continuing education units in wound care management~~, along with one hundred sixty (160) hours of supervised, on-the-job or clinical internship or affiliation training, pertaining to ~~each area of deep thermal, electrotherapeutic~~ such modalities ~~and wound care management~~. ~~(3-29-10)~~( )

**b.** If the person manages wound care, the person must have successfully completed one and one-half (1.5) continuing education units in wound care management, along with one hundred sixty (160) hours of supervised, on-the-job or clinical internship or affiliation training pertaining to wound care management. ( )

**c.** If the person utilizes both deep thermal, electrotherapeutic modalities and manages wound care, the person's supervised training for each may have overlapped, so that the one hundred sixty (160) hours for each were obtained concurrently through the same supervised, on-the-job or clinical internship or affiliation. ( )

~~b~~**02. Obtaining Education and Supervised Training**. A student occupational therapist, graduate occupational therapist, and an occupational therapist may utilize deep thermal, electrotherapeutic modalities or manage wound care while working towards obtaining the education and supervised training described in Section 012 of these rules. The supervisor must provide at least direct supervision to the student occupational therapist, and at least routine supervision to the graduate occupational therapist or occupational therapist. An ~~certified~~ occupational therapy assistant may apply deep thermal and electrotherapeutic modalities ~~only while the occupational therapy assistant is working under the direct supervision of a qualified occupational therapist.~~ under routine supervision if the occupational therapy assistant has obtained an advanced level of skill as described in Subsection 011.01 of these rules and the education and training described in Subsection 012.01 of these rules. Otherwise, the occupational therapy assistant must work under direct supervision while applying such modalities. ~~(3-29-10)~~( )

**03. Supervised Training by Qualified Individual**. The supervised training described in Section 012 of these rules must be provided by an occupational therapist who is qualified as specified in this Subsection 012.01, or by another type of licensed health care practitioner whose education, training, and scope of practice enable the practitioner to competently supervise the person as to the modalities utilized and wound care management provided. ( )

***(BREAK IN CONTINUITY OF SECTIONS)***

## 022. LICENSE EXPIRATION AND RENEWAL.

**01. Expiration Date**. An individual's license expires on the individual's birth date. The individual must annually renew the license before the individual's birth date in accordance with Section 67-2614, Idaho Code. Licenses not so renewed will be cancelled in accordance with

Section 67-2614, Idaho Code. (3-29-10)

**02. Reinstatement**. A license cancelled for failure to renew may be reinstated in accordance with Section 67-2614, Idaho Code. Reinstatement of a license from inactive to active status is governed by Section 030. ~~(3-29-10)~~( )

**03. Application for Renewal**. In order to renew a license, a licensee must submit a timely, completed, Board-approved renewal application form and pay the required renewal fees. (3-29-10)

### *(BREAK IN CONTINUITY OF SECTIONS)*

## 030. INACTIVE STATUS.

~~*The Board shall grant inactive status to a licensee who makes application for inactive status; or who does not practice as an Occupational Therapist or Occupational Therapy Assistant in Idaho.*~~ ~~*(1-5-88)*~~

**01. Request for Inactive Status**. Occupational Therapists and Occupational Therapy Assistants requesting an inactive status during the renewal of their active license must submit a written request and pay the established fee. ( )

**02. Inactive License Status**. ( )

**a.** Licensees may not practice in Idaho while on inactive status. ( )

**b.** All continuing education requirements will be waived for any year or portion thereof that a licensee maintains an inactive license and is not actively practicing or supervising in Idaho, subject to Subsection 030.03 of these rules. ( )

**c.** Inactive license renewal notices and licenses will be marked "Inactive." ( )

**03. Reinstatement to Full Licensure from Inactive Status**. An inactive licensee may reinstate to active status by submitting a completed, Board-approved application and paying the appropriate fee. The licensee's application must demonstrate, to the Board's satisfaction, that during the two (2) years immediately preceding the application, the licensee completed at least two (2) CEUs recommended by the Idaho Occupational Therapy Association and approved by the Board, along with at least ten (10) Board-approved professional development units (PDUs), as specified in Section 025 of these rules. ( )

## 031. ~~*REINSTATEMENT TO FULL LICENSURE FROM INACTIVE STATUS*~~ (RESERVED).

~~*An individual desiring reinstatement to full active licensure to practice as an Occupational Therapist or Occupational Therapy Assistant shall submit a completed written application to the Board, on the forms prescribed by the Board together with the license and reinstatement fees. The application shall be verified and under oath (Subsection 021.01, above). The Board may request*~~

~~*such other information deemed necessary to identify and evaluate the applicant's proficiency.*~~ ~~*(1-5-88)*~~

### *(BREAK IN CONTINUITY OF SECTIONS)*

## 041. FEES.

**01. Fees**. Necessary fees shall accompany applications. Fees shall not be refundable. (3-29-10)

**02. Initial Licensure**. The fee for initial licensure of occupational therapists shall be one hundred fifteen dollars ($115) and the fee for occupational therapy assistants shall be eighty-five dollars ($85). (3-29-10)

**03. Limited Permit or Temporary License**. The fee for a limited permit or temporary license shall be thirty dollars ($30). (3-29-10)

**04. Active License Renewal Fee**. The annual renewal fee for an active license shall be seventy dollars ($70) for occupational therapists and fifty dollars ($50) for occupational therapy assistants. ~~*(3-29-10)*~~(    )

**05. Reinstatement Fee**. The fee to reinstate a lapsed license shall be thirty-five dollars ($35). (3-29-10)

**06. Inactive License Renewal Fee**. The annual renewal fee for an inactive licens~~*ur*~~e shall be fifty dollars ($50) for occupational therapists and occupational therapy assistants. ~~*(3-29-10)*~~(    )

**07. Inactive to Active License Fee**. The fee for reinstating ~~*A*~~an inactive license ~~*may be converted*~~ to an active license ~~*by application to the Board and payment of required*~~ is the difference between the current inactive and active license renewal fees. (    )

~~***a.*** *The fee for converting an inactive to an active license shall be forty dollars ($40) and the annual renewal fee for each year not actively licensed minus inactive fees previously paid.*~~ ~~*(3-29-10)*~~

~~***b.*** *Before the license will be converted the applicant must account for the time during which an inactive license was held. The Board may, in its discretion, require a personal interview.*~~ ~~*(4-2-03)*~~

# IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

## 24.09.01 - RULES OF THE BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS

## DOCKET NO. 24-0901-1001

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 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(s) 54-1604, 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 6, 2010 Idaho Administrative Bulletin, Vol. 10-10, pages 392 through 394.**

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

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning this pending rule, contact Cherie Simpson at 208 334-3233.

DATED this 3rd day of November, 2010.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
700 W. State Street
Boise, ID 83702
(208) 334-3233 phone
(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 54-1604, 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 20, 2010.

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 Examiners of Nursing Home Administrators would like verification that an applicant obtained supervised experience in all six domains and that the preceptor training be in addition to full time work. The rule clarifies that full time shall be at least thirty-two hours per week which would allow at least eight hours per week for direct training between the preceptor and trainee. It also requires that the preceptor be re-certified every ten years.**

**FEE SUMMARY:** The following is a specific description of the fee or charge imposed or increased: None.

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

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because discussion on the changes were noticed on an agenda and discussed in a public meeting.

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

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at 208 334-3233.

Anyone may submit written comments regarding this proposed rulemaking. All written

comments must be directed to the undersigned and must be delivered on or before October 27, 2010.

DATED this 13th day of August, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-0901-1001***

## 400. NURSING HOME ADMINISTRATORS-IN-TRAINING (RULE 400).

**01. Related Health Care Field**. "Related health care field" shall mean a field in health care related to administration. (7-1-93)

**02. Trainees**. Trainees must work on a full time basis in any capacity in an Idaho licensed nursing home setting. Full time shall be at least a ~~*forty*~~ thirty-two (~~*40*~~32) hour per week work schedule with consideration for normal leave taken. Failure to comply with this rule or Section 54-1610, Idaho Code, shall not receive credit as a Nursing Home Administrator-In-Training. ~~*(4-2-08)*~~(____)

**a.** Each trainee shall register with the Board as a Nursing Home Administrator-In-Training (AIT) by submitting an application provided by the Board together with the required fee. The effective date of each AIT program shall be the date the Board approves the application. (3-13-02)

**b.** Quarterly reports for those trainees employed in a nursing home must reflect that the preceptor of the trainee has instructed, assisted and given assignments as deemed necessary to fulfill the requirements of Subsection 400.03. (7-1-98)

**03. Nursing Home Administrator-in-Training Requirements**. A Nursing Home Administrator-in-Training shall be required to train in all ~~*phases*~~ domains of nursing home administration including the following: ~~*(7-1-93)*~~(____)

**a.** Resident Care Management. (7-1-98)

**b.** Personnel Management. (7-1-93)

**c.** Financial Management. (7-1-93)

**d.** Environmental Management. (7-1-98)

**e.** Meeting Regulations and Governing Entities Directives. (7-1-98)

**f.** Organizational Management. (7-1-98)

**g.** Completion of a specialized course of study in nursing home long-term health care administration approved by NAB or otherwise approved by the Board. (4-6-05)

**04. Facility Administrator**. The trainee must spend no less than thirty-two (32) hours a month with the preceptor in a training and/or observational situation in the six (6) ~~*areas*~~ domains of nursing home administration as outlined in Subsection 400.03. Time spent with the preceptor must be in addition to the full time work that the trainee must perform under Subsection 400.02, unless the Administrator-in-Training role is designated as a full time training position. Collectively, over the twelve (12) month period, ~~*Q*~~quarterly reports must reflect particular emphasis on ~~*the*~~ all six (6) ~~*phases*~~ domains of nursing home administration during the time spent in the nursing home. ~~*(5-3-03)*~~(     )

**05. Preceptor Certification**. (7-1-93)

**a.** A nursing home administrator who serves as a preceptor for a nursing home administrator-in-training must be certified by the Board of Examiners of Nursing Home Administrators. The Board will certify the Idaho licensed nursing home administrator to be a preceptor who: (7-1-98)

i. Is currently practicing as a nursing home administrator and who has practiced a minimum of two (2) consecutive years as a nursing home administrator; and (7-1-98)

ii. Who successfully completes a six (6) clock hour preceptor orientation course approved by the Board. (7-1-93)

**b.** The orientation course will cover the philosophy, requirements and practical application of the nursing home administrator-in-training program and a review of the six (6) phases of nursing home administration as outlined in Subsection 400.03. (7-1-93)

**c.** The preceptor must be re-certified by the Board every ten (10) years. (     )

# IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

## 24.13.01 - RULES OF THE PHYSICAL THERAPY LICENSURE BOARD

## DOCKET NO. 24-1301-1001

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 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(s) 54-2206, Idaho Code.

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

**The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 6, 2010 Idaho Administrative Bulletin, Vol. 10-10, pages 395 and 396.**

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

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning this pending rule, contact Cherie Simpson at 208 334-3233.

DATED this 3rd day of November, 2010.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
1109 Main St., STE 220
Boise, ID 83702
(208) 334-3233 phone
(208) 334-3945 fax

***THIS NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE***

**EFFECTIVE DATE: The effective date of the temporary rule is July 16, 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 Section 54-2206, Idaho Code.

**PUBLIC HEARING SCHEDULE:** Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 20, 2010.

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 2010 legislature passed House Bill 470 which amended Section 54-2212, Idaho Code, to require that foreign educated physical therapists pass an English proficiency examination to qualify for a license if English is not the applicant's native language. This rule identifies the standardized examinations.**

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

**To comply with a new law which passed last session.**

**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: None.

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

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the changes are due to amendment in statute and were discussed in an open, noticed meeting.

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

this rule: N/A

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the temporary and proposed rule, contact Cherie Simpson at 208 334-3233.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 27, 2010.

DATED this 20th day of August, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-1301-1001***

**175. REQUIREMENTS FOR LICENSURE (RULE 175).**
An individual shall be entitled to a license upon meeting the following requirements: (4-2-08)

**01. Application**. Submission of a complete application establishing that the individual has met the qualifications as set forth in these rules. (4-2-08)

**02. Examination**. Submission of proof that the individual has successfully passed the NPTE with a scaled score of at least six hundred (600) and the jurisprudence examination with a score of at least seventy-five percent (75%). Foreign educated individuals whose native language is not English shall submit proof of successfully passing one (1) of the following English proficiency exams: ~~(4-2-08)~~( )

**a.** Test of English as a Foreign Language (TOEFL) with minimum passing scores of two hundred twenty (220) for computer test and five hundred sixty (560) for paper test; ( )

**b.** Test of English as a Foreign Language - internet based test (TOEFL IBT) with minimum passing scores of twenty-four (24) in writing; twenty-six (26) in speaking, twenty-one (21) in reading, and eighteen (18) in listening; or ( )

**c.** As otherwise approved by the Board. ( )

# IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

## 24.13.01 - RULES OF THE PHYSICAL THERAPY LICENSURE BOARD

## DOCKET NO. 24-1301-1002

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 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(s) 54-2206, Idaho Code.

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

**The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 6, 2010 Idaho Administrative Bulletin, Vol. 10-10, pages 397 through 402.**

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

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning this pending rule, contact Cherie Simpson at 208 334-3233.

DATED this 3rd day of November, 2010.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
700 W. State Street
Boise, ID 83702
(208) 334-3233 phone
(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 54-2206, Idaho Code.

**PUBLIC HEARING SCHEDULE:** Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 20, 2010.

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

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

**The Physical Therapy Board is updating its rules to correct the name of the U.S. Department of Education and to allow a successor entity. The Board is also adding a section to allow for termination of applications that have lacked activity for one year upon notification to the applicant. This will help reduce the number of files that need to be maintained. Finally, the Board would like to allow four (4) hours continuing education credit for the supervision of physical therapist students or physical therapist assistant students as this supervision is an important part of the training of future licensees.**

**FEE SUMMARY:** The following is a specific description of the fee or charge imposed or increased: None.

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

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because discussion on the changes were noticed on an agenda and discussed in a public meeting.

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

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at 208 334-3233.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 27, 2010.

DATED this 20th day of August, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-1301-1002***

**010. DEFINITIONS (RULE 10).**

**01. Board**. The Physical Therapy Licensure Board. (3-19-07)

**02. Bureau**. Bureau means the Idaho Bureau of Occupational Licenses as created in section 67-2602, Idaho Code. (3-19-07)

**03. Physical Therapist**. An individual who meets all the requirements of Title 54, Chapter 22, Idaho Code, holds an active license and who engages in the practice of physical therapy. (3-19-07)

**04. Physical Therapist Assistant**. An individual who meets the requirements of Title 54, Chapter 22, Idaho Code, holds an active license, and who performs physical therapy procedures and related tasks that have been selected and delegated only by a supervising physical therapist. (3-19-07)

**05. Supportive Personnel**. An individual, or individuals, who are neither a physical therapist or a physical therapist assistant, but who are employed by and/or trained under the direction of a licensed physical therapist to perform designated non-treatment patient related tasks and routine physical therapy tasks. (3-19-07)

**06. Non-Treatment Patient Related Tasks**. Actions and procedures related to patient care that do not involve direct patient treatment or direct personal supervision, but do require a level of supervision not less than general supervision, including, but not limited to: treatment area preparation and clean-up, equipment set-up, heat and cold pack preparation, preparation of a patient for treatment by a physical therapist or physical therapist assistant, transportation of patients to and from treatment, and assistance to a physical therapist or physical therapist assistant when such assistance is requested by a physical therapist or physical therapist assistant when safety and effective treatment would so require. (3-19-07)

**07. Routine Physical Therapy Tasks**. Actions and procedures within the scope of practice of physical therapy, which do not require the special skills or training of a physical therapist or physical therapist assistant, rendered directly to a patient by supportive personnel at the request of and under the direct personal supervision of a physical therapist or physical therapist assistant. (3-19-07)

**08. Testing**. (3-19-07)

**a.** Standard methods and techniques used in the practice of physical therapy to gather data about individuals including: (3-19-07)

i. Electrodiagnostic and electrophysiological measurements; (3-19-07)

ii. Assessment or evaluation of muscle strength, force, endurance and tone; (3-19-07)

iii. Reflexes; (3-19-07)

iv. Automatic reactions; (3-19-07)

v. Posture and body mechanics; (3-19-07)

vi. Movement skill and accuracy; (3-19-07)

vii. Joint range of motion and stability; (3-19-07)

viii. Sensation; (3-19-07)

ix. Perception; (3-19-07)

x. Peripheral nerve function integrity; (3-19-07)

xi. Locomotor skills; (3-19-07)

xii. Fit, function and comfort of prosthetic, orthotic, and other assistive devices; (3-19-07)

xiii. Limb volume, symmetry, length and circumference; (3-19-07)

xiv. Clinical evaluation of cardiac and respiratory status to include adequacy of pulses, noninvasive assessment of peripheral circulation, thoracic excursion, vital capacity, and breathing patterns; (3-19-07)

xv. Vital signs such as pulse, respiratory rate, and blood pressure; (3-19-07)

xvi. Activities of daily living; and the physical environment of the home and work place; and (3-19-07)

xvii. Pain patterns, localization and modifying factors; and (3-19-07)

xviii. Photosensitivity. (3-19-07)

**b.** Specifically excluded are the ordering of electromyographic study, electrocardiography, thermography, invasive vascular study, selective injection tests, or complex

cardiac or respiratory function studies without consultation and direction of a physician. (3-19-07)

**09. Functional Mobility Training**. Includes gait training, locomotion training, and posture training. (3-19-07)

**10. Manual Therapy**. Skilled hand movements to mobilize or manipulate soft tissues and joints for the purpose of: (3-19-07)

**a.** Modulating pain, increasing range of motion, reducing or eliminating soft tissue swelling, inflammation or restriction; (3-19-07)

**b.** Inducing relaxation; (3-19-07)

**c.** Improving contractile and non-contractile tissue extensibility; and (3-19-07)

**d.** Improving pulmonary function. (3-19-07)

**11. Physical Agents or Modalities**. Thermal, acoustic, radiant, mechanical, or electrical energy used to produce physiologic changes in tissues. (3-19-07)

**12. General Supervision**. A physical therapist's availability at least by means of telecommunications, which does not require a physical therapist to be on the premises where physical therapy is being provided, for the direction of a physical therapist assistant. (3-19-07)

**13. Direct Supervision**. A physical therapist's or physical therapist assistant's physical presence and availability to render direction in person and on the premises where physical therapy is being provided. (3-19-07)

**14. Direct Personal Supervision**. A physical therapist's or physical therapist assistant's direct and continuous physical presence and availability to render direction, in person and on the premises where physical therapy is being provided. The physical therapist or physical therapist assistant must have direct contact with the patient during each session and assess patient response to delegated treatment. (3-19-07)

**15. Supervising Physical Therapist**. A licensed physical therapist who developed and recorded the initial plan of care and/or who has maintained regular treatment sessions with a patient. Such physical therapist's designation of another licensed physical therapist if the physical therapist who developed and recorded the initial plan of care or maintained regular treatment sessions is not available to provide direction at least by means of telecommunications. (3-19-07)

**16. Nationally Accredited School**. A school or course of physical therapy or physical therapist assistant with a curriculum approved by: (3-19-07)

**a.** The American Physical Therapy Association (APTA) from 1926 to 1936; or the APTA Accreditation Commission; or (3-19-07)

**b.** The Council on Medical Education and Hospitals of the American Medical

Association from 1936 to 1960; or (3-19-07)

**c.** An accrediting agency recognized by the U.S. ~~*Commissioner*~~ Department of Education, the Council on Postsecondary Accreditation, or a successor entity, or both. ~~*(3-19-07)*~~(____)

**17. Examination**. The examination shall be the National Physical Therapy Examination (NPTE) administered by Federation of State Boards of Physical Therapy. The examination may also include a jurisprudence examination adopted by the Board. (4-2-08)

***(BREAK IN CONTINUITY OF SECTIONS)***

**150. APPLICATION (RULE 150).**

Each applicant shall submit a completed written application on forms provided by the Board together with applicable fees. The application shall be verified under oath and shall require the following information: (3-19-07)

**01. Education**. The educational background of the applicant; (3-19-07)

**02. Evidence of Graduation**. Evidence of graduation from a nationally accredited school; (3-19-07)

**03. Criminal Convictions**. The disclosure of any criminal conviction or charges against the applicant other than minor traffic offenses; (3-19-07)

**04. Disciplinary Action**. The disclosure of any disciplinary action against the applicant by any professional regulatory agency; (3-19-07)

**05. License or Registration Denial**. The disclosure of the denial of registration or licensure by any state or district regulatory body; (3-19-07)

**06. References**. Two (2) references from individuals, other than relatives or individuals living with the applicant, who have at least two (2) years of personal knowledge of the applicant's character and ability to provide physical therapy; (3-19-07)

**07. Photograph**. An un-mounted passport type photograph of the applicant, taken not more than one (1) year prior to the date of application; and (3-19-07)

**08. Other Information**. Such other information as the Board deems necessary to identify and evaluate the applicant's credentials. (3-19-07)

**09. Incomplete applications**. The Board shall not review incomplete applications and shall not approve licensure for applicants who have failed to provide adequate proof of having met the licensure requirements. (3-19-07)

**10. Lack of Activity**. Applications on file with the Board where an applicant has failed to respond to a Board request or where the applications have lacked activity for twelve (12) consecutive months shall be deemed denied and shall be terminated upon thirty (30) days written notice unless good cause is established to the Board. ( )

***(BREAK IN CONTINUITY OF SECTIONS)***

**250. CONTINUING EDUCATION REQUIREMENT (RULE 250).**

On and after January 1, 2008, every person holding a license issued by the Board must annually complete sixteen (16) contact hours of continuing education prior to license renewal. (3-19-07)

**01. Contact Hours**. The contact hours of continuing education shall be obtained in areas of study germane to the practice for which the license is issued as approved by the board. (3-19-07)

**02. Documentation of Attendance**. It shall be necessary for the applicant to provide documentation verifying attendance by securing authorized signatures or other documentation from the course instructors, providers, or sponsoring institution substantiating any hours attended by the licensee. This documentation must be maintained by the licensee and provided to the board upon request by the board or its agent. (3-19-07)

**03. 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. Hours in excess of the required hours may 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. (3-19-07)

**04. 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. (3-19-07)

**05. 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 provide any information requested by the board to assist in substantiating hardship cases. This exemption is granted at the sole discretion of the board. (3-19-07)

**06. Continuing Education Credit Hours**. Hours of continuing education credit may be obtained by attending and participating in a continuing education activity approved by the Board. (3-19-07)

**a.** General Criteria. A continuing education activity which meets all of the following criteria is appropriate for continuing education credit: (3-19-07)

i. Constitutes an organized program of learning which contributes directly to the professional competency of the licensee; (3-19-07)

ii. Pertains to subject matters integrally related and germane to the practice of the profession; (3-19-07)

iii. Conducted by individuals who have specialized education, training and experience to be considered qualified to present the subject matter of the program. The Board may request documentation of the qualifications of presenters; (3-19-07)

iv. Application for Board approval is accompanied by a paper, manual or outline which describes the specific offering and includes the program schedule, goals and objectives; and (3-19-07)

v. Provides proof of attendance to licensees in attendance including: Date, location, course title, presenter(s); Number of program contact hours (One (1) contact hour equals one (1) hour of continuing education credit.); and the official signature or verification of the program sponsor. (3-19-07)

**b.** Specific Criteria. Continuing education hours of credit may be obtained by: (3-19-07)

i. Presenting professional programs which meet the criteria listed in these rules. Two (2) hours of credit will be awarded for each hour of presentation by the licensee. A course schedule or brochure must be maintained for audit; (3-19-07)

ii. Providing official transcripts indicating successful completion of academic courses which apply to the field of physical therapy in order to receive the following continuing education credits: (3-19-07)

(1) One (1) academic semester hour = fifteen (15) continuing education hours of credit; (3-19-07)

(2) One (1) academic trimester hour = twelve (12) continuing education hours of credit; (3-19-07)

(3) One (1) academic quarter hour = ten (10) continuing education hours of credit. (3-19-07)

iii. Attending workshops, conferences, symposiums or electronically transmitted, live interactive conferences which relate directly to the professional competency of the licensee; (3-19-07)

iv. Authoring research or other activities which are published in a recognized professional publication. The licensee shall receive five (5) hours of credit per page; (3-19-07)

v. Viewing videotaped presentations if the following criteria are met: (3-19-07)

(1) There is a sponsoring group or agency; (3-19-07)

(2) There is a facilitator or program official present; (3-19-07)

(3) The program official may not be the only attendee; and (3-19-07)

(4) The program meets all the criteria specified in these rules; (3-19-07)

vi. Participating in home study courses that have a certificate of completion; (3-19-07)

vii. Participating in courses that have business-related topics: marketing, time management, government regulations, and other like topics; (3-19-07)

viii. Participating in courses that have personal skills topics: career burnout, communication skills, human relations, and other like topics; ~~*and*~~ ~~*(3-19-07)*~~(____)

ix. Participating in courses that have general health topics: clinical research, CPR, child abuse reporting, and other like topics~~.~~; and ~~*(3-19-07)*~~(____)

x. Supervision of a physical therapist student or physical therapist assistant student in an accredited college program. The licensee shall receive four (4) hours of credit per year. (____)

**07. Submitting False Reports or Failure to Comply**. The Board may condition, limit, suspend, or refuse to renew the license of any individual whom the Board determines submitted a false report of continuing education or failed to comply with the continuing education requirements. (3-19-07)

**08. Failure to Receive the Renewal Application**. Failure to receive the renewal application shall not relieve the licensee of the responsibility of meeting the continuing education requirements and submitting the renewal application and renewal fee. (3-19-07)

# IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

## 24.14.01 - RULES OF THE STATE BOARD OF SOCIAL WORK EXAMINERS

## DOCKET NO. 24-1401-1001

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 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(s) 54-3204, Idaho Code.

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

**The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 6, 2010 Idaho Administrative Bulletin, Vol. 10-10, pages 403 through 406.**

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

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning this pending rule, contact Cherie Simpson at 208 334-3233.

DATED this 15th day of November, 2010.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
700 W. State Street
Boise, ID 83702
(208) 334-3233 phone
(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 54-3204, Idaho Code.

**PUBLIC HEARING SCHEDULE:** Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 20, 2010.

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 Social Work Examiners is removing rules given passage of House Bill 537 which eliminated licensure based upon education in a related field. The Board is also clarifying the type of supervised experience required for licensure at the clinical level. This clarification is needed to ensure that clinical level social workers have adequate experience in treatment.**

**FEE SUMMARY:** The following is a specific description of the fee or charge imposed or increased: None.

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

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because discussions were held in a noticed, open meeting of the Board.

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

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at (208) 334-3233.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 27,

2010.

DATED this 26th day of August, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-1401-1001***

## 100. APPROVED COLLEGES *AND RELATED FIELDS* (RULE 100).

*Social work and social work practice is a professional discipline requiring specialized knowledge and training.* *(7-1-93)*

***01. College or University Approved by the Board***. Any college, university, or school of social work which is accredited or is a candidate for accreditation by the Northwest Association of Secondary and Higher Schools or any similar accrediting body. *(5-3-03)*( )

***02. Related Fields****. A baccalaureate degree that includes thirty-six (36) semester credit hours with a grade of "C" or above in each course, in which the content is consistent with that recommended as minimal to social work training by an approved accrediting body. Eighteen (18) of the thirty-six (36) semester credit hours shall be taught by a social worker with a graduate degree from an accredited school of social work. The basic content areas to be required shall include:* *(5-3-03)*

***a.*** *Social work practice is to include a methods content of a minimum of six (6) semester credit hours; and a social work practicum with a minimum of nine (9) semester credit hours. The methods courses are to be taken previous to participation in practicum and are to be taught by a faculty member with a graduate degree (MSW) from an accredited school of social work. The practicum is to be supervised by a faculty member who has a graduate degree (MSW) from an accredited school of social work. The on-site supervisor is to be a licensed social worker. Both the methods courses and the practicum must have been completed within the past five (5) years (date computed from time of application). The program providing the practice content and internship experience is developed and monitored to assure that internship students demonstrate application of the knowledge, values and skills taught within the required basic content areas.* *(7-1-96)*

***b.*** *Social welfare policy and services shall include current policies and services, and shall be taught by a faculty member with a graduate degree in social work.* *(7-1-96)*

***c.*** *Human behavior and social environment shall include human behavior in the social environment with demonstrated content representing five (5) human systems: individual, family, group, organization and community.* *(7-1-96)*

***d.*** *Social research shall include social statistics and research methods.* *(7-1-96)*

***e.*** *Ethics shall include any three (3) credit course from a "college or university*

~~*approved by the board" which includes the word "ethics" in the course title.*~~ ~~*(7-1-96)*~~

~~***f.***~~ ~~*Cultural diversity shall include a three (3) credit course from a "college or university approved by the board" which includes content specific to ethnic minority group(s).*~~ ~~*(7-1-96)*~~

~~***g.***~~ ~~*Course content and curriculum preparing students for practice will be evaluated by board review of course and program description provided by the college or university.(7-1-96)*~~

## *(BREAK IN CONTINUITY OF SECTIONS)*

## 201. PRACTICE OF SOCIAL WORK.

**01. Baccalaureate Social Work**. The application of social work theory, knowledge, methods, and ethics to restore or enhance social or psychosocial functioning of individuals, couples, families, groups, organizations, and communities. Baccalaureate social work is a generalist practice that includes assessment, planning, intervention, evaluation, case management, information and referral, supportive counseling, supervision, and consultation with clients. Baccalaureate social work also includes advocacy, education, community organization, and the development, implementation and administration of policies, programs, and activities. Bachelor level social workers are prohibited from performing psychotherapy. (3-20-04)

**02. Master's Social Work**. The application of social work theory, knowledge, methods and ethics, and the professional use of self to restore or enhance social, psychosocial or biopsychosocial functioning of individuals, couples, families, groups, organizations, and communities. Master's social work requires the application of specialized knowledge and advanced practice skills in the areas of assessment, treatment planning, implementation and evaluation, case management, information and referral, supportive counseling, supervision and consultation with clients, advocacy, teaching, research, community organization, and the development, implementation, and administration of policies, programs, and activities. Master level social workers who do not hold clinical licensure may provide psychotherapy only under the supervision of a licensed clinical social worker, psychologist, or psychiatrist and in accordance with an approved supervision plan. (3-20-04)

**03. Clinical Social Work**. The practice of clinical social work is a specialty within the practice of master's social work and requires the application of specialized clinical knowledge and advanced clinical skills in the areas of assessment, diagnosis, and treatment of mental, emotional, and behavioral disorders, conditions and addictions. Clinical social work is based on knowledge and theory of psychosocial development, behavior, psychopathology, motivation, interpersonal relationships, environmental stress, social systems, and cultural diversity, with particular attention to person-in-environment. It shares with all social work practice the goal of enhancement and maintenance of psychosocial functioning of individuals, families, and small groups. Clinical social work includes, but is not limited to, individual, couples, family and group psychotherapy, and includes independent and private practice. (3-20-04)

**04. Private Practice of Social Work**. As defined in Section 54-3207, Idaho Code, is that independent practice in which an individual sets up and maintains responsibility for the contractual conditions of payment with clients, agencies, or institutions. (5-3-03)

**05. Employment of a Social Worker**. A social worker employed directly by a physician, psychologist or other social worker, or by a public or private agency, institution, hospital, nursing home, rehabilitation center, or any similar facility, is not to be considered within the definition of an independent practitioner. Furthermore, a social worker who contracts with an agency or institution that assumes full responsibility for and supervises the services provided to clients is not considered to be a private practitioner. (5-3-03)

**06. Supervision**. Supervised experience shall be required for both independent practice status and clinical licensure. Consultative-teaching supervision is directed toward enhancement and improvement of the individual's social work values, knowledge, methods, and techniques. A total of three thousand (3,000) hours of supervised social work experience accumulated in not less than two (2) years is required. Actual supervisor contact shall be face-to-face and provided by a qualified and experienced professional working in the same area of practice and must occur on a regular and on-going basis and consist of a minimum of one hundred hours (100) hours. Ratio of supervisor/supervisee shall not exceed two (2) social workers to one (1) supervisor per hour of supervision. Group supervision totaling no more than fifty (50) hours will be allowed for groups of no more than six (6) persons and the allowable credit shall be prorated at the two to one (2 to 1) ratio (total session minutes divided by total supervisees multiplied by two (2) equals maximum allowable credit per supervisee for the session. i.e. an individual attending a one (1) hour group supervisory session consisting of six (6) supervisees shall be allowed twenty (20) minutes of group supervision credit). Supervisors must hold a degree in social work and a current license in good standing, except as noted in Subsection 201.06.c. (4-2-08)

**a.** Supervision of baccalaureate social workers pursuing licensure as independent practitioners must be provided by a licensed social worker approved to provide independent practice at the baccalaureate, masters, or clinical level. (3-20-04)

**b.** Supervision of masters social workers pursuing licensure as independent practitioners must be provided by a licensed social worker approved to provide independent practice at the masters or clinical level. (5-3-03)

**c.** Supervision of master level social workers pursuing licensure as clinical level practitioners must be provided by either a licensed clinical social worker who is registered as a supervisor, a licensed clinical psychologist, a person licensed to practice medicine and surgery who practices in the area of psychiatry, a licensed clinical professional counselor registered as a supervisor by the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists or a licensed marriage and family therapist registered as a supervisor by the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists and must focus on clinical social work as defined. No less than fifty percent (50%) of supervised experience must be provided by a licensed clinical social worker registered as a supervisor. A master level social worker pursuing licensure at the clinical level must document three thousand (3000) hours of supervised practice as follows: (    )

i. ~~o~~One thousand seven hundred fifty (1,750) hours of direct client contact ~~*of the required three thousand (3,000) hours*~~ involving treatment in clinical social work as defined~~.~~; and ~~*(4-2-08)*~~( )

ii. One thousand two hundred fifty (1,250) hours involving assessment, diagnosis, and other clinical social work as defined. ( )

**d.** Supervision reports shall be submitted from each supervisor directly to the Board within thirty (30) days following each six (6) month period. Failure of the supervisor to submit the required reports in a timely manner may result in the supervisor being restricted by the Board from providing further supervision. (3-20-04)

**07. Supervised Practice Required**. To be eligible for licensure as an independent practitioner a candidate must: (5-3-03)

**a.** Meet the requirements set forth in Subsection 201.06; (4-2-08)

**b.** Develop a plan for supervision that must be approved by the Board prior to commencement of supervision. Prior to a change in supervisors, the supervisee must notify the Board and the change must be approved by the Board prior to the commencement of supervision by the new supervisor; and (5-3-03)

**c.** Not have more than two (2) supervisors at any given time. (5-3-03)

**08. Out-of-State Supervised Experience**. The Board may consider supervised experience obtained outside the state of Idaho submitted for Idaho license purposes. Supervised experience must be provided by a licensed clinical social worker, licensed marriage and family therapist, licensed clinical psychologist, or a person licensed to practice medicine and surgery who practices in the area of psychiatry. No less than fifty percent (50%) of supervised experience must be provided by a licensed clinical social worker. The applicant must meet the other requirements of supervised practice as set forth in these rules. (4-2-08)

# IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

## 24.26.01 - RULES OF THE IDAHO STATE BOARD OF MIDWIFERY

## DOCKET NO. 24-2601-1001

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 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(s) 54-5405, 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 July 7, 2010 Idaho Administrative Bulletin, Vol. 10-7, pages 94 and 95.**

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

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning this pending rule, contact Cherie Simpson at 208 334-3233.

DATED this 3rd day of November, 2010.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
700 W. State Street
Boise, ID 83702
(208) 334-3233 phone
(208) 334-3945 fax

***THIS NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE***

**EFFECTIVE DATE:** The effective date of the temporary rule is **April 30, 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 [54-5505] 54-5404 and [54-5505] 54-5405, 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 21, 2010.

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 185 which created the State Board of Midwifery. The proposed rule is necessary to protect the public by allowing the board to establish and consider standards of conduct for licensure, renewal and reinstatement that includes: discipline against the applicant or individual's license in this or another state; or consideration of a felony conviction or any lesser crime that reflects adversely on the person's fitness to be a licensed midwife.**

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

**In order to protect the public this change allows the board to establish and consider standards of conduct for licensure, renewal and reinstatement that includes: discipline against the applicant or individual's license in this or another state; or consideration of a felony conviction or any lesser crime that reflects adversely on the person's fitness to be a license midwife.**

**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: There is no fiscal impact.

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the changes were noticed on an agenda and discussed in a public meeting.

**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 July 28, 2010.

DATED this 28th day of May, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-2601-1001***

**450. *~~DISCIPLINE~~* UNPROFESSIONAL CONDUCT (RULE 450).**

**01.** ***~~Grounds for Discipline~~* Standards of Conduct**. *~~The Board may discipline a licensed midwife for unprofessional conduct, including,~~* If a licensed midwife or an applicant for licensure, renewal, or reinstatement has engaged in unprofessional conduct, the Board may refuse to issue, renew, or reinstate the applicant's license and may discipline the licensee. Unprofessional conduct includes, without limitation, any of the following: *~~(3-29-10)~~*(____)

**a.** Disregarding a client's dignity or right to privacy as to her person, condition, possessions, or medical record; (3-29-10)

**b.** Breaching any legal requirement of confidentiality with respect to a client, unless ordered by a court of law; (3-29-10)

**c.** Submitting a birth certificate known by the licensed midwife to be false or fraudulent, or willfully making or filing false or incomplete reports or records in the practice of midwifery; (3-29-10)

**d.** Failing to provide information sufficient to allow a client to give fully informed consent; (3-29-10)

**e.** Engaging in the practice of midwifery while impaired because of the use of alcohol or drugs; (3-29-10)

**f.** Having a license suspended, revoked, or otherwise disciplined in this or any other state or jurisdiction; (____)

**g.** Having been convicted of any felony, or of a lesser crime that reflects adversely on the person's fitness to be a licensed midwife. Such lesser crimes include, but are not limited to, any crime involving the delivery of health care services, dishonesty, misrepresentation, theft, or an attempt, conspiracy or solicitation of another to commit a felony or such lesser crimes. ( )

***~~f~~*****h.** Violating any standards of conduct set forth in these rules, whether or not specifically labeled as such, and including without limitation any scope and practice standards, record-keeping requirements, notice requirements, or requirements for documenting informed consent. (3-29-10)

**02. Discipline*~~to Be Imposed~~*.** If the Board determines that *~~grounds for discipline exist~~* a licensed midwife has engaged in unprofessional conduct, it may impose discipline *~~on a~~* against the licensed midwife that includes, without limitation, the following: *~~(3-29-10)~~*( )

**a.** Require that a licensed midwife practice midwifery under the supervision of another health care provider. The Board may specify the nature and extent of the supervision and may require the licensed midwife to enter into a consultation, collaboration, proctoring, or supervisory agreement, written or otherwise, with the other health care provider; (3-29-10)

**b.** Suspend or revoke a license; (3-29-10)

**c.** Impose a civil fine not to exceed one thousand dollars ($1,000) for each violation of the Board's laws and rules; and (3-29-10)

**d.** Order payment of the costs and fees incurred by the Board for the investigation and prosecution of the violation of the Board's laws and rules. (3-29-10)

# IDAPA 27 - BOARD OF PHARMACY

## 27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

## DOCKET NO. 27-0101-1001

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 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 37-2715, 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.

**Changes remove unnecessary language from Subsection 159.02, and Paragraph 159.02.g. is being removed because manufacturers do not always include information regarding physical product descriptions.**

**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 October 6, 2010 Idaho Administrative Bulletin, Vol. 10-10, pages 425 through 435.**

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

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning the pending rule, contact Mark Johnston, R.Ph., Executive Director, at (208) 334-2356.

DATED this 1st day of November, 2010.

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 37-2715, 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 20, 2010.

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

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

**The proposed rule changes are necessary to allow the electronic prescribing of controlled substances, in conjunction with June 1, 2010 Drug Enforcement Administration (DEA) changes allowing the electronic prescribing of controlled substances. The proposed rules eliminate requirements for handwritten signatures; prescriptions written in ink, indelible pencil, or typewriter; documentation allowed only on paper, hard copy prescriptions; the need for a prescription hard copy; and certain prescriptions that must be promptly reduced to writing. Electronic prescribing and electronic prescription drug order records for controlled substances will be allowed in accordance with federal law, as per this proposed rule. The term "emergency" has also been defined, as required by Section 37-2722(b), Idaho Code. Additional updates include prescription drug order and prescription labeling minimum requirements, as well as listing additional circumstances when a controlled substance inventory is to be taken.**

**FEE SUMMARY:** The following is a specific description of the fee or charge imposed or increased: None.

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

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because these changes were necessitated to be in harmony with 2010 federal DEA rule changes.

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

this rule: N/A

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the proposed rule, contact Mark Johnston, R.Ph., Executive Director, at (208) 334-2356.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 27, 2010.

DATED this 27th day of August, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 27-0101-1001***

**159. PRESCRIPTION DRUG ORDER MINIMUM REQUIREMENTS.**

**01. Prescription Drug Order Requirements**. *All prescriptions shall at a minimum indicate* A prescription drug order must comply with applicable requirements of federal law and must include at least the following: ( )

**a.** *t*The name and, if for a controlled substance, the full name and address of the patient; ( )

**b.** *t*The date *written* issued; ( )

**c.** The name, strength, quantity, and if for a controlled substance, the dosage form of the medication prescribed; ( )

**d.** *t*The directions for use; ( )

**e.** *t*The name and, *strength, and amount of the medication* if for a controlled substance, the address and DEA registration number of the prescriber; and ( )

**f.** *the name of the prescriber; and, i*If *written* paper, the pre-printed, stamped, or hand-printed name of the prescriber and, if paper or electronic, the *handwritten* prescriber's written or electronic signature *of the prescriber. No prescription is refillable unless specifically indicated by the prescriber. Further requirements for controlled substance prescriptions are contained in Subsection 433.10. of these rules*. *(7-1-98)*( )

**02. Prescription Labels**. Unless otherwise directed by these rules, *A*any prescription drug must be dispensed *shall* in a container that bears *a label containing* the following information: ( )

a. tThe name, address, and telephone number of the dispenser (person or business),; ( )

b. tThe serial number; ( )

c. *and* The date *of* the prescription *or its filling,* is filled; ( )

d. tThe name of the prescriber; ( )

e. *and t*The name of the patient,; ( )

f. Unless otherwise directed on the order by the prescriber, the name and strength of the drug (the generic name and its manufacturer's name or the brand name); ( )

g. The quantity of item dispensed; ( )

h. tThe directions for use*, name (generic or brand) of the medication (including the manufacturer's name if a generic), and*; ( )

i. aAny cautionary *statements* information as may be required *to protect the consumer including, when advisable* or desirable for proper use and patient safety; ( )

j. An expiration date which is the lesser of: ( )

i. One (1) year from the date of dispensing; ( )

ii. tThe manufacturer's original expiration date*, the quantity of item dispensed and*; ( )

iii. The appropriate expiration date for a reconstituted suspension or beyond use date for a compounded product; or ( )

iv. A shorter period when warranted, pursuant to the pharmacist's professional judgment, to protect the health or safety of the individual; ( )

k. The number of refills authorized; and ( )

l. tThe initials of the *person* dispensing *the prescription and the statement: "Warning: Federal or state law prohibits the transfer of this prescription to any person other than the person for whom it was prescribed." When appropriate, the prescriber may request "Do Not Label", in such cases the medication name will not appear* pharmacist. *(7-1-98)*( )

**160. PRESCRIPTION DRUG ORDER TRANSFER.**

**01. Communicating Prescription Drug Order Transfers**. Except for prescription drug orders for Schedule II controlled substances, Aa pharmacist may transfer prescription drug order information for the purpose of filling or refilling a prescription *only* if the information is communicated *orally* verbally directly from pharmacist to pharmacist. ( )

**a.** ~~*Such oral*~~ Prescription drug order information ~~*can*~~ may also be communicated verbally 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. ( )

**b.** ~~*In the alternative, the*~~ When 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*~~ the transfer document must be signed by the transferring pharmacist. ~~*(3-29-10)*~~( )

**02. Documentat~~ing~~ion Required of the Transferring ~~*of a Prescription*~~ Pharmacy**. The pharmacist ~~*who transfers the*~~ transferring prescription ~~*shall:*~~ drug order information must void or otherwise ~~*(5-8-09)*~~

~~***a.***~~ ~~*I*~~invalidate the original prescription ~~*by writing the word "void" across the face of the form;*~~ drug order and ~~*(7-1-93)*~~

~~***b.***~~ ~~*On the back of the form,*~~ record the following information: ( )

**a.** ~~*his*~~ The name of the transferring pharmacist; ( )

**b.** The name of the receiving ~~*individual*~~ pharmacist; ( )

**c.** The name of the receiving pharmacy; ( )

**d.** The date of the transfer~~,~~; ( )

**e.** ~~*and t*~~The number of authorized refills available~~.~~; and ~~*(7-1-93)*~~( )

**f.** For a prescription drug order written for a controlled substance, the address and DEA registration number of the receiving pharmacy. ( )

**03. Documentat~~ing~~ion Required of the ~~*Receipt of a Transferred Prescription*~~ Receiving Pharmacy**. The pharmacist ~~*who*~~ receiv~~*es*~~ing a ~~*the*~~ transferred prescription drug order ~~*shall:*~~ must ~~*(5-8-09)*~~

~~***a.***~~ ~~*Reduce the transferred information to writing including all information required by law or rule and a notation*~~ document that the prescription drug order is a "transfer"~~;~~ and ~~*(7-1-93)*~~

~~***b.***~~ ~~*On the form,*~~ record the following information: ( )

**a.** ~~*his*~~ The name of the receiving pharmacist; ( )

**b.** ~~*t*~~The name of the transferring ~~*individual*~~ pharmacist; ( )

**c.** ~~*t*~~The name of the transferring pharmacy; ( )

**d.** ~~*t*~~The date of issuance of the original ~~*dispensing and transfer,*~~ prescription drug order; ( )

**e.** ~~*t*~~The number of refills authorized by the original prescription drug order~~,~~; ( )

**f.** ~~*t*~~The number of ~~*valid*~~ authorized refills ~~*remaining,*~~ available; and ( )

**g.** If transferring a prescription drug order written for a controlled substance: ( )

i. ~~*t*~~The date and locations of ~~*the last*~~ all previous refills~~,~~; and ( )

ii. ~~*t*~~The ~~*serial*~~ address, DEA registration number, and assigned prescription number of the transferring pharmacy that originally filled the prescription, ~~*transferred*~~ when different. ~~*(3-29-10)*~~( )

~~***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. (3-29-10)*~~

~~***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. (3-29-10)*~~

**0~~7~~4. ~~*Transferring Prescription Between*~~ Pharmacies Using Common Electronic ~~*Prescription*~~ Files.** ~~*(7-1-98)*~~( )

**a.** ~~*Two (2) or more p*~~Pharmacies may establish and use a common electronic ~~*prescription*~~ file to maintain required dispensing information. Pharmacies using ~~*the*~~ a common electronic file are not required to transfer prescription~~*s or*~~ drug order information for dispensing purposes between or among other pharmacies ~~*using in*~~ sharing the ~~*same*~~ common electronic ~~*prescription*~~ file. ~~*(3-29-10)*~~( )

**b.** ~~*All c*~~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)*~~( )

**0~~*1*~~5. Transferring Prescription~~*s*~~ Drug Orders for Controlled Substances.** A prescription drug order for a controlled substance listed in Schedules III, IV, or V may be transferred only from the pharmacy where it was originally filled and never from the pharmacy that received the transfer, except that pharmacies electronically sharing a real-time, online database may transfer up to the maximum refills permitted by law and the prescriber's

authorization. ~~(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)~~

**06. Transferring Prescription Drug Order Refills**. Prescription~~s~~ drug orders for non-controlled ~~drugs~~ substances may be transferred more than one (1) time ~~as long as~~ if there are refills remaining and all ~~of the provisions of these rules~~ other legal requirements are ~~followed~~ satisfied. ~~(7-1-93)~~( )

***(BREAK IN CONTINUITY OF SECTIONS)***

**162. PRESCRIPTION DRUG ORDER EXPIRATION.**

Prescription drug orders ~~that are legally refillable must have the refill instructions indicated on their face. All prescription orders~~ expire no later than fifteen (15) months after the date of issue. ~~For long term medication orders a~~A new prescription drug order must be obtained and a new file number issued at least every fifteen (15) months for maintenance medications. ~~(4-6-05)~~( )

***(BREAK IN CONTINUITY OF SECTIONS)***

**433. DEFINITIONS -- (H - Z).**

**01. Hospital**. The term "hospital" means an institution for the care and treatment of the sick and injured approved by the Idaho Department of Health and Welfare and entrusted with the custody of controlled substances and the professional use of controlled substances under the direction of a practitioner. (7-1-93)

**02. Individual Practitioner**. The term "individual practitioner" means a physician, dentist, veterinarian, or other individual licensed, registered, or otherwise permitted by the state in which he practices to dispense a controlled substance in the course of professional practice, but does not include a pharmacist, a pharmacy, or an institutional practitioner. (7-1-93)

**03. Institutional Practitioner**. The term "institutional practitioner" means a hospital or other person (other than an individual) licensed, registered, or otherwise permitted by the United States or the jurisdiction in which it practices to dispense a controlled substance in the course of professional practice, but does not include a pharmacy. (7-1-93)

**04. Laboratory**. The term "laboratory" means a laboratory approved by the Board and

entrusted with the custody and use of controlled substances for scientific and medical purposes and for purposes of instruction and administered by a person licensed by the state of Idaho to possess such substances. (7-1-93)

**05. Name**. The term "name" means the official name, common or usual name, chemical name, or brand name of a substance. (7-1-93)

**06. Official Idaho Register**. The term "Official Idaho Register" is defined as the official register issued by the Board that contains the required information to record the sales or disposition of Schedule V substances. The book shall be in duplicate bearing the notice to the public on the reverse side of the original sheet which is permanently bound in the book, and shall be retained for a period of two (2) years after the last dated entry. (7-1-93)

**07. Owner**. The term "owner" means any person having any right, title, or interest in a referenced vehicle. (7-1-93)

**08. Pharmacist**. The term "pharmacist" means any pharmacist licensed by a state to dispense controlled substances and includes any other person (for example, student pharmacist) authorized by a state to dispense controlled substances under the supervision of a licensed pharmacist. (7-1-93)

**09. Pharmacy**. The term "pharmacy" means every store or other place of business where prescriptions are compounded, dispensed, or sold by a pharmacist and where prescription~~s~~ drug orders for controlled substances are received or processed in accordance with federal law and the pharmacy laws and rules of this state. ~~(7-1-93)~~(____)

~~***10. Prescription**. The term "prescription" means a prescription for a controlled substance in Schedules III, IV, or V that is an oral order given individually for the person for whom prescribed directly from the prescriber or by the prescriber's employee or agent to the pharmacist, or indirectly by means of an order written in ink, indelible pencil, typewritten, or a computer-generated hard copy signed by the prescriber, and contains the address of the prescriber, the prescriber's federal registry number, the name and address of the patient, the name and quantity of the drug prescribed, directions for use, and dated as of the date on which it is written. Written prescriptions may be prepared by the secretary or agent for the signature of a practitioner, but the prescribing practitioner is responsible in case the prescription does not conform in all respects to federal and state laws, regulations, and rules. A corresponding liability rests upon the pharmacist who fills a prescription not prepared in the form prescribed by these rules. (4-11-06)*~~

**1~~1~~0. Register, Registration**. The terms "register" and "registration" refer only to registration required and permitted by Section 37-2717, Idaho Code. (7-1-93)

**1~~2~~1. Registrant**. The term "registrant" means any person who is registered. (7-1-93)

**1~~3~~2. Readily Retrievable**. The term "readily retrievable" means that certain records are kept by automatic data processing systems or other electronic or mechanized recordkeeping systems in such a manner that they can be separated out from all other records in a reasonable time or records are kept on which certain items are asterisked, redlined, or in some other manner

visually identifiable apart from other items appearing on the records, or both. (7-1-93)

**1~~4~~3.** **Sale**. The term "sale" as used herein includes barter, exchange, gift, or offer thereof, and each such transaction made by any person, whether as principal, proprietor, agent, servant, or employee. (7-1-93)

**1~~5~~4.** **Transport**. The term "transport" with reference to controlled substances, includes "conceal," "convey," and "carry." (7-1-93)

**1~~6~~5.** **Vehicle**. The term "vehicle" means any vehicle or equipment used for the transportation of persons or things. (7-1-93)

**1~~7~~6.** **Physician, Veterinarian, Dentist, Podiatrist, Osteopath, Optometrist, Pharmacist**. These titles or any similar designation, refer to persons who hold valid, unrevoked licenses to practice their respective professions in this state, issued by their respective examining boards. (12-7-94)

**1~~8~~7.** **Physician**. The term "physician" includes only persons licensed under Title 54, Chapter 18, Idaho Code. (7-1-93)

### *(BREAK IN CONTINUITY OF SECTIONS)*

**442. ~~REQUIREMENT OF~~ EMERGENCY PRESCRIPTION DRUG ORDER - SCHEDULE II.**
~~-~~An emergency ~~situation~~, as ~~defined~~ referenced in Section 37-2722(b), Idaho Code, ~~a pharmacist may dispense a~~ is one in which the prescriber determines: immediate administration of the controlled substance ~~listed in~~ is necessary for proper treatment of the intended ultimate user; and that no appropriate alternative treatment is available, including administration of a drug which is not a Schedule II ~~upon receiving oral authorization of a prescribing individual practitioner~~ controlled substance; and that it is not reasonably possible for the prescriber to provide a written prescription drug order to be presented to the person dispensing the substance prior to the dispensing. ~~(7-1-93)~~(    )

**~~a~~01.** **Quantity Limited**. The quantity prescribed and dispensed ~~is~~ must be limited to the amount adequate to treat the patient during the emergency period (dispensing beyond the emergency period must be pursuant to a written prescription drug order signed by the prescrib~~ing~~er ~~individual practitioner~~). ~~(7-1-93)~~(    )

**~~b~~02.** **Prescription Drug Order Reduced to Writing**. The prescription ~~shall~~ drug order must be immediately reduced to writing by the pharmacist and ~~shall~~ must contain all of the information required in Section 37-2723, Idaho Code, except for the signature of the prescrib~~ing~~er ~~individual practitioner~~. ~~(7-1-93)~~(    )

~~**c.** If the prescribing individual practitioner is not known to the pharmacist, he must make a reasonable effort to determine that the oral authorization came from a registered~~

individual practitioner, which may include a callback to the prescribing individual practitioner using his phone number as listed in the telephone directory or other good faith effort to ensure his identity, or both. (7-1-93)

d03. **Written Prescription Drug Order**. Within seven (7) days after authorizing issuing verbal authorization for the dispensing of an emergency oral prescription for a Schedule II controlled substance, the prescribinger individual practitioner shall cause must provide a written prescription drug order for the emergency quantity prescribed to be delivered to the dispensinged pharmacist. In addition to conforming to the requirement of Section 37-2723, Idaho Code, the prescription shall drug order must have written on its face "Authorization for Emergency Dispensing" and the date of the oral verbal prescription drug order was issued. (7-1-99)( )

e04. **Delivery of Paper Prescription Drug Order** The written paper prescription drug order may be delivered to the pharmacist in person or by mail; however, if delivered by mail, it must be postmarked within the seven (7)-day period. (7-1-99)( )

f05. **Attachment of Paper Prescription Drug Order**. Upon receipt, the dispensing pharmacist shall attach the written A paper prescription drug order must be attached to the oral verbal emergency prescription drug order that had was previously been reduced to writing. For electronic prescriptions, the pharmacist must annotate the record of the electronic prescription with the original authorization and date of the verbal order. (7-1-93)( )

g06. **Notification to the Board**. The pharmacist shall must notify the Board if the prescribinger individual practitioner fails to deliver provide a written prescription to him drug order within the seven (7)-day period. Failure of the pharmacist to so notify the Board shall void the prescribing individual practitioner's authority, conferred by this Subsection to dispense without a written prescription. (7-1-93)( )

*(BREAK IN CONTINUITY OF SECTIONS)*

**444. PARTIAL-FILLING DISPENSING OF SCHEDULE II PRESCRIPTIONS.**

01. **Conditions for Partial-Fill Dispensing**. The partial filling of a prescription for a controlled substance listed in A Schedule II is permissible if controlled substance prescription may be partially filled and dispensed when the pharmacist is unable to supply the full quantity called for in a written or emergency oral prescription and a notation is made of the quantity supplied on the face of the written prescription (or written record of the emergency oral prescription) ordered. (7-1-93)( )

01a. **Remaining Portion of Prescription**. The remaining portion of the prescription may only be filled within the seventy-two (72) hours period of the first partial filling; however, if the remaining portion is not or cannot be filled within seventy-two (72) hours, the pharmacist shall must so notify the prescribinger individual practitioner. (7-1-93)( )

02b. **Supplying Further Quantity**. No further quantity may Additional quantities must

not be *supplied* dispensed after *the* seventy-two (72) hours *period* from the time the initial quantity was dispensed without a new prescription drug order. *(7-1-93)*( )

0*3*2. **Partial-Fill *Quantities* Dispensing to LTCF and Terminal Illness Patients**. A Schedule II controlled substance prescription *for a Schedule II controlled substance written* for a patient in a Long Term Care Facility (LTCF) or for a patient with a *medical diagnosis* document*ing*ed *a* terminal illness may be filled in partial quantities *to include* and individual dosage units. ( )

a. If there is any question as to whether a patient may be classified as having a terminal illness, the pharmacist must contact the prescriber prior to partially filling the prescription. Both the pharmacist and the prescriber have a corresponding responsibility to ensure that the controlled substance is for a terminally ill patient. ( )

b. The pharmacist must record *on* that the *prescription whether the* patient is either "terminally ill" or an "LTCF patient." *(7-1-99)*( )

*a*03. **Partial-Fill Documentation**. For each *partial filling, the dispensing pharmacist shall record on the back of the* partially filled prescription *(or on another appropriate record, uniformly maintained and readily retrievable)* dispensed, the following information must be recorded: ( )

a. *t*The date *of the partial filling,*; ( )

b. The quantity dispensed*,*; ( )

c. The remaining quantity authorized *to be* for dispens*ed*ing*,*; and ( )

d. *t*The identification of the dispensing pharmacist. *(7-1-99)*( )

*b. Schedule II prescriptions for patients in a LTCF or patients with a medical diagnosis documenting a terminal illness shall be valid for a period not to exceed sixty (60) days from the issue date, unless sooner terminated by the discontinuance of medication. (7-1-99)*

## (BREAK IN CONTINUITY OF SECTIONS)

**446. *REQUIREMENT OF PRESCRIPTION - SCHEDULE III OR IV* PRESCRIBER ADMINISTRATION AND DELIVERY OF CONTROLLED SUBSTANCES.**

An authorized prescriber may administer or deliver a controlled substance listed in Schedules II, III, IV, or V in the course of the prescriber's professional practice, pursuant to the inventory and recordkeeping requirements of federal law; Section 37-2720, Idaho Code; and these rules. ( )

*01. **Dispensing a Controlled Substance -- Pharmacist**. A pharmacist may dispense a controlled substance listed in Schedule III or IV, that is a prescription drug as determined under the federal Food, Drug, and Cosmetic Act, only pursuant to either a written prescription signed*

~~*by a prescribing individual practitioner or an oral prescription made by a prescribing individual practitioner and promptly reduced to writing by the pharmacist containing all information required in Section 37-2722(e), Idaho Code, except for the signature of the prescribing individual practitioner. (7-1-93)*~~

~~***02. Dispensing a Controlled Substance -- Individual Practitioner**. An individual practitioner may administer or dispense a controlled substance listed in Schedule III or IV in the course of his professional practice without a prescription, subject to Section 37-2720, Idaho Code. (7-1-93)*~~

~~***03. Dispensing a Controlled Substance -- Institutional Practitioner**. An institutional practitioner may administer or dispense directly (but not prescribe) a controlled substance listed in Schedule III or IV pursuant to a written prescription signed by a prescribing individual practitioner, pursuant to an oral prescription made by a prescribing individual practitioner and promptly reduced to writing by the pharmacist (containing all of the information required in Section 37-2723, Idaho Code, except for the signature of the prescribing individual practitioner), or pursuant to an order for medication made by an individual practitioner that is dispensed for immediate administration to the ultimate user subject to Section 37-2720, Idaho Code. (7-1-93)*~~

***(BREAK IN CONTINUITY OF SECTIONS)***

## 450. ~~*REQUIREMENT OF PRESCRIPTION - SCHEDULE V*~~ RESERVED.

~~***01. Dispensing Schedule V Controlled Substances**. A pharmacist may dispense a controlled substance listed in Schedule V pursuant to a prescription as required for controlled substances listed in Schedule III and IV in Section 451 of these rules. (7-1-93)*~~

~~***02. Refilling Schedule V Controlled Substances Requires Authorization**. A prescription for a controlled substance listed in Schedule V may be refilled only as expressly authorized by the prescribing individual practitioner on the prescription. If no such authorization is given, the prescription may not be refilled. (7-1-93)*~~

~~***03. Labeling Schedule V Controlled Substances for Dispensing**. A pharmacist dispensing a Schedule V substance pursuant to a prescription shall label the substance in accordance with Section 448 of these rules and file the prescription in accordance with Section 449 of these rules. (7-1-93)*~~

~~***04. Dispensing Schedule V Controlled Substances by Individual Practitioner**. An individual practitioner may administer or dispense a controlled substance listed in Schedule V in the course of his professional practice without a prescription, subject to Section 37-2720, Idaho Code. (7-1-93)*~~

~~***05. Dispensing Schedule V Controlled Substances by Institutional Practitioner**. An institutional practitioner may administer or dispense directly (but not prescribe) a controlled substance listed in Schedule V only pursuant to a written prescription signed by the prescribing*~~

~~*individual practitioner, pursuant to an oral prescription made by a prescribing individual practitioner and promptly reduced to writing by the pharmacist (containing all information required in Section 37-2723, Idaho Code, except for the signature of the prescribing individual practitioner), or pursuant to an order for medication made by an individual practitioner that is dispensed for immediate administration to the ultimate user subject to Section 37-2720, Idaho Code.*~~ ~~*(7-1-93)*~~

***(BREAK IN CONTINUITY OF SECTIONS)***

**496. CONTROLLED SUBSTANCE INVENTOR~~Y~~IES, PRESCRIPTION DRUG ORDERS, AND RECORDS.**

Each ~~*registered pharmacy shall*~~ controlled substance registrant must maintain the prescription drug orders, inventories, and records of controlled substances as follows: ~~*(7-1-93)*~~( )

**01. Inventories and Records for Schedules I and II**. Prescription drug orders, ~~*I*~~inventories, and records of ~~*all*~~ controlled substances listed in Schedules I and II ~~*shall*~~ must be maintained separately from ~~*all*~~ other prescription drug orders and records of the pharmacy~~*, and prescriptions for Schedule I and II substances shall be maintained in a separate prescription file*~~. ~~*(7-1-93)*~~( )

**02. Inventories and Records for Schedules III, IV, and V**. Prescription drug orders, ~~*I*~~inventories, and records of controlled substances listed in Schedules III, IV, and V ~~*shall*~~ must be maintained ~~*either*~~ separately from ~~*all*~~ other prescription drug orders and records ~~*of the pharmacy*~~ or in such ~~*form*~~ manner that the information required is readily retrievable~~*from ordinary business records of the pharmacy. Prescriptions for such substances shall be maintained either in a separate prescription file for controlled substances listed in Schedules III, IV, and V only or in such form that they are readily retrievable from the other prescription records of the pharmacy*~~. ~~*(7-1-93)*~~( )

**03. Readily Retrievable Paper Prescription Drug Orders**. Controlled substance ~~*P*~~prescription~~*s*~~ ~~*will be deemed*~~ drug orders, inventories, and records are considered readily retrievable if~~*, at the time*~~ they are ~~*initially filed, the face of the prescription is stamped in red ink in the lower right corner with the letter "C" no less than one (1) inch high and filed either in the prescription file for controlled substances listed in Schedules I and II or in the usual consecutively numbered prescription file for non-controlled substances, except that for pharmacies employing*~~ stored in an electronic recordkeeping or an alternative system ~~*for prescriptions that permits identification by prescription number and retrieval of original documents by prescriber's name, patient's name, drug dispensed, and date filled, the requirement to mark the hard copy prescription with a red "C" is waived*~~ in such a manner that they can be separated from all other records in a reasonable time or if they are made in some manner visually identifiable and distinguished from other records or from other items appearing on the records. Electronic prescription drug order records must be maintained in compliance with applicable federal law. ~~*(7-1-99)*~~( )

**04. Annual Inventory of Stocks of Controlled Substances**. Each ~~*registered*~~

~~*pharmacy shall annually, within seven (7) days of the prior year's inventory, take*~~ controlled substance registrant must conduct an inventory of all stocks of controlled substances ~~*on hand, following*~~ at least annually in a form and manner that satisfies the ~~*general*~~ inventory requirements ~~*for inventories*~~ of federal law, regulations, and these rules. ~~*(5-8-09)*~~(     )

**a.** ~~*The annual inventory, required in these rules, shall be a written record resulting*~~ Inventories of controlled substances required by these rules must result from a physical (or actual) count of stock on hand or in the control of the ~~*pharmacist-in-charge of a particular pharmacy*~~ registrant. ~~*(7-1-93)*~~(     )

**b.** ~~*Automated data processing equipment*~~ An electronic recordkeeping system may be used to ~~*provide lists of items (products) and to*~~ record receipts and ~~*issues*~~ distributions of ~~*various items, but not*~~ controlled substances and to ~~*produce*~~ record the annual inventory if the inventory is also maintained in a written, typewritten, or printed form at the registered location. ~~*(7-1-93)*~~(     )

~~***c.***~~ ~~*The record of inventory shall be kept in the inventory book provided by the Board or in another bound book (not loose leaf) suitable to meet the needs of inventory reports. (7-1-93)*~~

**~~*d*~~c.** Upon completion, the inventory ~~*will*~~ must be dated as of the day ~~*taken*~~ conducted, ~~*indicating*~~ noted as to whether it was ~~*taken*~~ conducted at the opening or closing of business, and signed by the party that ~~*took*~~ completed the inventory. ~~*(7-1-93)*~~(     )

**d.** Complete inventories conducted as otherwise required by these rules may also be considered in complying with the annual inventory requirement. (     )

**05. Separate Inventories for Each Location**. A separate inventory ~~*shall*~~ must be ~~*made by a registrant for*~~ conducted and maintained at each registered location ~~*and shall be kept at the registered location*~~. ~~*(7-1-93)*~~(     )

**06. Inventory ~~*Must Be In Written Form*~~ on Change of Pharmacist-in-Charge (PIC)**. A~~*n*~~ complete controlled substance inventory must be ~~*maintained in a written, typewritten or printed form. If taken by use of an oral recording device it must be promptly transcribed*~~ conducted in the event of a PIC change. The inventory must be conducted following the close of business on the last day of employment of the outgoing PIC and prior to opening for business on the first day of employment of the incoming PIC. However, a single inventory is sufficient if there is no lapse of employment between the outgoing and the incoming PICs. ~~*(7-1-93)*~~(     )

~~***07. Maintaining Written Inventory**. Such inventory must be maintained on the premises for a minimum of three (3) years. (7-1-93)*~~

**07. Inventory on Discovery of Theft or Loss of Controlled Substances**. A complete controlled substance inventory must be conducted within forty-eight (48) hours of the discovery of a theft or reportable loss of a controlled substance. (     )

**08. Inventory on Addition~~*s*~~ to Schedule~~*s*~~ of Controlled Substances**. On the effective date of ~~*a rule adding*~~ an addition of a substance to a~~*ny*~~ schedule of controlled substances, ~~*which substance was, immediately prior to that date, not listed on a schedule,*~~ every registrant ~~*required to keep records*~~ who possesses that substance ~~*shall take*~~ must conduct an inventory of all

stocks of the substance on hand, and thereafter, ~~*such substance shall be*~~ include~~*d*~~ the substance in each inventory ~~*made*~~ conducted by the registrant ~~*pursuant to Subsection 496.04 of these rules*~~. ~~*(7-1-93)*~~( )

**09. Maintaining ~~*Current List*~~ Record of Each Substance**. Each ~~*registered pharmacy shall*~~ controlled substance registrant must maintain a current, complete, and ~~*current list*~~ accurate record of each substance manufactured, imported, received, ordered, sold, delivered, exported, or otherwise disposed of by the ~~*pharmacy; order forms; and other required records*~~ registrant in ~~*such*~~ a ~~*manner as to be*~~ readily retrievable manner, except that a registrant is not required by this rule to maintain a perpetual inventory. ~~*(7-1-93)*~~( )

**10. Maintaining Inventories**. Inventories must be maintained on the registered premises for a minimum of three (3) years. ( )

# IDAPA 27 - BOARD OF PHARMACY

## 27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

## DOCKET NO. 27-0101-1002

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 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 37-2715, 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.

**Public comment has resulted in changes to the definitions, record keeping requirements, and medication to be administered in the event of an emergency resulting from the administration of a vaccine.**

**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 October 6, 2010 Idaho Administrative Bulletin, Vol. 10-10, pages 436 through 438.**

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

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning the pending rule, contact Mark Johnston, R.Ph., Executive Director, at (208) 334-2356.

DATED this 1st day of November, 2010.

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 37-2715, 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 20, 2010.

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:

**Training and recordkeeping requirements for pharmacists administering immunizations are needed to protect the health and welfare of the citizens of Idaho. The proposed rule would establish qualifications for pharmacists to immunize and establish recordkeeping requirements.**

**FEE SUMMARY:** The following is a specific description of the fee or charge imposed or increased: None.

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

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(2), Idaho Code, informal negotiated rulemaking was held with the Idaho Pharmacy Leadership Counsel, whose members include the Idaho State Pharmacy Association, the Idaho Society of Health-Systems Pharmacists, and Idaho State University's School of Pharmacy.

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

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the proposed rule, contact Mark Johnston, R.Ph., Executive Director, at (208) 334-2356.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 27,

2010.

DATED this 27th day of August, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 27-0101-1002***

**166. IMMUNIZATION RECORD.**

**01. Definitions.** ( )

*a. "Absolute Contraindication" means a situation that makes a particular treatment or procedure inadvisable.* ( )

**b.** ACPE means the Accreditation Council for Pharmacy Education. ( )

*c. AED means automated electronic defibrillator.* ( )

*d. AHA means American Heart Association.* ( )

**e.** CDC means the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. ( )

**f.** "Compromised Patient" means an individual who may have an absolute or relative contraindication to receive immunizations. ( )

*g. CPR means cardiopulmonary resuscitation.* ( )

**h.** "Healthy Patient" means an individual with no contraindications to receive immunizations. ( )

*i. IRIS means the Idaho Immunization Reminder Information System.* ( )

*j. "Relative Contraindication" means a condition that makes a particular treatment or procedure somewhat inadvisable but does not rule it out.* ( )

*k. VAERS means Vaccine Adverse Event Reporting System.* ( )

**02. Qualifications.** ( )

**a.** A pharmacist may administer immunizations to healthy patients, and pursuant to *a* prescription drug order to compromised patients. ( )

**b.** To qualify to administer immunizations, a pharmacist must first; ( )

i. Successfully complete an ACPE accredited or comparable course that meets the standards for pediatric, adolescent, and adult immunization practices recommended and approved by the *CDC's* Advisory Committee on Immunization Practices and includes at least; ( )

(1) Basic immunology, vaccine and immunization protection; ( )

(2) Diseases that are preventable through vaccination and immunization; ( )

(3) Recommended immunization schedules; ( )

(3) *Current r*ecommended immunization schedules; ( )

(4) Vaccine and immunization storage and management; ( )

(5) Informed consent; ( )

(6) Physiology and techniques for administration of immunizations; ( )

(7) Pre-immunization and post-immunization assessment and counseling; ( )

(8) Immunization reporting and records management; and ( )

(9) Identification, response, documentation, and reporting of adverse events. ( )

ii. Hold a current certification in basic *life support for healthcare providers* (CPR *and AED program*) offered by AHA or *any nationally recognized training program that follows AHA guidelines for said healthcare provider certification that includes AED training and requires hands-on skills assessment by an authorized instructor*; ( )

**c.** Pharmacists qualified to administer immunizations must also annually complete a minimum of one (1) hour of ACPE approved continuing education related to vaccines, immunizations, or their administration within the continuing education required by Section 134 of these rules. ( )

**d.** The authority to administer immunizations may not be delegated; however, a registered student pharmacist that has satisfied the immunizing pharmacist qualifications may administer immunizations under the direct supervision of a qualified immunizing pharmacist. ( )

**e.** An immunizing pharmacist must maintain written policies and procedures for disposal of used or contaminated supplies. ( )

**f.** An immunizing pharmacist must report*:* ( )

*i.* *Any* adverse events to the health care provider identified by the patient, if any, and to the *VAERS.* ( )

*ii.* *Any applicable immunization to IRIS.* ( )

**03. Immunization Administration**. Immunizations must be administered pursuant to the latest recommendations issued by the CDC *or other qualified government authorities*. A pharmacist must have a current copy of, or on-site access to, the CDC's "Epidemiology and Prevention of Vaccine-Preventable Diseases." *( )*

**04. Vaccine Information Statement**. A current CDC-issued Vaccine Information Statement corresponding to the vaccine administered must be provided to the patient or the patient's representative for each immunization administered. ( )

**05. Recordkeeping**. For each immunization administered, the following information must be maintained in the patient profile: ( )

**a.** The name, address, allergies, and date of birth of the patient; ( )

**b.** The date of administration; ( )

**c.** The *product* name, manufacturer, dose, lot number, and expiration date of the vaccine; *( )*

**d.** Documentation identifying the Vaccine Information Statement provided; ( )

**e.** The site and route of administration *and the dose in series, if applicable*; *( )*

**f.** The name of the patient's health care provider, if any; *( )*

**g.** The name*s* of the immunizing pharmacist and student pharmacist, *if any*; *( )*

**h.** Any adverse events encountered; *( )*

**i.** The date on which an adverse event was reported to the patient's health care provider, if any*; and* *( )*

***j.*** *Completed informed consent forms.* *( )*

**06. Emergencies**. ( )

**a.** An immunizing pharmacist must maintain a immediately-retrievable emergency kit sufficiently stocked to manage an acute allergic reaction to an immunization. *( )*

**b.** An immunizing pharmacist may initiate and administer auto-inject epinephrine, *injectable diphenhydramine, or oral diphenhydramine* to treat an acute allergic reaction to an immunization pursuant to guidelines issued by the American Pharmacy Association (APhA). *( )*

**16*6*7. -- 175. (RESERVED).**

# IDAPA 27 - BOARD OF PHARMACY

## 27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

## DOCKET NO. 27-0101-1003

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 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 37-2715, 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 6, 2010 Idaho Administrative Bulletin, Vol. 10-10, page 439.**

**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 Mark Johnston, R.Ph., Executive Director, (208) 334-2356.

DATED this 28th day of October, 2010.

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 37-2715, 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 20, 2010.

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 358 (IDAPA 27.01.01.358) needs to be stricken because it is in conflict with the Idaho Wholesale Drug Distribution Act, Sections 54-1752(16) and 54-1753, Idaho Code. The proposed change strikes Rule 358 in its entirety because it is in conflict with the Idaho Wholesale Drug Distribution Act.**

**FEE SUMMARY:** The following is a specific description of the fee or charge imposed or increased: None.

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

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the Idaho Wholesale Drug Distribution Act prohibits the acts allowed by this rule. Interested parties were notified in writing that they would need to initiate a proposed change to Idaho Code in order to continue the acts detailed in this rule.

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

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the proposed rule, contact Mark Johnston, R.Ph., Executive Director, at (208) 334-2356.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 27,

2010.

DATED this 27th day of August, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 27-0101-1003***

**358. ~~*DISTRIBUTION*~~ RESERVED.**

~~*Wholesale distribution of legend drugs will be permitted only to registered veterinarians or other licensed retail veterinary drug outlets.*~~ ~~*(7-1-93)*~~

# IDAPA 27 - BOARD OF PHARMACY

## 27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

## DOCKET NO. 27-0101-1004

## NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2011 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 37-2715, 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 6, 2010 Idaho Administrative Bulletin, Vol. 10-10, pages 440 and 441.**

**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 Mark Johnston, R.Ph., Executive Director, (208) 334-2356.

DATED this 28th day of October, 2010.

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 37-2715, 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 20, 2010.

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 is necessary to include information on controlled substances delivered by practitioners in the controlled substances prescriptions database maintained by the Board pursuant to Sections 37-2726 and 37-2730(A), Idaho Code. This information is not currently captured in the database and should be included in order to protect the health and welfare of the citizens of Idaho. The proposed rule would mandate that prescribers who deliver controlled substances to ultimate users would have to report certain data to the Board, just as dispensing pharmacies are required to do currently.**

**FEE SUMMARY:** The following is a specific description of the fee or charge imposed or increased: None.

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

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted as the need for this rule was not apparent until such time that negotiated rulemaking was infeasible; however, informal negotiated rulemaking is scheduled with entities, including the Idaho Board of Medicine, before the public comment period ends, allowing for potential changes before the rule becomes pending.

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

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the proposed rule, contact Mark

Johnston, R.Ph., Executive Director, at (208) 334-2356.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 27, 2010.

DATED this 27th day of August, 2010.

***THE FOLLOWING IS THE TEXT OF DOCKET NO. 27-0101-1004***

**469. PRESCRIPTION DRUG ORDER REPORTING.**

Certain data on all controlled substances must be reported weekly or more often as required by the Board by ~~*A*~~all pharmacies ~~*that*~~ holding a DEA retail pharmacy registration ~~*will report certain data on all Schedule II, III, IV, and V*~~ that dispense controlled substances, ~~*prescriptions filled, as required by the Board, by the first of every month or more often, as directed by the Board*~~ and by practitioners that deliver controlled substances. ~~*The data may be reported in the form of diskette, direct computer link, magnetic tape or other method approved by the Board.*~~ Data on controlled substance prescription drug samples does not need to be reported. ~~*(5-8-09)*~~(    )

# IDAPA 41 - PUBLIC HEALTH DISTRICTS

## 41.03.01 - RULES OF THE SOUTHWEST DISTRICT HEALTH DEPARTMENT

## DOCKET NO. 41-0301-1001 (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 2011 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, 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 1, 2010, Idaho Administrative Bulletin, Vol. 10-9, page 444.**

**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 David M. Loper, Environmental Health Director, Southwest District Health, 208.455.5401.

DATED this 15th day of October, 2010.

Bruce Krosch, Director
Southwest District Health
920 Main Street
Caldwell, ID 83605
phone: 208.455.5315
fax: 208.454.7722

***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, 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 15, 2010.

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

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

**This rulemaking is being done to repeal IDAPA 41.03.01, "Rules of the Southwest District Health Department," because this rule is outdated and is no longer being used by the Department.**

**FEE SUMMARY:** The following is a specific description of the fee or charge imposed or increased: There are no fees or charges 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: N/A

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because of the need to repeal IDAPA 41.03.01 which is outdated and no longer being used. The proposed rulemaking is not anticipated to have interested stakeholders, thus negotiated rulemaking is not necessary.

**INCORPORATION BY REFERENCE:** Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: There are no documents being incorporated by reference.

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the proposed rule, contact David M. Loper, REHS/RS, Director, Environmental Health Services, Southwest District Health, (208) 455-4501. 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 30, 2010.

DATED this 29th day of July, 2010.

**IDAPA 41.03.01 IS BEING REPEALED IN ITS ENTIRETY**