PENDING RULES

COMMITTEE RULES
REVIEW BOOK

Submitted for Review Before

House Health & Welfare Committee

68th Idaho Legislature
First Regular Session – 2025

Prepared by:

Office of the Administrative Rules Coordinator
Division of Financial Management

January 2025

HOUSE HEALTH & WELFARE COMMITTEE

ADMINISTRATIVE RULES REVIEW

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2025 Legislative Session

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.01.01 – EMERGENCY MEDICAL SERVICES

DOCKET NO. 16-0101-2401 (NEW CHAPTER)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202, Idaho Code, as well as Sections 56-1003 and 56-1011 through 56-1030, 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:

Chapters 16.01.02, 16.01.03, 16.01.05, 16.01.07, 16.01.12, 16.02.01 and 16.02.02 are being repealed and consolidated into a singular EMS chapter (16.01.01) that will be published in this bulletin. The language in chapter 16.01.07 (Personnel Licensure Rules) was updated as part of Zero-Based Regulation and is included in the proposed new chapter 16.01.01.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 4th, 2024, Idaho Administrative Bulletin, Vol. 24-9, pages 54 through 117.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

N/A. Fees are not increased as a result of this rulemaking. The fees listed in this new rule chapter simply represent the consolidation of the fees previously listed in Chapters 16.01.02, 16.01.03, 16.01.05, 16.01.07, 16.01.12, 16.02.01 and 16.02.02.

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

There will not be a negative fiscal impact exceeding $10,000 to the state by this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at 208-334-5500.

DATED this 26th day of September, 2024.

Alex J. Adams, PharmD, MPH
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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 56-202, Idaho Code, as well as Sections 56-1003 and 56-1011 through 56-1030, Idaho Code.

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

VIRTUAL TELECONFERENCE Via WebEx
Thursday, September 19, 2024 **10:00 a.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m7de9a7fc693b06f80698ba5191f190b9** **Join by meeting number** **Meeting number (access code): 2828 383 0931** **Meeting password: m52kCv3pMdM (65252837 when dialing from a phone or video system)** **Tap to join from a mobile device (attendees only)** **+1-415-527-5035,,28283830931#65252837# United States Toll** **+1-303-498-7536,,28283830931#65252837# United States Toll (Denver)** **Some mobile devices may ask attendees to enter a numeric password** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)** **Global call-in numbers**

VIRTUAL TELECONFERENCE Via WebEx

Tuesday, September 24, 2024
6:30 p.m. (MT)

Join from the meeting link
https://idhw.webex.com/idhw/j.php?MTID=m89d9401ca99d899d95fab8e7651a36f7

Join by meeting number
Meeting number (access code): 2822 377 4080
Meeting password: uMCx3MZaJ43 (86293692 when dialing from a phone or video system)

Tap to join from a mobile device (attendees only)
+1-415-527-5035,,28223774080#86293692# United States Toll
+1-303-498-7536,,28223774080#86293692# United States Toll (Denver)
Some mobile devices may ask attendees to enter a numeric password

Join by phone
+1-415-527-5035 United States Toll
+1-303-498-7536 United States Toll (Denver)
Global call-in numbers

Join from a video system or application
Dial 28223774080@idhw.webex.com

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:

Chapters 16.01.02, 16.01.03, 16.01.05, 16.01.07, 16.01.12, 16.02.01 and 16.02.02 are being repealed and consolidated into a singular EMS chapter (16.01.01) that will be published in this bulletin. The language in chapter 16.01.07 (Personnel Licensure Rules) was updated as part of Zero-Based Regulation and is included in the proposed new chapter 16.01.01.

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

Fees will not be increased as a result of repealing this chapter.

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:

There will not be a negative fiscal impact exceeding $10,000 to the state by this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted on chapters 16.01.02, 16.01.03, 16.01.05, 16.01.12, 16.02.01 and 16.02.02 because those chapters are simply being proposed to be repealed and consolidated with all other chapters of EMS. Negotiated rulemaking was conducted for chapter 16.01.07 on April 18 and April 23, 2024. Negotiated Rulemaking for chapter 16.01.07 was published in the April 3, 2024, Idaho Administrative Bulletin, Volume 24-4, pages 20 through 21.

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

The following documents are incorporated by reference into the proposed new chapter. All incorporated documents were previously incorporated by reference in the rule chapters that are being repealed by this rulemaking. No changes are being made to any incorporated documents in this rulemaking.

1. EMS Agency Standards Manual, Edition 2024-1
2. EMS Data Collection Standards Manual, Edition 2023-1
3. Idaho EMS Education Equipment Standards, Edition 2016-1
4. Idaho EMS Education Standards Manual, Edition 2022-1
5. Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, Edition 2020-1
6. Minimum Equipment Standards for Licensed EMS Services, Edition 2016-1
7. Time Sensitive Emergency Standards Manual, Edition 2023-1

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jared Larsen at 208-334-5500.

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 25th, 2024.

DATED this 18th day of July, 2024.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0101-2401

16.01.01 – EMERGENCY MEDICAL SERVICES

000. LEGAL AUTHORITY.
The EMS Bureau is authorized under Section 56-1023, Idaho Code, to adopt rules and standards concerning the administration of the Idaho Emergency Medical Services Act, Sections 56-1011 through 56-1030, Idaho Code. The Director is authorized under Section 56-1003, Idaho Code, to supervise and administer an emergency medical services program. ( )

001. INCORPORATION BY REFERENCE.
The following documents are incorporated by reference: ( )

01. EMS Agency Standards Manual, Edition 2024-1, hereafter referred to as the EMS Agency Standards Manual, is incorporated by reference in this chapter of rules. Copies of the manual may be obtained online at: EMS Agency Standards Manual 2024-1 (idaho.gov). ( )

02. EMS Data Collection Standards Manual, Edition 2023-1, hereafter referred to as the EMS Data Collection Standards, is incorporated by reference in this chapter of rules. Copies of the manual may be obtained online at: EMS Data Collection Standards Manual 2023 (idaho.gov). ( )

03. Idaho EMS Education Equipment Standards, Edition 2016-1, hereafter referred to as the EMS Education Equipment Standards, is incorporated by reference in this chapter of rules. Copies of the manual may be obtained online at: EducationEquipmentStandards2016 (idaho.gov). ( )

04. **Idaho EMS Education Standards Manual**, Edition 2022-1, hereafter referred to as the EMS Education Standards Manual, is incorporated by reference in this chapter of rules. Copies of the manual may be obtained online at: IdahoEMSEducationStandards. ( )

05. **Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual**, Edition 2020-1. hereafter referred to as the EMSPC Standards Manual, is incorporated by reference in this chapter of rules. Copies of the manual may be obtained online at: EMSPC_StandardsManual2020-1 (idaho.gov). ( )

06. **Minimum Equipment Standards for Licensed EMS Services**, Edition 2016-1, hereafter referred to as the EMS Agency Equipment Standards Manual, is incorporated by reference in this chapter of rules. Copies of the manual may be obtained online at: EMS_Minimum_Equipment_Standards_for_Licensed_EMS_Service (idaho.gov). ( )

07. **Time Sensitive Emergency Standards Manual**, Edition 2023-1, hereafter referred to as the TSE Standards Manual, is incorporated by reference in this chapter of rules. Copies of the manual may be obtained online at https://tse.idaho.gov/. ( )

002. ADMINISTRATIVE LICENSE OR CERTIFICATION ACTION.
Any license, designation or certification may be suspended, revoked, denied, or retained with conditions for noncompliance with any standard or rule. Administrative license, designation or certification actions, including fines, imposed by the EMS Bureau for any action, conduct, or failure to act that is inconsistent with the professionalism, or standards, or both, are provided under Sections 56-1011 through 56-1030, Idaho Code, and these rules. ( )

003. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.
Individuals applying for any of the following must successfully pass a criminal history background check: ( )

01. **Initial Instructor Certification**. ( )

02. **Initial Personnel Licensure**. ( )

03. **Reinstatement of Personnel Licensure**. ( )

04. **Certificate of Eligibility**. ( )

004. ADDITIONAL CRIMINAL BACKGROUND CHECK.
The EMS Bureau may require an updated or additional criminal background check at any time, without expense to the candidate, if there is cause to believe new or additional information will be disclosed. ( )

SUBPART A – DEFINITIONS (Sections 005 - 099)

005. DEFINITIONS AND ABBREVIATIONS A THROUGH B.
For the purposes of this chapter, the following definitions apply: ( )

01. **911 Call**. Any request for emergency services that is received or dispatched by a CECS or PSAP, regardless of the method the request was received. ( )

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

a. Has met the qualifications for licensure under Sections 56-1011 through 56-1023, Idaho Code, and these rules; ( )

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

c. Carries out the practice of emergency medical care within the scope of practice for AEMT determined by the Idaho Emergency Medical Services Physician Commission (EMSPC), and ( )

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

03. Advanced Life Support (ALS). The provision of medical care, medication administration and treatment with medical devices that correspond to the knowledge and skill objectives in the Paramedic curriculum currently approved by the State Health Officer and within the scope of practice authorized by the EMSPC, by persons licensed as Paramedics by the EMS Bureau. ( )

04. Advanced Practice Registered Nurse. A person who meets the requirements and is licensed as an Advanced Practice Registered Nurse under Sections 54-1401 through 54-1418, Idaho Code. ( )

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

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

07. Affiliating EMS Agency. The licensed EMS agency(s) under which licensed personnel are authorized to provide patient care. ( )

08. Air Ambulance. Any privately or publicly owned fixed wing or rotary wing aircraft used for, or intended to be used for, the transportation of persons experiencing physiological or psychological illness or injury who may need medical attention during transport. This may include dual or multipurpose vehicles that comply with Sections 56-1011 through 56-1023, Idaho Code, and these rules. ( )

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

10. Air Medical Transport Service. An air medical service type that licenses an agency to provide air medical reponse and transport of patients from an emergency scene, and hospital-to-hospital transfers of patients utilizing an air ambulance. ( )

11. Air Medical Rescue Service. An air medical service type that licenses an agency to provide air medical response and transport of patients from an emergency scene to a rendezvous with air medical transport or ground transport ambulance services. ( )

12. Air Medical Response. The deployment of an aircraft to respond to an emergency scene for the purpose of patient treatment and transportation. ( )

13. Ambulance. Any privately or publicly owned motor vehicle, or nautical vessel, used for, or intended to be used for, the transportation of sick or injured persons who may need medical attention during transport. This may include dual or multipurpose vehicles that comply with Sections 56-1011 through 56-1023, Idaho Code, and specifications under these rules. ( )

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

15. Ambulance Certification. Designation issued by the EMS Bureau to a licensed EMR indicating that the EMR has completed ambulance certification training, examination, and credentialing as required by the EMS Bureau. The ambulance certification allows a licensed EMR to serve as the sole patient care provider in an ambulance during transport or transfer. ( )

16. Ambulance Service. An agency licensed by the EMS Bureau and operated with the intent to provide pe6sonnel and equipment for medical treatment at an emergency scene, during transportation or during transfer of persons experiencing physiological or psychological illness or injury who may need medical attention

during transport. ( )

17. **Ambulance Service Type**. An agency that is licensed as an ambulance service is intended for patient transport or transfer. ( )

18. **Applicant**. Any organization that is requesting an agency license under Sections 56-1011 through 56-1023, Idaho Code, and these rules including the following: ( )

a. An organization seeking a new license; ( )

b. An existing agency that intends to: ( )

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

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

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

19. **Basic Life Support (BLS)**. The provision of medical care, medication administration, and treatment with medical devices that correspond to the knowledge and skill objectives in the EMR or EMT curriculum currently approved by the State Health Officer and within scope of practice established by the EMSPC, by persons licensed as EMRs or EMTs by the EMS Bureau. ( )

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

006. DEFINITIONS AND ABBREVIATIONS C THROUGH E.
For the purposes of the Emergency Medical Services (EMS) chapters of rules, the following definitions apply: ( )

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

02. **Candidate**. Any individual who is requesting an EMS personnel license under Sections 56-1011 through 56-1023, Idaho Code, and these rules. ( )

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

04. **Certification**. A credential issued by a designated certification body for a specified period indicating that minimum standards have been met. ( )

05. **Certified EMS Instructor**. An individual approved by the EMS Bureau, who has met the requirements in these rules to provide EMS education and training. ( )

06. **CoAEMSP**. Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions. ( )

07. **Cognitive Exam**. Computer-based exam to demonstrate knowledge learned during an EMS education program. ( )

08. **Community Health EMS (CHEMS)**. The practice of deploying EMS personnel to provide evaluation, advice, or treatment of eligible recipients outside of a hospital setting as part of a community-based team of health and social services providers as authorized by local medical control. ( )

09. **Conflict of Interest**. A situation in which a decision by personnel acting in their official capacity is influenced by or may be a benefit to their personal interests. ( )

10. **Consolidated Emergency Communications System (CECS)**. An emergency communication system operated or coordinated by a government entity that is composed of facilities, equipment, and dispatching services directly related to establishing, maintaining, or enhancing a 911 emergency communications service defined in Section 31-4802, Idaho Code. ( )

11. **Core Content**. Set of educational goals, explicitly taught (and not taught), focused on making sure that all students involved learn certain material tied to a specific educational topic and defines the entire domain of out-of-hospital practice and identifies the universal body of knowledge and skills for emergency medical services providers who do not function as independent practitioners. ( )

12. **Course**. The specific portions of an education program that delineate the beginning and end of an individual's EMS education. A course is also referred to as a "section" on the NREMT website. ( )

13. **Course Physician**. A physician charged with reviewing and approving both the clinical and didactic content of a course. ( )

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

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

16. **Critical Care**. The treatment of a patient with continuous care, monitoring, medication, or procedures requiring knowledge or skills not contained within the Paramedic curriculum approved by the State Health Officer. Interventions provided by Paramedics are governed by the scope of practice authorized by the EMSPC. ( )

17. **Critical Care Agency**. An ambulance or air medical EMS agency that advertises and provides all of the skills and interventions defined as critical care per the incorporated EMSPC Standards Manual. ( )

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

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

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

21. **Director**. The Director of the Department or their designee. ( )

22. **Division**. The Department's Division of Public Health. ( )

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

24. **Emergency Driving Procedures**. Any EMS response to an emergency utilizing emergency lights, sirens, and traffic exemptions under Section 49-623, Idaho Code. ( )

25. **Emergency Medical Care**. The care provided to a person suffering from a medical condition, the

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

26. **Emergency Medical Responder (EMR)**. A person who: ( )

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

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

c. Carries out the practice of emergency medical care within the scope of practice for EMR determined by the EMSPC; and ( )

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

27. **Emergency Medical Services (EMS)**. Under Section 56-1012(16), Idaho Code, EMS is aid rendered by an individual or group of individuals who do the following: ( )

a. Respond to a perceived need for medical care to prevent loss of life, aggravation of physiological or psychological illness, or injury; ( )

b. Are prepared to provide interventions that are within the scope of practice as defined by the EMSPC. ( )

c. Use an alerting mechanism to initiate a response to requests for medical care; and ( )

d. Offer, advertise, or attempt to respond as described in these rules. ( )

28. **Emergency Medical Technician (EMT)**. A person who: ( )

a. Has met the qualifications under Sections 56-1011 through 56-1023, Idaho Code, and these rules; ( )

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

c. Carries out the practice of emergency medical care within the scope of practice for EMT determined by the EMSPC; and ( )

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

29. **Emergency Response**. Any EMS response to an emergency utilizing emergency lights, sirens, and traffic exemptions under Section 49-623, Idaho Code. ( )

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

31. **EMS Agency**. Any organization licensed under Sections 56-1011 through 56-1023, Idaho Code, and these rules that operates an air medical service, ambulance service, or non-transport service. ( )

32. **EMS Bureau**. The Bureau of Emergency Medical Services (EMS) and Preparedness. ( )

33. **EMS Education Program**. The institution or agency holding an EMS education course. ( )

34. **EMS Education Program Director**. The individual responsible for an EMS education program(s). ( )

35. EMS Education Program Objectives. The measurable outcome used by the program to determine student competencies. ( )

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

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

38. EMS Response. A response to a request for assistance that would involve the medical evaluation or treatment of a patient, or both. ( )

007. DEFINITIONS AND ABBREVIATIONS F THROUGH N.
For the purposes of the Emergency Medical Services (EMS) chapters of rules, the following definitions apply: ( )

01. Facility. A health care organization that is voluntarily seeking designation from the Idaho TSE Council. A facility may be any of the following: ( )

a. Center as designated by the Idaho TSE Council. ( )

b. Freestanding emergency department: ( )

i. Owned by a hospital with a dedicated emergency department; ( )

ii. Located within thirty-five (35) miles of the hospital that owns or controls it; ( )

iii. Provides emergency services twenty-four (24) hours per day, seven (7) days per week on an outpatient basis; ( )

iv. Physically separate from a hospital; and ( )

v. Meets the staffing and service requirements in IDAPA 16.03.14, "Hospitals." ( )

c. Hospital as defined in Section 39-1301, Idaho Code. ( )

d. A health care clinic in a rural area that is located more than thirty-five (35) miles from a hospital via maintained roads and can provide emergency care to patients. ( )

02. Formative Evaluation. Assessment, including diagnostic testing, that is a range of formal and informal assessment procedures employed by teachers during the learning process. ( )

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

04. Heart Attack. STEMI, a common name for ST-elevation myocardial infarction, is a more precise definition for a type of heart attack caused by a prolonged period of blocked blood supply that affects a large area of the heart and has a substantial risk of death or disability calling for a quick response. ( )

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

06. Hospital Supervising Physician. A physician who supervises the medical activities of licensed EMS personnel while employed or utilized for delivery of services in a hospital. ( )

07. Idaho Time Sensitive Emergency (TSE) System Council. The Idaho TSE System Council established in Section 56-1027, Idaho Code. ( )

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

09. Instructor. Person who assists a student in the learning process and meets the requirements to obtain instructor certification. ( )

10. Instructor Certification. A credential issued to an individual by the EMS Bureau for a specified period of time indicating that minimum standards for providing EMS instruction under these rules have been met. ( )

11. Intermediate Life Support (ILS). The provision of medical care, medication administration, and treatment with medical devices that correspond to the knowledge and skill objectives in the AEMT curriculum currently approved by the State Health Officer and within the scope of practice defined by the EMSPC, by persons licensed as AEMTs by the EMS Bureau. ( )

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

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

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

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

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

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

18. Medical Clinic Supervising Physician. A physician who supervises the medical activities of licensed EMS personnel while employed or utilized for delivery of services in a medical clinic. ( )

19. Medical Supervision. The advice and direction provided by a physician, or under the direction of a physician, to licensed EMS personnel who are providing medical care, including direct and indirect supervision. ( )

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

21. National Accrediting Body. An organization whose standards criteria is recognized by the Idaho TSE System Council and verifies compliance with those standards. ( )

22. National Emergency Medical Services Information System (NEMSIS). The national repository used to store national EMS data that sets the uniform data conventions and structure for the Data Dictionary and collects and provides aggregate data available for analysis and research through its technical assistance center

accessed at http://www.nemsis.org. ( )

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

24. **Non-Transport Service**. An EMS agency that provides emergency medical care, but does not transport patients and does not respond to 911 calls or respond to calls using emergency driving procedures unless requested by CECS, PSAP, or a 911 Response agency. ( )

25. **Non-Transport Service Type**. An agency that is licensed as a non-transport service type, is not intended for patient transport or transfers, and cannot advertise ambulance services. ( )

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

27. **Nurse Practitioner**. An Advanced Practice Registered Nurse, licensed in the category of Nurse Practitioner, under IDAPA 24.34.01, "Rules of the Idaho Board of Nursing." ( )

008. **DEFINITIONS AND ABBREVIATIONS O THROUGH Z.**
For the purposes of the Emergency Medical Services (EMS) chapters of rules, the following definitions apply: ( )

01. **Optional Module (OM)**. Skills identified by the EMSPC that exceed the floor level Scope of Practice for EMS personnel and may be adopted by the agency medical director. ( )

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

03. **Paramedic**. A person who: ( )

a. Has met the qualifications under Sections 56-1011 through 56-1023, Idaho Code, and of these rules; ( )

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

c. Carries out the practice of emergency medical care within the scope of practice for paramedics determined by the EMSPC; and ( )

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

04. **Paramedicine**. Providing emergency care to sick and injured patients at the ALS level with defined roles and responsibilities to be credentialed at the Paramedic level. ( )

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

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

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

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

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

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

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

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

13. Prehospital. A setting where emergency medical care is provided prior to or during transport to a hospital. ( )

14. Psychomotor Exam. Practical demonstration of skills learned during an EMS education course. ( )

15. Public Safety Answering Point (PSAP). An emergency communication center operated or coordinated by a government entity that is connected to local 911 phone services for the purpose of dispatching emergency services. ( )

16. Regional Time Sensitive Emergency (TSE) Committee. An Idaho regional TSE committee established under Section 56-1030, Idaho Code. ( )

17. REPLICA. The Recognition of EMS Personnel Licensure Interstate Compact that allows recognition of EMS personnel licensed in other jurisdictions that have enacted the compact to have personnel licenses reciprocated in the state of Idaho. ( )

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

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

20. Special Pathogens Transport (SPT). The practice of deploying specially trained EMS personnel and specialized equipment to provide medical care and transport of patients suffering from exposure or disease caused by highly infectious special pathogens. ( )

21. State Health Officer. The Administrator of the Department's Division of Public Health. ( )

22. STEMI. STEMI is an ST segment elevation myocardial infarction that is a particular type of heart attack, or MI (myocardial infarction), that is caused by a prolonged period of blocked blood supply. It affects a large area of the heart muscle, and so causes changes on the ECG as well as in blood levels of key chemical markers. This is considered a major heart attack and is referred to in medical shorthand as a STEMI. ( )

23. Stroke. An interruption of blood flow to the brain causing paralysis, slurred speech, or altered brain function usually caused by a blockage in a blood vessel that carries blood to the brain (ischemic stroke) or by a blood vessel bursting (hemorrhagic stroke). ( )

24. Summative Evaluation. End of topic or end of course evaluation that covers both didactic and practical skills application. ( )

25. Supervision. The medical direction by a licensed physician of activities provided by licensed

personnel affiliated with a licensed ambulance, air medical, or non-transport service, including: ( )

a. Establishing standing orders and protocols; ( )

b. Reviewing performance of licensed personnel; ( )

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

d. Other oversight. ( )

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

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

28. Tactical EMS (TEMS). The practice of deploying specially trained EMS personnel to provide emergency medical care in support of law enforcement activities. ( )

29. Time Sensitive Emergency (TSE). Time sensitive emergencies specifically for this chapter of rules are trauma, stroke, and heart attack. ( )

30. Transport Service. An agency that provides emergency medical care during transports or transfers, but does not respond to 911 calls. Transport services only respond to calls using emergency driving procedures for emergency hospital-to-hospital transfers and when requested by CECS, PSAP, or a 911 Response agency. ( )

31. Trauma. The result of an act or event that damages, harms, or hurts a human being resulting in intentional or unintentional damage to the body resulting from acute exposure to mechanical, thermal, electrical, or chemical energy, or from the absence of such essentials as heat or oxygen. ( )

32. TSE Designated Center. A facility that has voluntarily applied for TSE designation, has met designation criteria, remains in compliance with the designation criteria of these rules, and that the TSE Council has designated as one (1) or more of the following: ( )

a. Level I Trauma Center; ( )

b. Level II Trauma Center; ( )

c. Level III Trauma Center; ( )

d. Level IV Trauma Center; ( )

e. Level V Trauma Center; ( )

f. Pediatric Level I Trauma Center; or ( )

g. Pediatric Level II Trauma Center; ( )

h. Level I Stroke Center (Comprehensive); ( )

i. Level II+ Stroke Center (Thrombectomy Capable); ( )

j. Level II Stroke Center (Primary); or ( )

k. Level III Stroke Center (Acute Stroke Ready); ( )

l. Level I+ STEMI Center (Cardiogenic Shock Capable); ( )

m. Level I STEMI Center (Heart Attack Receiving); or ( )

n. Level II STEMI Center (Heart Attack Referring). ( )

33. TSE Registry. The population-based data system defined under Section 57-2003, Idaho Code. ( )

34. TSE System. An organized statewide approach to treating trauma, stroke, and heart attack patients that establishes and promotes standards for patient transportation, equipment, and information analysis for effective and coordinated TSE care. ( )

009. – 099. (RESERVED)

SUBPART B – AGENCY LICENSING REQUIREMENTS (Sections 100 - 299)

SUBAREA B1: EMS AGENCY GENERAL LICENSURE REQUIREMENT (Sections 100 - 104)

100. AGENCY LICENSE REQUIRED.
Any organization that advertises or provides ambulance, air medical, or non-transport EMS in Idaho must be licensed as an EMS agency under Sections 56-1011 through 56-1023, Idaho Code, and these rules. ( )

101. EXEMPTION OF EMS AGENCY LICENSURE.
An organization, licensed without restriction to provide EMS in another state and not restricted from operating in Idaho by the EMS Bureau, may provide EMS in Idaho within the limits of its license without an Idaho EMS license only when the organization meets one (1) of the following: ( )

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

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

03. Transfer of Patient From Out-of-State Medical Facility. The organization is transferring a patient from an out-of-state medical facility: ( )

a. To a medical facility in Idaho. The organization may return the patient to the point of origin; or ( )

b. Through the state of Idaho. ( )

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

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

b. To a rendezvous with another ambulance. ( )

102. SERVICES PROVIDED BY A LICENSED EMS AGENCY.
An EMS agency can provide only those services that are within the agency's service types and clinical levels stated on the most recent license issued by the EMS Bureau, except when the agency has a planned deployment agreement described in these rules. ( )

103. ELIGIBILITY FOR EMS AGENCY LICENSURE.

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

104. (RESERVED)

SUBAREA B2: EMS AGENCY LICENSURE MODEL
(Sections 105 - 119)

105. EMS AGENCY-- LICENSING MODEL.

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

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

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

04. Multiple Organization EMS Agency. An EMS agency may be comprised of multiple organizations licensed under a single responsible authority to which the governing officials of each organization agree. The authority must establish a deployment strategy that declares in which areas and at what times within their geographical response area will be covered by the declared service types and clinical levels. ( )

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

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

a. 911 Response Transport Service. Available to an agency that provides emergency medical care at emergency scenes, during transports or transfers, and has the primary responsibility of responding to 911 calls dispatched by a Public Safety Answering Point (PSAP) or Consolidated Emergency Communication System (CECS) within a specified geographical area. ( )

b. Transport Service. Available to an agency that provides emergency medical care during transports or transfers but does not respond to 911 calls. Transport services only respond to calls using emergency driving procedures for emergency hospital-to-hospital transfers and when requested by a CECS, PSAP, or a 911 Response agency. ( )

02. Non-Transport Service Types. An agency that is licensed as a non-transport service is not intended for patient transport or transfers and cannot advertise ambulance services. ( )

a. 911 Response Non-Transport Service. Available to an agency that provides emergency medical care at an emergency scene and has the primary responsibility of responding to 911 calls dispatched by a CECS or PSAP within a specified geographical area. ( )

b. Non-Transport Service. Available to an agency that provides emergency medical care but does not respond to 911 calls or respond to calls using emergency driving procedures unless requested by a CECS, PSAP, or a 911 Response agency. ( )

03. Air Medical Service Types. An agency that is licensed with an air medical service type is intended for patient transport, transfer, or rescue. ( )

a. Air Medical Transport Service. Available to an agency that provides air medical response and transport of patients from emergency scenes and hospitals utilizing a fixed-wing or rotary-wing air ambulance. ( )

b. Air Medical Rescue Service. Available to an agency that provides air medical response via fixed-wing or rotary-wing aircraft to emergency scenes for transportation of patients from an emergency scene to a rendezvous with a ground or air medical transport agency. ( )

107. EMS AGENCY – CLINICAL LEVELS.
An EMS agency is licensed at one (1) or more of the following clinical levels depending on the agency's highest level of licensed personnel and life support services advertised or offered, and provided according to requirements per the incorporated EMSPC Standards Manual. ( )

01. Basic Life Support (BLS). Deploys licensed EMS personnel trained and equipped to provide all EMR or EMT skills. ( )

02. Intermediate Life Support (ILS). Deploys licensed EMS personnel trained and equipped to provide Advanced EMT skills. ( )

03. Advanced Life Support (ALS). Deploys licensed EMS personnel trained and equipped to provide Paramedic skills. ( )

108. EMS AGENCY -- SPECIALTY SERVICES.
Each EMS agency offering the following specialty services must report such services to the EMS Bureau. ( )

01. Critical Care (CC). The provision of EMS personnel trained, credentialed, and equipped to provide all critical care skills and required staffing per the incorporated EMSPC Standards Manual. ( )

02. Community Health EMS (CHEMS). The provision of evaluation, advice, or treatment of eligible recipients outside of a hospital setting as part of a community-based team of health and social services providers as authorized by local medical control. ( )

a. Clinical treatments and patient assessments cannot exceed the agency's licensed clinical level. ( )

b. Community Health EMS involving or related to emergency response must be provided by or in coordination with the primary 911 Response Transport agency for that area. ( )

03. Tactical EMS (TEMS). The provision of emergency medical care in support of law enforcement activities. ( )

a. The Tactical EMS specialty service must be formally affiliated with one (1) or more local law enforcement agencies. ( )

b. Clinical treatments of patients cannot exceed the agency's licensed clinical level unless authorized by the EMSPC. ( )

04. Special Pathogen Transport (SPT). The provision of emergency medical care and transport of patients suffering from exposure or disease caused by highly infectious special pathogens. ( )

109. (RESERVED)

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

A non-transport agency can move a patient by vehicle only when: ( )

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

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

a. EMT level or higher; or ( )

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

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

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

111. – 119. (RESERVED)

SUBAREA B3: PERSONNEL REQUIREMENTS FOR EMS AGENCY LICENSURE (Sections 120 - 129)

120. EMS AGENCY – GENERAL PERSONNEL REQUIREMENTS.
Personnel must be licensed as described in these rules. ( )

01. Personnel Requirements for EMS Agency Licensure. Each agency must ensure availability of affiliated personnel licensed and credentialed at or above the clinical level for the entire anticipated call volume, except that an agency holding a 911 Response Transport or 911 Response Non-transport license may request a waiver of this requirement from the EMS Bureau. ( )

02. Personnel Requirements for an Agency Utilizing Emergency Medical Dispatch. An agency dispatched by a CECS that uses an emergency medical dispatch (EMD) process to determine the clinical needs of the patient must ensure availability of personnel licensed and credentialed at clinical levels appropriate to the anticipated call volume for each of the clinical levels the agency provides. ( )

03. Personnel Requirements for an Agency Utilizing Ambulance-Based Clinicians. An agency may use ambulance-based clinicians to meet the licensed personnel requirements for agency licensure as follows: ( )

a. 911 Response Transport, or 911 Response Non-transport Service licensed at the BLS or ILS clinical level. ( )

b. Transport Service licensed at the ALS clinical level. ( )

121. EMS AGENCY -- SPECIALTY SERVICE PERSONNEL REQUIREMENTS.
Each EMS agency offering specialty services as described in these rules is responsible for reporting personnel trained and credentialed to provide those services to the EMS Bureau. ( )

01. Critical Care. EMS personnel must have been formally trained, credentialed, and equipped to provide all critical care skills per the incorporated EMSPC Standards Manual. ( )

02. Community Health EMS. Licensed EMS personnel must have received standardized CHEMS training recognized by the EMS Bureau to participate in patient care related to CHEMS. ( )

03. Tactical EMS. Licensed EMS personnel must have received specialized training to provide emergency medical care in support of law enforcement activities. ( )

04. Special Pathogens Transport. Licensed EMS personnel must have received specialized training specific to the transport of patients suffering from exposure or disease caused by highly infectious special pathogens. Such training must include, at a minimum, proper use of appropriate PPE, avoiding disease exposure, use of specialized equipment and containment systems used during transport, crew member and public safety concerns, and proper waste management. ( )

122. AMBULANCE SERVICE -- PERSONNEL REQUIREMENTS.
Each ambulance service must ensure that there is one (1) EMS provider providing patient care, not including the driver, on each patient transport or transfer. The crew member providing patient care, at a minimum, must be a licensed EMR with an ambulance certification or a licensed EMT. ( )

01. Emergency Scene ALS. A licensed paramedic must be present whenever ALS services are provided at an emergency scene or during patient transport to a medical facility. ( )

02. Interfacility Transfers ALS. ( )

a. A licensed paramedic or ambulance-based clinician must provide ALS services during interfacility transfers. ( )

b. A BLS or ILS 911 Response Transport Service may conduct ALS interfacility transfers with a licensed paramedic or ambulance-based clinician if equipped with ALS equipment necessary to provide appropriate patient care and ALS interventions. ( )

03. Critical Care. A minimum of one (1) credentialed critical care provider and one (1) additional paramedic or ambulance-based clinician are required in the patient compartment during patient transport. Special consideration may be given for the second provider based on a specific specialized patient need. ( )

123. AIR MEDICAL TRANSPORT SERVICE -- PERSONNEL REQUIREMENTS.
Each air medical transport service must ensure that the standard medical flight crew consists of, at a minimum, one (1) licensed Paramedic and one (1) licensed Registered Nurse. At least one (1) crew member on each flight must hold critical care credentials per the incorporated EMSPC Standards Manual. Air Medical Transport Services may utilize alternate medical crew configurations for specific situations as stated below: ( )

01. Emergency Scene Transports. Alternate crew configurations for emergency scene response and patient transport. ( )

a. Two (2) Paramedics. ( )

b. When no other crew with a licensed Paramedic and no other Air Medical Transport Service with a Paramedic crew member is available, an Air Medical Transport Service may deploy a crew of two (2) licensed Registered Nurses. ( )

02. Interfacility Transfers. Alternate crew configurations for interfacility transfers, based on patient need. ( )

a. Two (2) Registered Nurses. ( )

b. One (1) Registered Nurse and One (1) Respiratory Therapist. ( )

c. Two (2) Paramedics when both possess critical care credentials as described in the incorporated EMSPC Standards Manual. ( )

124. PERSONNEL FOR AIR MEDICAL RESCUE SERVICE.
An Air Medical Rescue service must ensure that each flight includes a minimum of one (1) patient care provider

licensed at or above the agency's clinical level of licensure, not including the pilot. The crew member providing patient care, at a minimum, must be a licensed EMT. ( )

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

126. AMBULANCE-BASED CLINICIANS -- PERSONNEL REQUIREMENTS.

01. Ambulance-Based Clinician Certified by the EMS Bureau. An EMS agency that advertises or provides out-of-hospital patient care by affiliating and utilizing a currently licensed registered nurse, advanced practice registered nurse, or physician assistant, must ensure that those individuals maintain a current ambulance-based clinician certificate issued by the EMS Bureau. See Section 127 of these rules for exceptions to this requirement. ( )

02. Obtaining an Ambulance-Based Clinician Certificate. An agency, on behalf of an individual who desires an ambulance-based clinician certificate, must provide on the EMS Bureau's application documentation that the individual: ( )

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

b. Has successfully completed an EMS Bureau-approved ambulance-based clinician training; or ( )

c. Has successfully completed an EMT course. ( )

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

04. Revocation of an Ambulance-Based Clinician Certificate. The EMS Bureau may revoke an ambulance-based clinician certificate based on the procedures for administrative license actions described in these rules. ( )

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

127. UTILIZING PHYSICIAN ASSISTANTS, REGISTERED NURSES, OR ADVANCED PRACTICE REGISTERED NURSES.
An AEMT/ILS ambulance agency may use a non-certified physician assistant, licensed registered nurse, or advanced practice registered nurse as the crew member who is providing ILS patient services, only when accompanied by a licensed EMR with an ambulance certification or a licensed EMT in the patient compartment of the transport vehicle. ( )

128. -- 129. (RESERVED)

SUBAREA B4: EMS AGENCY VEHICLE REQUIREMENTS
(Sections 130 - 139)

130. EMS AGENCY -- VEHICLE REQUIREMENTS.

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

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

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

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

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

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

131. NON-TRANSPORT EMS AGENCY -- VEHICLES.
A licensed non-transport EMS agency may use ambulance vehicles to provide non-transport services. ( )

132. EMS AGENCY -- MINIMUM EQUIPMENT INSPECTION REQUIREMENTS.
Any newly acquired EMS response vehicle must be inspected by the EMS Bureau for medical care supplies and devices as specified in the "Minimum Equipment Standards for Licensed EMS Services" document incorporated in these rules before being put into service, except when the newly acquired vehicle is a replacement vehicle and all equipment and supplies are transferred from the vehicle being taken out of service. ( )

133. EMS AGENCY -- GROUND VEHICLE SAFETY INSPECTION REQUIREMENTS.
Each EMS agency that deploys emergency vehicles titled and registered for use on roads and highways, except for all-terrain vehicles and utility vehicles, must meet the following. ( )

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

02. Response Vehicle Involved in a Crash. Each EMS response vehicle, that is involved in a crash that could result in damage to one (1) or more of the vehicle systems identified in Subsection 133.03 of this rule, has passed a safety inspection conducted by an inspector authorized to perform DOT vehicle safety inspections prior to being put back in service. ( )

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

04. Vehicle Inspection Records. Each EMS agency keeps records of all emergency response vehicle safety inspections and are available to the EMS Bureau upon request. ( )

134. -- 139. (RESERVED)

SUBAREA B5: EMS AGENCY REQUIREMENTS AND WAIVERS
(Sections 140 - 179)

140. EMS AGENCY -- GENERAL EQUIPMENT REQUIREMENTS AND MODIFICATIONS.
Each EMS agency must meet the requirements of the incorporated Minimum Equipment Standards document, in addition to the following: ( )

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

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

03. Modifications to an EMS Agency's Minimum Equipment List. An EMS agency's minimum equipment list may be modified upon approval by the EMS Bureau. Requests for equipment modifications are submitted to the EMS Bureau and include clinical and operational justification for the modification and are signed by the EMS agency's medical director. Approved modifications are granted by the EMS Bureau as either an exception or an exemption. ( )

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

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

04. Review of an Equipment Modification Request. Each request from an EMS agency for equipment modification will be reviewed by the EMS Bureau and may be reviewed by the EMSPC. The recommendations from EMSPC are submitted to the EMS Bureau which has the final authority to approve or deny the modification request. ( )

05. Denial of an Equipment Modification Request. An EMS agency may appeal the denial of an equipment modification request under Title 67, Chapter 52, Idaho Code. ( )

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

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

b. When the EMS agency changes its medical director. ( )

141. AIR MEDICAL EMS AGENCY -- EQUIPMENT REQUIREMENTS AND MODIFICATIONS.
Each air medical agency must meet the requirements under Section 140 of these rules, and the following: ( )

01. FAA 135 Certification. The air medical agency holds a Federal Aviation Administration 135 certification. ( )

02. Configuration and Equipment Standards. Aircraft and equipment configuration that does not compromise the ability to provide appropriate care or prevent emergency care providers from safely performing emergency procedures, if necessary, while in flight. ( )

142. -- 149. (RESERVED)

150. EMS AGENCY -- COMMUNICATION REQUIREMENTS.
Each EMS agency must meet the following to obtain or maintain agency licensure. ( )

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

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

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

151. EMS AGENCY -- DISPATCH REQUIREMENTS.

01. Twenty-four Hour Dispatch Arrangement. Each EMS agency must have a twenty-four (24) hour dispatch arrangement, except an agency with a twenty-four (24) hour response waiver may have a dispatch arrangement specific to the waiver deployment plan. ( )

02. Incoming Requests for Out-of-Hospital Response. Each ambulance agency that is not dispatched by a CECS or PSAP must record incoming requests for out-of-hospital transports and retain such recordings for a period of one (1) year. ( )

152. -- 159. (RESERVED)

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

161. NON-TRANSPORT EMS AGENCY -- WAIVER OF RESPONSE REQUIREMENT.
The controlling authority of a non-transport agency may petition the EMS Bureau for a waiver of the twenty-four (24) hour response requirement if one (1) or more of the following exist: ( )

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

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

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

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

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

01. Petition for Waiver. The controlling authority of an existing non-transport agency desiring a waiver of the twenty-four (24) hour response requirement must submit a petition for waiver to the EMS Bureau and provide the information described under the incorporated EMS Agency Standards Manual document. ( )

02. Waiver Declared on Initial Application. The controlling authority of an applicant non-transport agency desiring a waiver of the twenty-four (24) hour response requirement must declare the request for waiver on the initial application for agency licensure to the EMS Bureau and provide the information described under the incorporated document in the incorporated EMS Agency Standards Manual document. ( )

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

163. -- 164. (RESERVED)

165. AMBULANCE OR AIR MEDICAL EMS AGENCY -- WAIVER OF RESPONSE REQUIREMENT.
The controlling authority of an existing ambulance or air medical agency may petition the EMS Bureau for a waiver of the twenty-four (24) hour response requirement if one (1) or more of the following exist as a result of the provision of twenty-four (24) hour response: ( )

01. Undue Hardship on the Community Being Served by the Agency. ( )

02. Abandonment of the Service by the Agency. ( )

166. AMBULANCE OR AIR MEDICAL EMS AGENCY -- PETITION FOR WAIVER.
The controlling authority of an existing ambulance or air medical agency desiring a waiver of the twenty-four (24) hour response requirement must submit a petition for waiver to the EMS Bureau and provide the information described in the incorporated EMS Agency Standards Manual document. ( )

167. -- 169. (RESERVED)

170. EMS AGENCY -- MEDICAL SUPERVISION REQUIREMENTS.
Each EMS agency must comply with medical supervision plan requirements and designate a physician as the agency medical director who is responsible for the supervision of medical activities per the incorporated EMSPC Standards Manual ( )

171. -- 174. (RESERVED)

175. RECORDS, DATA COLLECTION, AND SUBMISSION REQUIREMENTS.
Each licensed EMS agency must collect and submit EMS response records to the EMS Bureau as follows: ( )

01. Records to be Maintained. Include a Patient Care Report completed for each EMS Response. ( )

02. Records to be Submitted. Ensure that an accurate and complete electronic Patient Care Report (ePCR) is submitted to the EMS Bureau using approved and validated software in a format determined by the EMS Bureau. ( )

03. Time Frame for Submitting Records. Submit each month's data to the EMS Bureau by the 15th of the following month in a format determined by the EMS Bureau. ( )

176. -- 179. (RESERVED)

SUBAREA B6: EMS AGENCY AGREEMENTS, PLANS, AND POLICIES (Sections 180 - 199)

180. EMS AGENCY -- AGREEMENTS, PLANS, AND POLICIES.
When applicable, each EMS agency must make the following agreements, plans, and policies available to the EMS Bureau upon request. ( )

181. EMS AGENCY – AMBULANCE SERVICE RESPONSE AGREEMENTS.
Each EMS agency with out-of-hospital customer service agreements to provide ambulance services that are not dispatched by the local CECS or PSAP must provide the customer with written criteria to reasonably identify potential medical emergencies that should be referred to a CECS or PSAP for dispatch of a 911 Response agency unless a staffed ambulance is already on site at the patient's location. ( )

182. EMS AGENCY -- PATIENT CARE INTEGRATION.

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

02. Cooperative Agreement for Non-Transport Agency. Each 911 Response non-transport EMS agency must have a cooperative written agreement with each of the 911 Response Transport Services that provide response and patient transportation within that geographical area. The agreement must address integration of patient care between the agencies. A non-transport agency may not provide a level of care that exceeds the clinical level of the responding 911 Response Transport Service unless the integration plan specifically addresses the continuation of the higher level of care throughout the patient transport. ( )

183. AIR MEDICAL EMS AGENCY -- PATIENT CARE INTEGRATION.
Each air medical agency must declare and make available its patient care integration policies to the EMS Bureau upon request. ( )

184. EMS AGENCY -- PLANNED DEPLOYMENT AGREEMENTS.
Each EMS agency that utilizes a planned deployment must develop a cooperative planned deployment agreement between the EMS agencies under the incorporated EMS Agency Standards Manual document. ( )

185. -- 189. (RESERVED)

190. AIR MEDICAL EMS AGENCY -- REQUIRED POLICIES.
Each air medical EMS agency must have the following policies on file with the EMS Bureau as described under the incorporated EMS Agency Standards Manual document: ( )

01. Non-Discrimination Policy. ( )

02. Weather Turn Down Policy. ( )

03. Patient Destination Procedure. ( )

04. Safety Program Policy. ( )

05. Training Policy. ( )

191. -- 199. (RESERVED)

SUBAREA B7: EMS AGENCY UTILIZATION OF AIR MEDICAL SERVICES (Sections 200 - 219)

200. EMS AGENCY -- CRITERIA TO REQUEST AN AIR MEDICAL RESPONSE.
Each ground EMS agency must establish written criteria as described in the incorporated EMS Agency Standards Manual document for the agency's licensed EMS personnel that provides decision-making guidance for requesting an air medical response to an emergency scene. This criteria must be approved by the agency's medical director. ( )

201. EMS AGENCY -- EMS PERSONNEL REQUEST FOR AIR MEDICAL RESPONSE.
Licensed EMS personnel en route to, or at, the emergency scene have the primary responsibility and authority to request the response of air medical services using the local incident management system and licensed EMS agency written criteria under the incorporated EMS Agency Standards Manual document. ( )

202. EMS AGENCY -- CANCELLATION OF AN AIR MEDICAL RESPONSE.
Following dispatch of air medical services, an air medical response may only be canceled upon completion of a

patient assessment performed by licensed EMS personnel. ( )

203. EMS AGENCY -- ESTABLISHED CRITERIA FOR SIMULTANEOUS DISPATCH.
Under the incorporated EMS Agency Standards Manual document, a ground EMS agency may establish criteria for simultaneous dispatch for air and ground medical response. ( )

204. EMS AGENCY-- SELECTION OF AIR MEDICAL AGENCY.
Each EMS agency has the responsibility to select an appropriate air medical service and have on file selection policies as described in the incorporated EMS Agency Standards Manual document. ( )

205. -- 209. (RESERVED)

210. EMS AGENCY -- LANDING ZONE PROCEDURES FOR AIR MEDICAL RESPONSE.
A licensed ambulance or non-transport EMS agency in conjunction with an air medical agency must have written procedures for the establishment of a landing zone. These procedures must be compatible with the local incident management system. ( )

211. EMS AGENCY -- REVIEW OF AIR MEDICAL RESPONSES.
Each EMS agency must provide incident-specific patient care related data identified and requested by the EMS Bureau in the review of air medical response criteria. ( )

212. -- 219. (RESERVED)

SUBAREA B8: EMS AGENCY INSPECTIONS (Sections 220 - 249)

220. EMS AGENCY -- INSPECTIONS BY THE EMS BUREAU.
The EMS Bureau is authorized to enter an agency's facility at reasonable times to inspect an agency's vehicles, equipment, response records, and other necessary items to determine that the EMS agency is in compliance with Idaho statutes and administrative rules. ( )

221. EMS AGENCY -- INSPECTION REQUESTS AND SCHEDULING.
An applicant eligible for agency inspection must contact the EMS Bureau to schedule an inspection. In the event that the acquisition of capital equipment, hiring, or licensure of personnel is necessary for the inspection process, the applicant must notify the EMS Bureau when ready for the inspection. ( )

222. EMS AGENCY -- INSPECTION TIMEFRAME AFTER NOTIFICATION OF ELIGIBILITY.
An applicant must schedule and have an inspection completed within six (6) months of notification of eligibility by the EMS Bureau. An application without an inspection completed within six (6) months is void and must be resubmitted as an initial application. ( )

223. -- 224. (RESERVED)

225. EMS AGENCY -- INITIAL AGENCY INSPECTION.
The EMS Bureau will perform an initial inspection, which is an integral component of the application process, to ensure the EMS agency applicant is complying with the following: ( )

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

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

226. EMS AGENCY -- DEMONSTRATION OF CAPABILITIES DURING INSPECTION.
The EMS Bureau will review historical and current information during the annual, random, and targeted inspections whereas an applicant must demonstrate the following during the initial inspection process: ( )

01. Validation of Ability to Submit Data. Each EMS agency applicant must demonstrate the ability to

submit data described in these rules. ( )

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

227. -- 229. (RESERVED)

230. EMS AGENCY -- CONDITION THAT RESULTS IN VEHICLE OR AGENCY OUT OF SERVICE.
Upon discovery of a condition during inspection that could reasonably pose an immediate threat to the safety of the public or agency staff, the EMS Bureau may declare the condition unsafe and remove the vehicle or agency from service until the unsafe condition is corrected. ( )

231. -- 239. (RESERVED)

240. EMS AGENCY -- EXEMPTIONS FOR AGENCIES CURRENTLY ACCREDITED BY A NATIONALLY RECOGNIZED PROFESSIONAL EMS ACCREDITATION AGENCY.
Upon petition by the accredited agency, the EMS Bureau will review the accreditation standards under which the accredited agency was measured and may waive specific duplicated annual inspection requirements where appropriate. If an external accreditation inspection is found to be more rigorous than that of the EMS Bureau, the EMS Bureau may elect to relax the frequency of annual inspections or waive annual inspections altogether. ( )

241. -- 249. (RESERVED)

SUBAREA B9: EMS AGENCY LICENSURE PROCESS (Sections 250 - 299)

250. EMS AGENCY -- APPLICATION FOR INITIAL LICENSURE.
To be considered for initial EMS agency licensure, an organization seeking licensure must request, complete, and submit the standardized EMS agency initial license application form provided by the EMS Bureau. ( )

251. EMS AGENCY -- LICENSURE EXPIRATION.
Each EMS agency license, unless otherwise declared on the license, is valid for one (1) year from the end of the month of issuance by the EMS Bureau. ( )

252. -- 259. (RESERVED)

260. LAPSED LICENSE.

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

02. Grace Period. No grace periods or extensions to an expiration date will be granted when an agency has not submitted a completed renewal application on, or before, the date the current license expires. ( )

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

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

261. -- 269. (RESERVED)

270. EMS AGENCY LICENSE -- NONTRANSFERABLE.
An EMS agency license issued by the EMS Bureau cannot be transferred or sold. ( )

271. CHANGES TO A CURRENT LICENSE.
An agency's officials must submit an agency update to the EMS Bureau within sixty (60) days of any of the following: ( )

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

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

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

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

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

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

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

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

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

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

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

d. An agency that intends to add a 911 Response to an Ambulance Service license or Non-Transport Service license. ( )

272. -- 279. (RESERVED)

280. TIME SENSITIVE EMERGENCY CERTIFICATION.
The EMS Bureau will certify an EMS Agency as a TSE Designated EMS Agency when such agency, upon proper application and verification, is found to meet the applicable designation criteria under the incorporated EMS Agency Standards Manual document. ( )

281. -- 299. (RESERVED)

SUBPART C – PERSONNEL LICENSING REQUIREMENTS (Sections 300 - 399)

300. STANDARDS OF PROFESSIONAL CONDUCT FOR EMS PERSONNEL.

01. Method of Treatment. EMS personnel must practice medically acceptable methods of treatment and must not endeavor to extend their practice beyond their competence and the authority vested in them by the medical director. EMS personnel must not perform any medical procedure or provide medication that deviated from or exceeds the scope of practice for the corresponding level of licensure established per these rules and the incorporated EMSPC Standards Manual. ( )

02. Knowledge and Proficiency. EMS personnel must maintain standards of knowledge and proficiency as required by this chapter of rules and the incorporated EMSPC Standards Manual. ( )

03. Respect for the Patient. EMS personnel must provide all services with respect for the dignity of the patient, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems. ( )

04. Confidentiality. EMS personnel must hold in strict confidence all privileged information concerning the patient except as disclosure or use of this information is permitted or required by law or EMS Bureau rule. ( )

05. Conflict of Interest. EMS personnel must not accept gratuities for preferential consideration of the patient and must guard against conflicts of interest. ( )

06. Professionalism. EMS personnel must uphold the dignity and honor of the profession and abide by its ethical principles and must be familiar with existing laws governing the practice of emergency medical services and comply with those laws. EMS personnel must never perform duties of the profession while under the influence of alcohol, illegal substances, or legal drugs or medication causing impairment of function. ( )

07. Cooperation and Participation. EMS personnel must cooperate with other health care professionals and participate in activities to promote community and national efforts to meet the health needs of the public. ( )

08. Ethical Responsibility. EMS personnel must refuse to participate in unethical procedures, and assume the responsibility to expose incompetence or unethical conduct of others to the appropriate authority in a proper and professional manner. Misrepresentation in an application or documentation for licensure by means of concealment of a material fact is a violation of ethical responsibility. ( )

09. Integrity. EMS personnel must act with honesty and integrity and assure that reports, applications and documentation for which they are responsible are free of fraudulent and false information. ( )

301. -- 304. (RESERVED)

305. ADVANCE DO NOT RESUSCITATE (DNR) DIRECTIVES.
Licensed EMS personnel must follow the DNR protocol established by the EMS Bureau. ( )

306. -- 309. (RESERVED)

SUBAREA C1: PERSONNEL LICENSURE REQUIREMENTS (Sections 310 - 374)

310. PERSONNEL LICENSURE REQUIRED.
Any individual who provides emergency medical care must obtain and maintain a current EMS personnel license issued by the EMS Bureau, or recognition by the EMS Bureau as described in these rules. The levels of Idaho personnel licensure are: ( )

01. Emergency Medical Responder (EMR). ( )

02. Emergency Medical Technician (EMT). ( )

03. Advanced Emergency Medical Technician (AEMT). ( )

04. Paramedic. ( )

311. AFFILIATION REQUIRED TO PRACTICE.
Licensed EMS personnel must be affiliated with an EMS agency, and only practice under the supervision of the agency medical director as required in these rules and the incorporated EMSPC Standards Manual. ( )

312 -- 314. (RESERVED)

315. RECOGNITION OF EMS PERSONNEL LICENSURE INTERSTATE COMPACT (REPLICA).

01. Licensed EMS Personnel from a REPLICA Member State. Obtaining an Idaho EMS personnel license is not required as long as a REPLICA member state license is maintained. An individual who possesses a current, valid, and unrestricted EMS personnel license from a REPLICA member state, upon request by the individual, will be issued an Idaho EMS personnel license at the same level of licensure as the REPLICA home state license provided the individual is affiliated with an Idaho licensed EMS agency. ( )

316 -- 319. (RESERVED)

320. APPLICATION AND INSTRUCTIONS FOR EMS PERSONNEL LICENSURE.
A personnel license or certificate of eligibility application and instructions may be obtained from the EMS Bureau, see online at: http://www.idahoems.org. ( )

321. TIME FRAME FOR PERSONNEL LICENSURE AFTER SUCCESSFUL COMPLETION OF EDUCATION COURSE.
An individual who has successfully completed an EMS education course is eligible to attempt the standardized examination for the appropriate level of licensure. ( )

01. Standardized Examination. A candidate must successfully complete all components of the standardized examination within twenty-four (24) months of completing an EMS training course in order to be eligible for an Idaho EMS personnel license. ( )

02. Examination Not Completed. If all components of the standardized examination are not successfully completed period within twenty-four (24) months of course completion, the candidate must repeat the initial training course and all components of the standardized examination in order to be eligible for an Idaho EMS personnel license. ( )

322 -- 324. (RESERVED)

325. LICENSURE OF MEMBERS OF THE MILITARY, VETERANS, AND SPOUSES.
A member of the military, a former member of the military after discharge under honorable conditions, a veteran, or a spouse of any such person who possesses a current, valid, and unrestricted EMS personnel license in another state, district, or territory of the United States is eligible for EMS personnel licensure in Idaho as follows: ( )

01. REPLICA State License. Those personnel who have a license from a REPLICA state are licensed under Section 315 of these rules; ( )

02. Non-REPLICA License. Those personnel who have a license from a non-REPLICA state are licensed under Section 326 of these rules. ( )

326. QUALIFICATIONS FOR LICENSURE BY ENDORSEMENT -- MEMBERS OF THE MILITARY, VETERANS, AND SPOUSES.
Members of the military, veterans, and their spouses may apply to the EMS Bureau for licensure by endorsement provided they meet the following: ( )

01. License from Another Jurisdiction. Possess a current, valid, and unrestricted EMS personnel license, at the same or higher level as the Idaho license being requested, from another state, district, or territory of the United States. The license of any individual subject to official investigation or disciplinary proceedings is not considered current, valid, and unrestricted. ( )

02. Previous Applications and Licensures. Declare each state or jurisdiction in which they have ever applied for, been denied, or held an EMS license or certification. ( )

03. Release of Information. Provide authorization for the EMS authority in other states or jurisdictions to release the candidate's registration, licensure, and certification information to the Idaho EMS Bureau. ( )

04. Current Affiliation with EMS Agency. Declare all organizations in which they are allowed to practice as licensed personnel. A candidate must have a current affiliation with a licensed EMS agency that functions at, or above, the level of licensure being sought by the candidate. ( )

05. Identification. Have a valid state driver's license, an Idaho identification card issued by a county driver's license examining station, or an identification card issued by the armed forces of the United States. ( )

327 -- 329. (RESERVED)

330. INITIAL PERSONNEL LICENSURE.
Upon successful completion of an approved education course recognized by the EMS Bureau an individual may apply to the EMS Bureau for licensure. The candidate must meet the following: ( )

01. Age Requirements. An individual applying for licensure must meet the following age requirements: ( )

a. An EMR and EMT candidate must be either sixteen (16) or seventeen (17) years old with parental or legal guardian consent, or eighteen (18) years old. ( )

b. An AEMT and Paramedic candidate must be eighteen (18) year old. ( )

02. Previous Applications and Licensures. A candidate must declare each state or jurisdiction in which they have applied for, been denied, or held an EMS license or certification. ( )

03. Release of Information. A candidate must provide authorization for the EMS authority in other states or jurisdictions to release the candidate's registration, licensure, and certification information to the Idaho EMS Bureau. ( )

04. Affiliation with EMS Agency. A candidate must declare all organizations in which they are allowed to practice as licensed personnel. A candidate must have a current affiliation with a licensed EMS agency that functions at, or above, the level of licensure being sought by the candidate. ( )

05. Identification. A candidate must have a valid state driver's license, an Idaho identification card issued by a county driver's license examining station, or an identification card issued by the Armed Forces of the United States. ( )

06. Criminal History and Background Check. A candidate must successfully complete a criminal history and background check. ( )

07. Standardized Examination. A candidate must successfully complete the standardized examination for the level of licensure on the application required under Section 430 of these rules. Current NREMT registration at the level of licensure requested or higher meets the examination requirement. ( )

a. A candidate for EMR licensure must have successfully completed the standardized examination at the EMR level or higher within the preceding thirty-six (36) months. ( )

b. A candidate for EMT licensure must have successfully completed the standardized examination at the EMT level or higher within the preceding thirty-six (36) months. ( )

c. A candidate for AEMT licensure must have successfully completed the standardized examination at the AEMT level or higher within the preceding twenty-four (24) months. ( )

d. A candidate for Paramedic licensure must have successfully completed the standardized examination at the Paramedic level within the preceding twenty-four (24) months. ( )

08. Exam Attempts For Initial Licensure. A candidate for initial licensure is allowed to attempt to

successfully pass the standardized exam as follows: ( )

a. An EMR candidate is allowed three (3) attempts to pass the exam, after which the initial EMR course must be successfully completed again before another three (3) attempts are allowed. ( )

b. An EMT candidate is allowed three (3) attempts to pass the exam, after which twenty-four (24) hours of remedial education must be successfully completed before another three (3) attempts are allowed. ( )

c. An AEMT candidate is allowed three (3) attempts to pass the exam, after which thirty-six (36) hours of remedial education must be successfully completed before another three (3) attempts are allowed. ( )

d. A Paramedic candidate is allowed three (3) attempts to pass the exam, after which forty-eight (48) hours of remedial education must be successfully completed before another three (3) attempts are allowed. ( )

09. Licensure Fee. A candidate for AEMT or Paramedic licensure must submit the applicable initial licensure fee provided in Section 331 of these rules. ( )

331. APPLICATION FEES FOR PERSONNEL LICENSURE.

01. Initial. A candidate applying for an initial personnel license must submit the following license fee at time of application: ( )

a. EMR and EMT have no license fee. ( )

b. AEMT and Paramedic license fee is thirty-five dollars ($35). ( )

c. There is no initial licensure fee for members of the military, former members of the military after discharge under honorable conditions, veterans, and their spouses who are applying under Section 325 of these rules. ( )

d. There is no initial licensure fee for personnel from a REPLICA member state applying under Section 315 of these rules. ( )

02. Renewal. A candidate applying for personnel license renewal must submit the following amount at the time of application: ( )

a. EMR and EMT have no license renewal fee. ( )

b. AEMT and Paramedic license renewal fee is twenty-five dollars ($25). ( )

03. Reinstatement. A candidate applying for a personnel license reinstatement must pay the following amount at the time of application: ( )

a. EMR and EMT have no reinstatement fee. ( )

b. AEMT and Paramedic reinstatement fee is thirty-five dollars ($35). ( )

332. -- 334. (RESERVED)

335. EMS PERSONNEL LICENSE DURATION.

Duration of a personnel license is determined using the following specified time intervals. ( )

01. Initial License Duration for EMR and EMT. EMR and EMT personnel licenses expire on March 31 or September 30. Expiration dates for EMR and EMT initial licenses are set for not less than thirty-six (36) months and not more than forty-two (42) months from the date of issue in order to establish an expiration date of March 31 or September 30. ( )

02. Initial License Duration for AEMT and Paramedic. AEMT and Paramedic personnel licenses expire on March 31 or September 30. Expiration dates for AEMT and Paramedic initial licenses are set for not less than twenty-four (24) months and not more than thirty (30) months from the date of issue in order to establish an expiration date of March 31 or September 30. ( )

03. Renewal Duration for EMR and EMT Level Licensure. An EMR and EMT level personnel license is renewed for three (3) years. ( )

04. Renewal Duration for AEMT and Paramedic Level Licensure. An AEMT and Paramedic level personnel license is renewed for two (2) years. ( )

05. REPLICA Licensure Duration. EMS personnel from another REPLICA state who become licensed in Idaho will have their Idaho EMS license expire March 31 or September 30 following the expiration of their EMS license from the original state. ( )

336. – 339. (RESERVED)

340. PERSONNEL LICENSE RENEWAL.
Licensed personnel must provide documentation that they meet the following requirements: ( )

01. Affiliation with EMS Agency. A candidate applying for renewal of licensure must be affiliated with a licensed EMS agency which functions at, or above, the level of licensure being renewed. Documentation that the license holder is currently credentialed or undergoing credentialing by an affiliating EMS agency medical director must be submitted as assurance of affiliation for license renewal. ( )

02. Continuing Education for Level of Licensure Renewal. A candidate for renewal of licensure must provide documentation of continuing education consistent with the license holder's level of licensure. All continuing education and skill proficiency requirements must be completed under the provisions in Sections 375 through 399 of these rules. The time frame for continuing education courses must meet the following requirements: ( )

a. All continuing education and skill proficiency requirements for renewal of an initial Idaho personnel license must be completed as follows: ( )

i. For EMR or EMT, within the thirty-six (36) months preceding expiration. ( )

ii. For AEMT and Paramedic, within the twenty-four (24) months preceding expiration. ( )

b. All continuing education and skill proficiency requirements for successive licenses must be completed between the effective and expiration dates of the license being renewed, or according to Section 345.01 of these rules. ( )

c. All continuing education and skill proficiency requirements for renewal of licenses obtained through conversion of a Certificate of Eligibility must be completed as follows: ( )

i. For EMR or EMT, within the thirty-six (36) months preceding expiration. ( )

ii. For AEMT and Paramedic, within the twenty-four (24) months preceding expiration. ( )

d. A licensee certified by a national EMS certification body may petition the EMS Bureau to review the certification standards under which the licensee was certified. The EMS Bureau may waive specific duplicated continuing educational requirements where appropriate. When an external education requirement is found to be more rigorous than these rules, the EMS Bureau may elect to renew a license based on that education. ( )

03. Convictions or Adjudications. A candidate for renewal of licensure must provide a declaration of any misdemeanor or felony adjudications. ( )

04. Time Frame. Documentation of license renewal requirements is due to the EMS Bureau prior to the license expiration date. Failure to submit a complete renewal application by the license expiration date renders the license invalid and the individual must not practice or represent himself as a license holder. ( )

05. Renewal Fees. A candidate for AEMT or Paramedic license renewal must submit the applicable fee provided in Section 331 of these rules. ( )

341. -- 344. (RESERVED)

345. SUBMISSION OF EMS PERSONNEL LICENSURE APPLICATION AND DOCUMENTATION.
Each EMS personnel license holder or candidate is responsible for meeting license renewal requirements and submitting completed license renewal documentation to the EMS Bureau by the current license expiration date. ( )

01. Early Submission. ( )

a. Licensed EMS personnel may submit renewal application and documentation to the EMS Bureau up to six (6) months prior to the current license expiration date. ( )

b. Continuing education (CE) taken after early submission of a renewal application may be counted as CE for the next licensure cycle. Prior to the expiration date of the current license, the licensee must submit written notification to the EMS Bureau of the intention to use those CE hours for the next licensure cycle. ( )

02. Expiration Date on a Non-Work Day. When a license expiration date falls on a weekend, holiday, or other day the EMS Bureau is closed, the EMS Bureau will accept applications until the close of the next regular business day following the non-work day. ( )

346. -- 349. (RESERVED)

350. LAPSED LICENSE.
Licensed personnel who fail to submit a complete renewal application prior to the expiration date of their license cannot practice or represent themselves as licensed EMS personnel. ( )

01. Failure to Submit. No grace periods or extensions to an expiration date may be granted. After the expiration date the EMS personnel license will no longer be valid. ( )

02. Application Under Review. Provided the license renewal candidate submitted the renewal application to the EMS Bureau prior to the application deadline, a personnel license does not lapse while under review by the EMS Bureau. ( )

03. Failure to Provide Application Information. After the expiration date of a license, a candidate for license renewal who does not provide the information requested by the EMS Bureau within twenty-one (21) days from the date of notification to the last known address, will be considered to have a lapsed license. ( )

04. Reinstatement of Lapsed EMS Personnel License. In order to reinstate a lapsed license, a candidate must submit an application for license reinstatement to the EMS Bureau within twenty-four (24) months of the expiration date of the lapsed license and meet the requirements in Section 351 of these rules. ( )

05. Reinstatement of an EMS Personnel License Lapsed for More Than Twenty-Four Months. An individual whose license has been lapsed for more than twenty-four (24) months must retake and successfully complete an initial education course for the level of licensure for reinstatement. The individual must then meet all requirements in Section 330 of these rules for an initial personnel license. ( )

351. REINSTATEMENT OF A LAPSED EMS PERSONNEL LICENSE.
An individual desiring to reinstate a lapsed personnel license must provide documentation that he meets the following requirements: ( )

01. Previous Applications and Licensures. A reinstatement candidate must declare each state or jurisdiction in which he has applied for, been denied, or held an EMS license or certification. ( )

02. Release of Information. A reinstatement candidate must provide authorization for the EMS authority in other states or jurisdictions to release the candidate's registration, licensure, and certification information to the Idaho EMS Bureau. ( )

03. Affiliation with EMS Agency. A reinstatement candidate must declare all organizations in which they are allowed to practice as licensed personnel. The candidate must have a current affiliation with a licensed EMS agency that functions at, or above, the level of licensure being sought by the candidate. ( )

04. Continuing Education. A candidate for reinstatement of a lapsed license must provide documentation of continuing education consistent with the license holder's lapsed license. Continuing education requirements are provided in Sections 375 through 399 of these rules. The time frame for meeting the continuing education requirements for reinstatement are as follows: ( )

a. The candidate must meet continuing education requirements under Sections 390 through 395 of these rules for the last valid licensure cycle; and ( )

b. Additional continuing education hours in any combination of categories and venues, proportionate to the amount of time since the expiration date of the lapsed license, as follows: ( )

i. EMR -- Three-quarters (3/4) of one (1) hour of continuing education per month of lapsed time. ( )

ii. EMT -- One and one-half (1 ½) hours of continuing education per month of lapsed time. ( )

iii. AEMT -- Two and one-quarter (2 ¼) hours of continuing education per month of lapsed time. ( )

iv. Paramedic -- Three (3) hours of continuing education per month of lapsed time. ( )

05. Identification. A reinstatement candidate must have a valid state driver's license, an Idaho identification card which is issued by a county driver's license examining station, or identification card issued by the Armed Forces of the United States. ( )

06. Criminal History and Background Check. A reinstatement candidate must successfully complete a criminal background check. ( )

07. Competency Certification. The Medical Director of the reinstatement candidate's affiliating EMS agency must certify that he has actively assessed the reinstatement candidate's competency in both the psychomotor and cognitive domains and found that the reinstatement candidate meets the baseline competency requirements for the level of the lapsed license. ( )

08. Licensure Fee. An AEMT or Paramedic candidate must submit the applicable reinstatement license fee provided in Section 331 of these rules. ( )

09. Expiration Date. The expiration date for a lapsed license that is reinstated is determined as provided in Section 335 of these rules. ( )

352. -- 359. (RESERVED)

360. RECOGNITION OF REGISTRATION, CERTIFICATION, OR LICENSURE FROM OTHER JURISDICTIONS.

01. EMS Personnel Licensed or Certified in Other States. An individual possessing an EMS personnel license or certification from a state other than Idaho, must have prior recognition or reciprocity granted by

the EMS Bureau prior to providing emergency medical care in Idaho. The following applies: ( )

a. An individual certified or licensed in a state that has an interstate compact with Idaho that allows reciprocal recognition of EMS personnel may practice as licensed personnel as defined in the interstate compact. ( )

b. An individual who is currently licensed or certified by another state to provide emergency medical care can apply to the EMS Bureau for limited recognition to practice in Idaho as provided in Subsection 360.02 of this rule. ( )

02. Limited Recognition. An individual, who is currently licensed or certified by another state to provide emergency medical care and applies to practice EMS within the confines of a specific incident, may be granted limited recognition by the EMS Bureau. Limited recognition allows an individual to practice EMS in Idaho only within the confines of the specific incident for which it was issued and only for a specified period of time not to exceed the duration of the incident for which it was issued. ( )

03. Personnel with NREMT Registration or Current EMS Certification. An individual, possessing a current NREMT registration or a current EMS certification or license from another state at or above the level of licensure they are seeking in Idaho, is eligible for an Idaho EMS personnel licensure if they satisfy the requirements in Section 330 of these rules. ( )

04. Personnel Licensure Candidate Trained in Other States. A candidate trained outside of Idaho must apply for and obtain an Idaho EMS license as required in Section 330 of these rules prior to providing emergency medical care in Idaho. A declaration that the candidate is fully eligible for EMS licensure in the state in which they were trained, must be obtained from the EMS licensing authority in that state and submitted to the EMS Bureau. ( )

361. -- 364. (RESERVED)

365. CHANGES TO AN EXISTING LICENSE.

01. Surrender of a Current EMS Personnel License. An individual who possesses a current EMS personnel license may surrender that license at any time by submitting a letter of intent and their license to the EMS Bureau. ( )

02. Surrender of License to Prevent Investigation or Disciplinary Action. Surrendering or expiration of a license does not prevent an investigation or disciplinary action against the individual. ( )

03. Relinquish a Current EMS Personnel License for a Lower Level License. An individual who possesses a current license may relinquish that license and receive a license at a lower level with the same expiration date as the original license. The individual must have current affiliation with a licensed EMS agency which functions at, or higher than, the level of licensure being sought. ( )

04. Relinquishment of a License to a Lower Level License to Prevent Investigation or Disciplinary Action. Relinquishing a personnel license does not prevent an investigation or disciplinary action against the individual. ( )

05. Reporting Requirements for Changes in Status. Licensed personnel must notify the EMS Bureau within thirty (30) days of a change in name, mailing address, telephone number or agency affiliation. ( )

06. Personnel License Duration Shortened. The EMS Bureau will issue a license with a shortened licensure duration upon the request of the license holder. ( )

366. MULTIPLE LICENSES.
An individual may hold more than one (1) level of personnel licensure in Idaho, but can only renew one (1) personnel license at one (1) level. ( )

367. -- 369. (RESERVED)

370. CERTIFICATE OF ELIGIBILITY REQUIREMENTS.

01. Personnel Licensure Requirements are Met. An individual, who has successfully completed an approved course, and meets all requirements for EMS personnel licensure required in Section 330 of these rules, except for obtaining an agency affiliation provided in Subsection 330.04 of these rules, may apply to the EMS Bureau for a certificate of eligibility. ( )

02. Duration. Duration of a certificate of eligibility is determined using the specified time intervals of the personnel licensure level requirements in Section 335 of these rules. ( )

03. Criminal History and Background Check. An individual applying for a certificate of eligibility must successfully complete a criminal history and background check within the six (6) months prior to the issuance or renewal of a certificate of eligibility. ( )

04. Renewal. An individual must provide documentation that the following requirements have been met in order to renew a certificate of eligibility: ( )

a. Continuing education requirements for the level of licensure listed under the license renewal requirements in Section 340 of these rules have been met; and ( )

b. Successful completion of the standardized examination designated by the EMS Bureau for the certificate of eligibility. ( )

05. Revocation. The EMS Bureau will revoke a certificate of eligibility if the certificate holder is determined to no longer meet eligibility requirements or has obtained a personnel license. ( )

371. AMBULANCE CERTIFICATION.

01. Certification Required. In order for a licensed EMR to serve as the sole patient care provider who is delivering patient care, the EMR must possess a current ambulance certification issued by the EMS Bureau. ( )

02. Certification Requirements. A licensed EMR applying for and meeting the requirements defined in this section of rule will be issued an ambulance certification. The requirements for ambulance certification are: ( )

a. Have a valid, unrestricted EMR license; ( )

b. Have successfully completed an ambulance certification training program, examination, and credentialing; ( )

03. Duration. Ambulance certifications are valid as long as the license holder is continually licensed. ( )

04. Disciplinary and Corrective Action. The EMS Bureau may impose disciplinary and corrective actions on an ambulance certification based on the procedures for administrative license actions described in Sections 500 - 579 of these rules. ( )

372. EMS BUREAU REVIEW OF APPLICATIONS.

01. Review of License Applications. The EMS Bureau reviews each application for completeness and accuracy. Random applications are selected for audit by the EMS Bureau. Applications will also be audited when information declared on the application appears incomplete, inaccurate, or fraudulent. ( )

02. Expiration While Under Review. A personnel license does not expire while under review by the

EMS Bureau, provided the license renewal candidate submitted the renewal application to the EMS Bureau prior to the application deadline. ( )

373. -- 374. (RESERVED)

SUBAREA C2: CONTINUING EDUCATIONAL AND SKILLS PROFICIENCY REQUIREMENTS FOR PERSONNEL LICENSURE (Sections 375-399)

375. CONTINUING EDUCATION AND SKILLS PROFICIENCY.

01. Continuing Education Must Meet Objectives of Initial Course Curriculum. All continuing education and skills proficiency assurance must be consistent with the objectives of the initial course curriculum or be a logical progression of those objectives. ( )

02. Documentation. Licensed personnel must maintain documentation of all continuing education as follows: ( )

a. An EMR and EMT must maintain documentation of continuing education for four (4) years. ( )

b. An AEMT and Paramedic must maintain documentation of continuing education for three (3) years. ( )

03. Transition to New Scope of Practice. Education required to transition to a new scope of practice must meet the following: ( )

a. Within the same level of licensure, all transition education may count on an hour-for-hour basis in the appropriate categories within a single venue. When transition education hours exceed seventy-five percent (75%) of the total continuing education hours required, all continuing education hours can be in a single venue; and ( )

b. Education must be completed during a single license duration. ( )

376. CONTINUING EDUCATION RECORDS ARE SUBJECT TO AUDIT.

The EMS Bureau reserves the right to audit continuing education records to verify that renewal requirements have been met. ( )

01. Documentation Record. All documentation for continuing education hours must include: ( )

a. Name of attendee; ( )

b. Date education was completed; and ( )

c. Education sponsor or instructor. ( )

02. Proof of Completion. The following are acceptable formats for proof of completion of continuing education: ( )

a. Signed course roster; ( )

b. Certificate of completion; ( )

c. Electronic verification of completion of on-line course; ( )

d. Verification of attendance from EMS conference; ( )

e. Verification or proof of providing instruction; or ( )

f. Agency training record validated by agency administrator. ( )

377. -- 379. (RESERVED)

380. CONTINUING EDUCATION CATEGORIES FOR PERSONNEL LICENSURE RENEWAL.

01. Airway. ( )

02. Cardiovascular. ( )

03. Trauma. ( )

04. Medical. ( )

05. Operations. ( )

06. Pediatrics. ( )

381. -- 384. (RESERVED)

385. VENUES OF CONTINUING EDUCATION FOR PERSONNEL LICENSURE RENEWAL.
Continuing education for all personnel must be from one or more of the following venues for each licensure period. ( )

01. Structured Classroom Sessions. ( )

02. Refresher Programs. Refresher programs that revisit the original curriculum and have an evaluation component. ( )

03. Nationally Recognized Courses. ( )

04. Regional and National Conferences. ( )

05. Teaching Continuing Education Topics. The continuing education topics being taught must fall under the categories in Section 380 of these rules. ( )

06. Agency Medical Director-Approved Self-Study or Directed Study. This venue is not allowed to be used for a certificate of eligibility continuing education requirement. ( )

07. Case Reviews and Grand Rounds. ( )

08. Distributed Education. This venue includes distance and blended education using computer, video, audio, Internet, and CD resources. ( )

09. Journal Article Review with an Evaluation Instrument. ( )

10. Author or Co-Author an EMS-Related Article in a Nationally Recognized Publication. ( )

11. Simulation Training. ( )

12. Evaluator at a State or National Psychomotor Exam. ( )

386. -- 389. (RESERVED)

390. LICENSE RENEWAL CONTINUING EDUCATION REQUIREMENTS.

A license renewal candidate must provide documentation of the following continuing education hours provided in the table below during each licensure period.

LICENSE RENEWAL CONTINUING EDUCATION (CE) REQUIREMENTS				
CE CATEGORIES	EMR 15 TOTAL CE Hours	EMT 36 TOTAL CE Hours	AEMT 40 TOTAL CE Hours	PARAMEDIC 60 TOTAL CE Hours
An individual must complete at least 1 hour of continuing education in each category.				
Airway, Respiration, and Ventilation	No more than 5 CE hours in any single category may be counted toward the total number of CE Hours needed for renewal.	No more than 12 CE hours in any single category may be counted toward the total number of CE Hours needed for renewal.	No more than 13 CE hours in any single category may be counted toward the total number of CE Hours needed for renewal.	No more than 20 CE hours in any single category may be counted toward the total number of CE Hours needed for renewal.
Cardiovascular				
Trauma				
Medical				
Operations: Landing Zone & Extrication Awareness				
Pediatrics	2 hours	4 hours	6 hours	8 hours

( )

391. -- 394. (RESERVED)

395. LICENSE RENEWAL SKILLS PROFICIENCY REQUIREMENTS.
A license renewal candidate must demonstrate proficiency in the skills necessary to provide safe and effective patient care at the licensure level consistent with the scope of practice provided in the incorporated EMSPC Standards Manual. ( )

396. -- 399. (RESERVED)

SUBPART D – EMERGENCY MEDICAL SERVICES: EDUCATION, INSTRUCTOR, AND EXAMINATION REQUIREMENTS (Sections 400 - 499)

400. STANDARDS OF PROFESSIONAL CONDUCT FOR EMS EDUCATION PROGRAM AND EXAM PERSONNEL.
All personnel associated with an EMS education program or exam must adhere to the following standards: ( )

01. Professional Conduct. EMS education program and exam personnel maintain the knowledge necessary to competently teach curriculum and evaluate students as outlined in the Idaho EMS Education Standards. EMS education program and exam personnel refrain from performing their duties while under the influence of alcohol, any illegal substance, or a legal drug or medication causing impairment of function. ( )

02. Professional Integrity. EMS education program and exam personnel: ( )

a. Cannot submit false information in any report, application, or documentation to the EMS Bureau, the National Registry of Emergency Medical Technicians, or any other governing, credentialing, accrediting, or certifying authority. ( )

b. Comply with state and federal laws relating to the confidentiality of student records; and ( )

c. Refrain from conduct demonstrating a professional conflict of interest during the performance of their duties as EMS educators or evaluators. ( )

03. Respectful Behavior. EMS education program and exam personnel ensure just and equitable treatment for all potential and current students and refrain from conduct involving EMS education or evaluation that is in violation of any current Idaho or federal anti-discrimination law or administrative rule. ( )

401. -- 404. (RESERVED)

SUBAREA D1: EMS EDUCATION PROGRAMS (Sections 405-414)

405. GENERAL REQUIREMENTS FOR EMS EDUCATION PROGRAMS.
EMS education programs must meet all requirements in these rules. A program may be approved by the EMS Bureau if all requirements are met. Each program must be approved and in good standing in order for graduates of courses provided by a program to qualify for access to an Idaho EMS certification examination. ( )

406. INSPECTION OF EMS EDUCATION PROGRAMS.
Representatives of the EMS Bureau are authorized to enter an EMS education facility at reasonable times for the purpose of assuring that an EMS education program meets the provisions of these rules. ( )

407. EMS EDUCATION PROGRAM ELIGIBILITY.
The following entities are eligible for approval as an EMS Education Program: ( )

01. EMS Agency. A licensed Idaho EMS agency, or applicant for agency licensure, that has met all of the agency licensure requirements in these rules with the exception of the personnel requirements in the case of an applicant agency. ( )

02. Governmental Entity. A recognized governmental entity within the State of Idaho; ( )

03. School. A proprietary, secondary, or post-secondary school as defined in Title 33, Idaho Code, and in accordance with IDAPA 08.01.11, "Registration of Post-Secondary Educational Institutions and Proprietary Schools"; or ( )

04. Hospital. An Idaho hospital as defined in IDAPA 16.03.14, "Hospitals." ( )

408. EMS EDUCATION PROGRAM APPROVAL REQUIREMENTS.
The following requirements must be met in order to be approved as an EMS Education Program: ( )

01. All Programs. All EMS educational programs must: ( )

a. Have the infrastructure elements described in the Idaho EMS Education Standards; ( )

b. Use a curriculum that meets the Idaho EMS Education Standards; ( )

c. Utilize personnel to fill the roles as defined in these rules; ( )

d. Provide sufficient quantities of supplies and equipment in good working order based on the curriculum and the minimum equipment list; and ( )

e. Have successfully completed a program review within the last three (3) years. ( )

02. Paramedicine Programs. Programs teaching paramedicine must be accredited by, or have a Letter of Review (LoR) from, the Committee on Accreditation of Educational Programs for the EMS Professions

(CoAEMSP). A representative of the EMS Bureau may attend the CoAEMSP site visit. Documentation of official correspondence between CoAEMSP and the program must be provided to the EMS Bureau within thirty (30) days. ( )

409. EMS EDUCATION PROGRAM ADMINISTRATION.
Each EMS Education Program must: ( )

01. Register And Maintain Program Information With The Ems Bureau And The National Certifying Body. ( )

02. Respond To All Program-specific Ems Bureau Inquiries Within Fifteen (15) Days. ( )

03. Submit Supporting Documentation Requested During An Audit To The Ems Bureau Within Twenty-one (21) Days Of The Request. ( )

04. Ensure That All Program Personnel Are Familiar With And Conduct Business According To These Rules. ( )

05. Notify The Ems Bureau Within Fifteen (15) Days Of Any Sanction Taken Against An Instructor That Affects Their Ability To Teach For The Program. ( )

410. EMS EDUCATION PROGRAM COURSE ADMINISTRATION.

01. Education. To prepare students to demonstrate the expected competencies, the EMS Education Program must: ( )

a. Deliver didactic education and psychomotor training that meets the objectives of the approved curriculum; ( )

b. Establish and maintain hospital/clinical and field/internship experience agreements to ensure student access under the Idaho EMS Education Standards; ( )

c. Ensure the majority of initial education is taught by certified EMS instructors. ( )

02. Evaluation. To assure that students can demonstrate the expected competencies, the EMS Education Program must: ( )

a. Establish and enforce pass/fail criteria that include evaluation of student performance and competency during labs, didactic, clinical, and field internship training; ( )

b. Provide formative evaluations during a course to monitor the progress of students; and ( )

c. Provide a formal summative evaluation that includes a variety of clinical behaviors and judgements at the end of the course to measure the student's mastery of the objectives of the approved curriculum. ( )

411. EMS EDUCATION PROGRAM COURSE DOCUMENTATION.
Each EMS Education Program must submit the following documentation to the EMS Bureau as described below, in the format provided by the EMS Bureau, and retain it for a minimum of three (3) years: ( )

01. Course Registration Number (CRN) issued by the EMS Bureau. ( )

02. Course Roster. ( )

03. Course Completion Record With Completion Status And Date Of Completion For All Students. ( )

04. EMR and EMT Programs. Results of formal summative evaluation. ( )

05. AEMT and Paramedic Programs. Proposed date and location of the psychomotor examination within the timeline required by the national certifying body. ( )

412. -- 414. (RESERVED)

SUBAREA D2: CRITERIA FOR EMS EDUCATION
(Sections 415-419)

415. INITIAL EMS EDUCATION REQUIREMENTS.

01. Consistency with Scope of Practice. All curricula must be consistent with the Idaho scope of practice for licensed personnel as set forth in the incorporated EMS Physician Commission Standards Manual which aligns with the clinical level of the course. ( )

02. Consistency with State and National Standards. All curricula must be consistent with Idaho EMS Education Standards incorporated in these rules, and the National EMS Scope of Practice Model. ( )

416. -- 419. (RESERVED)

SUBAREA D3: EMS EDUCATION PROGRAM PERSONNEL REQUIREMENTS, QUALIFICATIONS, AND RESPONSIBILITIES
(Sections 420-424)

420. REQUIRED PERSONNEL FOR EMS EDUCATION PROGRAMS.
Each program must: ( )

01. Program Director. Identify an individual to serve as the program director. The program director may also serve as teaching faculty provided that faculty qualifications are met. ( )

02. Teaching Faculty. Identify a sufficient number of teaching faculty who meet the qualifications described below. ( )

03. Course Physician. Identify an individual to serve as the course physician. The course physician may also serve as teaching faculty, provided that faculty qualifications are met. ( )

421. EMS EDUCATION PROGRAM PERSONNEL QUALIFICATIONS.

01. Program Director. Program directors must: ( )

a. Complete an Education Program Orientation Course within the previous twenty-four (24) months. ( )

b. Have knowledge of current Idaho EMS Education Standards and the requirements for state certification and licensure. ( )

02. Instructor. Instructors must possess a current instructor certification issued by the EMS Bureau. ( )

03. Adjunct Faculty or Guest Lecturers. Adjunct faculty and guest lecturers must be authorized by the course physician based on credentials, education, or expertise that corresponds to the knowledge and skill objectives they are teaching. ( )

04. Course Physician. Course physicians must: ( )

a. Be a Doctor of Osteopathy (DO) or Medical Doctor (MD) currently licensed to practice medicine with experience and current knowledge of emergency care of acutely ill and injured patients; and ( )

b. Have knowledge or experience in the delivery of out-of-hospital emergency care, including the proper care and transport of patients, medical direction, and quality improvement in out-of-hospital care. ( )

422. EMS EDUCATION PROGRAM PERSONNEL RESPONSIBILITIES.
An individual can have multiple personnel responsibilities, but must meet the applicable personnel requirements in these rules and fulfill all the responsibilities of each position they fill. ( )

01. Program Director. The program director's responsibilities include: ( )

a. Administrative oversight of the program; ( )

b. Ensuring that the program remains in compliance with these rules; and ( )

c. Serving as the program's point of contact for the EMS Bureau, or for a national EMS certification body, or both. ( )

02. Instructor. The instructor's responsibilities include: ( )

a. Delivery of didactic and psychomotor education that satisfies the curriculum objectives; ( )

b. Documentation of student performance and competency under the standards defined by the program; ( )

c. Following program policies, requirements, and these rules; ( )

03. Course Physician. The course physician is responsible for oversight of all medical aspects of instruction. ( )

423. -- 424. (RESERVED)

**SUBAREA D4: EMS INSTRUCTOR CERTIFICATION
(SECTIONS 425 - 429)**

425. EMS INSTRUCTOR CERTIFICATION REQUIREMENTS.

01. Instructor Certification is Required. To serve as an EMS instructor, an individual must possess a current EMS instructor certificate issued by the EMS Bureau. ( )

02. Instructor Certification Requirements. An individual applying for and meeting the requirements defined in this rule will be issued an initial EMS instructor certificate. For initial EMS instructor certification, the individual must: ( )

a. Pass an Idaho criminal history and background check; ( )

b. Complete an EMS Bureau-sponsored EMS Education Program Orientation Course within the preceding twenty-four (24) months; ( )

c. Complete a course that meets the requirements of an Adult Methodology Course. See a list of courses and required course content online at http://www.IdahoEMS.org; ( )

d. Hold a current EMS license or EMS certificate at or above the instructor level requested; and ( )

e. Have held an EMS license or EMS certificate at or above the level of instruction requested for a minimum of three (3) years. ( )

03. Duration of Certificate. EMS instructor certificates are good for up to three (3) years and are issued with an expiration date of June 30 no more than three (3) years after the date the application was approved by the EMS Bureau. ( )

426. EMS INSTRUCTOR CERTIFICATE RENEWAL.
An individual applying for and meeting the EMS instructor certificate requirements defined in this rule will be issued a renewed EMS instructor certificate. An individual seeking to renew an EMS instructor certificate must: ( )

01. Submit an Application. Submit an application for EMS instructor certification renewal in the format provided by the EMS Bureau prior to the expiration date of the current certificate. Certified EMS instructors may submit the renewal application and documentation to the EMS Bureau up to six (6) months prior to the current expiration date of the instructor certificate. ( )

02. Teaching Time. Document twenty-four (24) hours of teaching time during the current certification period. ( )

03. Continuing Education. Complete eight (8) hours of continuing education specific to adult education during the current certification period. ( )

04. License or Certificate. Possess a current Idaho EMS personnel license, a current Idaho certificate of eligibility, or a current national certification at or above the level of instructor certificate. ( )

427. LAPSED EMS INSTRUCTOR CERTIFICATE.

01. Timely Submission. An application is considered timely when it is submitted to the EMS Bureau prior to the expiration date of the EMS instructor certificate being renewed. ( )

02. Failure to Submit. An EMS instructor certificate will expire if an instructor fails to submit a complete and timely renewal application. ( )

03. No Grace Period. The EMS Bureau will not grant grace periods or extensions to an expiration date. ( )

04. Application Under Review. Provided the instructor submits a timely renewal application, an EMS instructor certificate will not lapse while under review by the EMS Bureau. ( )

05. Additional Information. The EMS Bureau may request additional information from the instructor to address an application that was found to be incomplete or otherwise non-compliant with these rules. The EMS Bureau will send the request to the instructor's last known address. The instructor has twenty-one (21) days from the date of notification to respond to the EMS Bureau after which the certificate will be considered lapsed. ( )

428. -- 429. (RESERVED)

SUBAREA D5: EMS EXAMINATIONS (Sections 430 - 499)

430. STANDARDIZED EMS EXAMINATIONS.
A graduate of an EMS course must successfully complete psychomotor and cognitive examinations in order to qualify for EMS personnel licensure. ( )

01. EMR and EMT Psychomotor Examination. The psychomotor examination requirement for EMR and EMT course graduates can be met by any of the following: ( )

a. Pass the end-of-course examination described in these rules. ( )

b. Pass a level-appropriate EMS Bureau-approved psychomotor examination. ( )

02. AEMT and Paramedic Psychomotor Examination. The psychomotor examination requirement for AEMT and Paramedic course graduates can only be met by passing a formal EMS Bureau-approved psychomotor examination. ( )

03. Cognitive Examination. The cognitive examination requirement for all levels of course graduates can only be met by passing the EMS Bureau-approved cognitive examination. ( )

431. EMS EXAM APPLICATIONS.
An organization other than the educational program that wishes to host a EMS Bureau-approved examination must notify the EMS Bureau at least sixty (60) days in advance of the proposed exam date. Educational programs must notify the EMS Bureau under Section 411 of these rules. ( )

432. -- 499. (RESERVED)

SUBPART E – COMPLAINTS, INVESTIGATIONS, AND DISCIPLINARY ACTIONS (Sections 500 - 599)

500. PEER REVIEW TEAM.
The EMS Bureau may elect to conduct a peer review for an alleged statute or rule violation when it determines that a peer review is an appropriate action. The EMS Bureau will determine who serves on a peer review team. ( )

501. MEMBERS OF A PEER REVIEW TEAM.
The peer review team will consist of four (4) team members selected by the EMS Bureau as appropriate to the case being considered from the following: ( )

01. Licensed Personnel. EMS personnel licensed at, or above, the license level of the subject; or ( )

02. Agency Administrator. EMS agency administrator; or ( )

03. Training Officer. EMS agency training officer; or ( )

04. Course Coordinator. Course coordinator of an EMS Bureau-approved education program or course; or ( )

05. Instructor. EMS Bureau-certified EMS instructor; and ( )

06. Chairman of Peer Review Team. Each peer review team will be chaired by a licensed Idaho EMS physician as follows: ( )

a. An Idaho EMS Physician Commissioner for cases involving EMS personnel; or ( )

b. An Idaho EMS agency medical director for cases involving an EMS agency; or ( )

c. An Idaho EMS Bureau-approved education program or course sponsoring physician for cases involving educators who are not licensed EMS personnel. ( )

502. QUALIFICATIONS REQUIRED OF A PEER REVIEW TEAM MEMBER.
An individual, serving as a member of an EMS peer review team, must have successfully completed an orientation to EMS-related statute, rules and procedures and have signed confidentiality and conflict of interest agreements provided by the EMS Bureau. ( )

503. -- 504. (RESERVED)

SUBAREA E1: REPORTING OF COMPLAINTS AND SUSPECTED VIOLATIONS (Sections 505 - 519)

505. COMPLAINT SUBMITTED WHEN A VIOLATION IS SUSPECTED.
Complaints must be submitted in writing on a complaint intake form found online at: http://www.idahoems.org. ( )

506. -- 509. (RESERVED)

510. REPORTING SUSPECTED VIOLATION.

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

02. Report Violation. To report a suspected violation, contact the EMS Bureau, see online at: http://www.idahoems.org. ( )

511. ANONYMOUS COMPLAINTS.
Anonymous complaints are accepted; however, the inability to collect further information from the complainant may hinder the progress of the investigation. ( )

512. -- 519. (RESERVED)

SUBAREA E2: INVESTIGATION OF COMPLAINTS AND SUSPECTED VIOLATIONS (Sections 520 - 529)

520. EMS BUREAU INITIATES OFFICIAL INVESTIGATION.
An official investigation will be initiated when the any of the following occurs: ( )

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

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

521. VIOLATIONS THAT MAY RESULT IN ADMINISTRATIVE ACTIONS.
The EMS Bureau may impose administrative actions, including denial, revocation, suspension, or retention under conditions specified in these rules. Administrative actions may be imposed on any of the following: the holder of, or an applicant or candidate for, an EMS license, certificate, education program approval, or recognition. Administrative actions may be imposed on any of the previously mentioned for any action, conduct, or failure to act that is inconsistent with the professionalism, standards, or both, established by statute or rule. ( )

522. -- 524. (RESERVED)

525. REFUSAL TO PARTICIPATE IN AN INVESTIGATION.
The refusal to participate by the subject will not prohibit full investigation or a peer review, nor prevent potential administrative license action. ( )

526. SURRENDER OR LAPSE OF LICENSE.
Surrender or lapse of a license will not prohibit full investigation with the potential consequence of EMS Bureau imposing a formal administrative license action or fine. ( )

527. INVESTIGATION CONFIDENTIALITY.

01. Informal Resolution. Informal resolution of complaints or non-compliance by guidance or negotiated resolution is not public information. ( )

02. Administrative License Action. Preliminary investigations and documents supplied or obtained in connection with them are confidential until a formal notice of administrative license action is issued. ( )

528. NOTICE OF THE FINAL DISPOSITION OF AN INVESTIGATION.

01. Subject. The EMS Bureau will send notification to the last known address of the subject of the disposition of the investigation, including any pending or current administrative actions. ( )

02. Other Jurisdiction for EMS Personnel. A copy of administrative action imposed on EMS personnel will be sent to each agency of affiliation, agency medical director, the National Practitioners Data Base, and the National Registry of Emergency Medical Technicians. ( )

03. Other Jurisdictions for EMS Agencies. A copy of administrative action or nature of fines imposed on EMS agencies will be sent to the agency governing authorities and the agency medical director. ( )

04. Other Jurisdictions for Educational Programs or Instructors. A copy of any administrative action imposed on an EMS educational program or instructor may be sent to the state Board of Education, the sponsoring physician, the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP), and the National Registry of Emergency Medical Technicians (NREMT). ( )

528. -- 529. (RESERVED)

**SUBAREA E3: DISCIPLINARY AND CORRECTIVE ACTIONS
(Sections 530 - 599)**

530. ACTIONS RESULTING FROM INVESTIGATIONS.
The following actions may be imposed upon the subject of an investigation by the EMS Bureau without peer review: ( )

01. Letter of Guidance. The EMS Bureau may issue a letter of guidance, directing the subject of the investigation to the standards, rules, educational resources, or local jurisdiction for resolution of minor non-compliance issues where no injury or threat of harm to the public, profession, or EMS system occurred. The subject of the investigation must show a willingness to become compliant and correct the issue within thirty (30) days of receipt of the personnel guidance letter. ( )

02. Warning Letter. The EMS Bureau may issue a warning letter for a first offense where an unlicensed individual is providing patient care in violation of Section 56-1020, Idaho Code. ( )

03. Negotiated Resolution. The EMS Bureau may negotiate a resolution with the subject of an investigation where allegations of misconduct or medical scope of practice non-compliance, if found to be true, did not cause, or is not likely to cause, injury or harm to the public, profession, or EMS system. The issue must be resolved and corrected within thirty (30) days of the negotiated resolution or settlement agreed to by both the subject of the investigation and the EMS Bureau. ( )

a. Negotiated resolution participants will include the subject of the investigation, EMS Bureau staff and other parties deemed appropriate by the EMS Bureau. ( )

b. During the negotiated resolution process, the subject of the investigation may be offered specific remediation or disciplinary action by consent, which, if agreed to, will resolve the matter with no further right to appeal unless stipulated and agreed to at the time that the remediation or disciplinary action is agreed upon. ( )

c. When the remediation or disciplinary action is not agreed to by consent of both the subject of the investigation and the EMS Bureau, the matter may then be referred to a peer review. ( )

531. -- 534. (RESERVED)

535. PEER REVIEW.
The EMS Bureau may elect to conduct a peer review for alleged statute or rule violations when it determines that a peer review is an appropriate action, or a negotiated resolution or settlement agreement described in these rules, is not reached. The peer review is conducted as follows: ( )

01. Review of Case by Peer Review Team. The peer review team reviews the case details, subject's background, affiliation, licensure history, associated evidence, and documents, and then considers aggravating and mitigating circumstance as follows: ( )

a. Aggravating circumstances can include prior or multiple offenses, vulnerability of victim, obstruction of the investigation, and dishonesty. ( )

b. Mitigating circumstances can include absence of prior offenses, absence of dishonest or selfish motive, timely effort to rectify situation, interim successful rehabilitation, misdirection per agency protocol, or medical direction. ( )

02. Subject Given Opportunity to Respond. The subject of the investigation will be given the opportunity to respond in writing, by teleconference, or at the option of the EMS Bureau, in person to the alleged violation. ( )

03. Evaluation of Evidence. The peer review team will evaluate the evidence and make a majority decision of the finding for each alleged statute, rule, or standards violation, including any additional detected violations. ( )

04. Recommend Action. The peer review team will recommend actions to the EMS Bureau. If subject is found to have violated statutes, rules, or standards, the recommendations may include the following: ( )

a. Administrative license action, time frames, conditions, and fines, if imposed, on an EMS agency; ( )

b. Administrative license action, time frames, and conditions, if imposed, on EMS personnel; or ( )

c. Administrative action, time frames, conditions, and fines, if imposed, on an EMS approved education program or instructor certificate. ( )

536. -- 539. (RESERVED)

540. ADMINISTRATIVE ACTIONS.
The EMS Bureau may impose the following administrative actions: ( )

01. Deny Application. The EMS Bureau may deny an application for an EMS personnel license, EMS certificate of eligibility, EMS personnel limited recognition, EMS agency license, EMS education program approval, or an EMS instructor certification: ( )

a. When the application is not complete or the applicant does not meet the eligibility requirements provided in Sections 56-1011 through 56-1023, Idaho Code, the incorporated EMSPC Standards Manual, these rules; or ( )

b. For any reason that would justify an administrative action according to Section 521 of these rules. ( )

02. Refuse to Renew. The EMS Bureau may refuse to renew an EMS personnel license, EMS personnel certificate of eligibility, EMS agency license, EMS education program approval, or EMS instructor certification: ( )

a. When the renewal application is not complete or does not meet the eligibility requirements provided in Sections 56-1011 through 56-1023, Idaho Code, the incorporated EMSPC Standards Manual, these rules; or ( )

b. Pending final outcome of an investigation or criminal proceeding when criminal charges or

allegations indicate an imminent danger or threat to the health, safety, or well-being of persons or property; or ( )

c. For any reason that would justify an administrative action according to Section 521 of these rules. ( )

03. Retain with Probationary Conditions. The EMS Bureau may allow the holder of an EMS personnel license, EMS certificate of eligibility, EMS personnel limited recognition, EMS agency license, EMS education program approval, or EMS instructor certification to retain a license, approval, or certificate as agreed to in a negotiated resolution, settlement, or with conditions imposed by the EMS Bureau. ( )

04. Suspend. The EMS Bureau may suspend an EMS personnel license, EMS certificate of eligibility, EMS personnel limited recognition, EMS agency license, EMS education program approval, or EMS instructor certification for: ( )

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

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

05. Revoke. The EMS Bureau may revoke an EMS personnel license, EMS certificate of eligibility, EMS personnel limited recognition, EMS agency license, EMS education program approval, or EMS instructor certification when: ( )

a. A peer review team recommends revocation; or ( )

b. The license or certificate holder is found to no longer be eligible for criminal history clearance. ( )

c. The EMS Bureau will notify the city, fire district, hospital district, ambulance district, dispatch center, and county in which an EMS agency provides emergency prehospital response upon revocation of an EMS agency license. ( )

06. Review of Administrative Actions by the EMS Physician Commission. The EMS Physician Commission must review, at their next available meeting, administrative actions taken by the EMS Bureau. ( )

541. -- 544. (RESERVED)

545. VIOLATIONS THAT MAY RESULT IN FINES BEING IMPOSED ON EMS AGENCY.
In addition to administrative license actions provided in Section 56-1022, Idaho Code, and these rules, a fine may be imposed by the EMS Bureau upon recommendation of a peer review team on a licensed EMS agency as a consequence of agency violations. Fines may be imposed for the following violations: ( )

01. Operating An Unlicensed EMS Agency. Operating without a license required in Sections 100 - 299 of these rules including: ( )

a. Failure to obtain an initial license; ( )

b. Failure to obtain a license upon change in ownership; or ( )

c. Failure to renew a license and continues to operate as an EMS agency. ( )

02. Unlicensed Personnel Providing Patient Care. Allowing an unlicensed individual to provide patient care without first obtaining an EMS personnel license at the appropriate level for the EMS agency. ( )

03. Failure to Respond. Failure of the EMS agency to respond to a 911 request for service within the agency primary response area in a typical manner of operations when dispatched to a medical illness or injury, except

when the responder reasonably determines that: ( )

a. There are disaster conditions; ( )

b. Scene safety hazards are present or suspected; or ( )

c. Law enforcement assistance is necessary to assure scene safety, but has not yet allowed entry to the scene. ( )

04. Unauthorized Response by EMS Agency. Responding to a request for service which deviates from or exceeds those authorized by the EMS agency license requirements in these rules. ( )

05. Failure to Allow Inspections. Failure to allow the EMS Bureau or its representative to inspect the agency facility, equipment, records, and other licensure requirements provided in these rules. ( )

06. Failure To Correct Unacceptable Conditions. Failure of the EMS agency to correct unacceptable conditions within the time frame provided in a negotiated resolution settlement, or a warning letter issued by the EMS Bureau. Including the following: ( )

a. Failure to maintain an EMS vehicle in a safe and sanitary condition; ( )

b. Failure to have available minimum EMS Equipment; ( )

c. Failure to correct patient or personnel safety hazards; or ( )

d. Failure to retain an EMS agency medical director: ( )

07. Failure to Report Patient Care Data. Failure to submit patient care data as required in these rules. ( )

546. FINES IMPOSED ON EMS AGENCY.

In addition to administrative license action allowed by statute and rule, a fine may be imposed by the EMS Bureau upon the recommendation of a peer review team. Fines are imposed on licensed EMS agency as a consequence of agency licensure violations. ( )

01. Maximum Amount of a Fine. A fine may not exceed one thousand dollars ($1,000) for each specified violation. ( )

02. Fines Levied After Peer Review. The EMS Bureau may levy a fine against an EMS agency following a peer review that has a majority decision on finding and outcomes, and includes a fine be imposed as part of the recommended action. ( )

03. Table for Maximum Fine Amount. The maximum amount of a fine that may be imposed on an EMS agency for certain violations listed in Section 545 of these rules are provided in the table below:

EMS AGENCY FINE AMOUNT FOR VIOLATIONS		
Rule Violation Subsection	**TYPE OF VIOLATION**	**Maximum Fine (each violation)**
340.01.	**Operating an Unlicensed EMS Agency.** **a.** Failure to obtain an initial license: **b.** Failure to obtain a license upon change of ownership: **c.** Failure to successfully renew a license:	 $1000 $500 $500

EMS AGENCY FINE AMOUNT FOR VIOLATIONS		
Rule Violation Subsection	**TYPE OF VIOLATION**	**Maximum Fine (each violation)**
340.02.	**Unlicensed EMS Personnel Providing Patient Care.**	$500
340.03.	**Failure to Respond.**	$750
340.04.	**Unauthorized Response by EMS Agency.** Licensed EMS agency responds to a request for service which deviates from or exceeds those authorized by the EMS agency license.	$500
340.05.	**Failure to Allow an Inspection of an EMS Agency.**	$500
340.06.	**Failure to Correct Unacceptable Conditions.** **a.** Failure to maintain an EMS vehicle in a safe and sanitary condition: **b.** Failure to have available minimum EMS equipment: **c.** Failure to correct patient or personnel safety hazards: **d.** Failure to retain an EMS agency medical director:	 $250 $250 $250 $500
340.07.	**Failure to Report Patient Care Data.**	$500

( )

547. COLLECTED FINES.
Money collected from EMS agency fines will be deposited into the Emergency Medical Services Fund III provided for in Section 56-1018B, Idaho Code, a dedicated fund account for the purpose of providing grants to acquire vehicles and equipment for use by emergency medical services personnel in the performance of their duties. ( )

548. -- 549. (RESERVED)

550. REINSTATEMENT FOLLOWING REVOCATION.
An application for any revoked license, certificate, or educational program approval, may be filed with the EMS Bureau no earlier than one (1) year from the date of the revocation. ( )

01. Peer Review for Reinstatement. The EMS Bureau will conduct a peer review to consider the reinstatement application. ( )

02. Recommendation of Peer Review Team. The peer review team will make a recommendation to the EMS Bureau to accept or reject the application for reinstatement. ( )

03. Reinstatement Determination. The EMS Bureau will accept or reject the reinstatement application based on the peer review team recommendation and other extenuating circumstances. ( )

a. Reinstatement of a revoked EMS personnel license is subject to the lapsed license reinstatement requirements in these rules. ( )

b. Reinstatement of a revoked EMS agency license will be subject to an initial agency application requirements in these rules. ( )

551. -- 599. (RESERVED)

SUBPART F – IDAHO TIME SENSITIVE EMERGENCY SYSTEM COUNCIL (Sections 600 - 699)

600. TSE COUNCIL.

Under Section 56-1027, Idaho Code, the TSE Council will consist of members appointed by the Governor of Idaho and the chair of each regional TSE committee and is responsible for duties described under Section 56-1028, Idaho Code. ( )

601. TSE REGIONS.
Under Section 56-1028, Idaho Code, the TSE Council is required to establish TSE regions that provide more effective access to the Idaho TSE system through education, but not for the purpose of promoting competition, restricting, or directing patient referrals within the region. The TSE Council has established six (6) regions in Idaho described in the TSE Standards Manual. ( )

602. REALIGNMENT OF TSE REGION.
The TSE Council may realign a region by initiation of the TSE Council, or at the request of a regional TSE committee, a county or local government entity within the region, a TSE designated center, or a licensed EMS agency within the region. ( )

01. Requesting Entity. The requesting entity must forward correspondence to the TSE Council specifying the reason for the realignment request that includes: ( )

a. Existing patient routing patterns used by both EMS agencies and health care centers; ( )

b. Distances and transport times involved in patient routing patterns; ( )

c. A list of all entities affected by the request; ( )

d. A list of all other licensed health care facilities and licensed EMS agencies in the county; and ( )

e. Documentation that all affected regional TSE committees are agreeable to the realignment. ( )

02. Copies of Request. The entity requesting the TSE Council for realignment must provide copies of the correspondence to all affected regional TSE committees, county and local governments, licensed health care facilities, and EMS agencies in the requesting entity's county. ( )

03. TSE Decision. The TSE Council will evaluate the request for realignment based on the impact to patient care and will notify all parties of the council's decision. ( )

603. REGIONAL TSE COMMITTEES.
The regional TSE committees' organization and responsibilities are described under Section 56-1030, Idaho Code. ( )

604. (RESERVED)

605. DESIGNATION OF TSE CENTERS -- CRITERIA.
Under Section 56-1029, Idaho Code, the TSE Council will designate a hospital as a trauma, stroke, or STEMI center when such hospital, upon proper application and verification, is found by the TSE Council to meet an applicable designation level for trauma, stroke, or STEMI designation criteria established in the TSE Standards Manual. ( )

606. TRAUMA DESIGNATION CENTERS.
To be a TSE designated Level I, II, III, IV, V, or a Pediatric Level I or Level II Trauma Center, a facility must meet or exceed required standards published for state designation in the TSE Standards Manual. ( )

607. STROKE DESIGNATION CENTERS.
To be a TSE designated Level I, II+ (Thrombectomy), II, or III Stroke Center, a facility must meet or exceed required standards published for state designation in the TSE Standards Manual. ( )

608. STEMI DESIGNATION CENTERS.
To be a TSE designated Level I+ (Cardiogenic Shock), I or II STEMI Center, a facility must meet or exceed required

standards published for state designation in the TSE Standards Manual. ( )

609. (RESERVED)

610. DESIGNATION OF CENTERS -- GENERAL REQUIREMENTS.

01. Application. A facility applying for initial TSE designation must apply along with applicable fees for each designation it is requesting. Application process and requirements are provided in the TSE Standards Manual. ( )

02. Initial Designation. Initial designation requires completion of appropriate application, submission of appropriate fees, and completion of an appropriate site survey based on the TSE Standards Manual. ( )

611. -- 619. (RESERVED)

620. TSE DESIGNATION -- LENGTH OF DESIGNATION.
A TSE center will be designated for a period of three (3) years unless the designation is rescinded by the TSE Council for noncompliance with the designation standards of these rules or adjusted to coincide with applicable external verification timetables. ( )

621. RENEWAL OF TSE DESIGNATION.
A TSE center must submit its renewal application and applicable fees no later than three (3) months prior to the center's designation expiration date. Designation will not lapse due to a delay in scheduling the site survey if the delay is through no fault of renewing center. ( )

622. NOTIFICATION OF LOSS OF CERTIFICATION OR LICENSURE.
Any TSE designated center that has a loss of certification or licensure must immediately notify the TSE Council. ( )

623. -- 624. (RESERVED)

625. DESIGNATION AND TSE SITE SURVEY FEES.

01. Application With National Verification. An applicant applying for a TSE designation that is verified by a national accrediting body must submit the appropriate designation fees with its application for initial designation and renewal. The designation fees are for a three (3) year designation and are payable on an annual basis. TSE designation fees are not to exceed those listed in Subsections 625.03 through 625.05 of this rule. ( )

02. Application Without National Verification. An applicant who requires a TSE site survey prior to designation is required to pay the applicable site survey fee at the time of application. TSE designation and site survey fees are not to exceed those listed in Subsections 625.03 through 625.05 of this rule. ( )

03. Trauma Designation and TSE Site Survey Fees.

TRAUMA DESIGNATIONS 625.03	DESIGNATION FEE 3-year / Annual (Not to exceed)	TSE SITE SURVEY FEE (Not to exceed)
LEVEL I	$45,000 / $15,000	$3,000 / Not applicable with national or acceptable state verification
LEVEL II	$36,000 / $12,000	$3,000 / Not applicable with national or acceptable state verification

TRAUMA DESIGNATIONS 625.03	DESIGNATION FEE 3-year / Annual (Not to exceed)	TSE SITE SURVEY FEE (Not to exceed)
LEVEL III	$24,000 / $8,000	$3,000 / Not applicable with national or acceptable state verification
LEVEL IV	$12,000 / $4,000	$1,500 / Not applicable with national or acceptable state verification
LEVEL V	$3,000 / $1,000	$1,500
PEDIATRIC LEVEL I and LEVEL II	$36,000 / $12,000	No fee. Must be ACS verified

( )

04. Stroke Designation and TSE Site Survey Fees.

STROKE DESIGNATIONS 625.04	DESIGNATION FEE 3-year / Annual (Not to exceed)	TSE SITE SURVEY FEE (Not to exceed)
LEVEL I	$21,000 / $7,000	$3,000 / Not applicable with national or acceptable state verification
LEVEL II+ and LEVEL II	$12,000 / $4,000	$3,000 / Not applicable with national or acceptable state verification
LEVEL III	$1,500 / $500	$1,500/ Not applicable with national or acceptable state verification

( )

05. STEMI Designation and TSE Site Survey Fees.

STEMI DESIGNATIONS 625.05	DESIGNATION FEE 3-year / Annual (Not to exceed)	TSE SITE SURVEY FEE (Not to exceed)
LEVEL I+ and LEVEL I	$21,000 / $7,000	$3,000 / Not applicable with national or acceptable state verification
LEVEL II	$1,500 / $500	$1,500 / Not applicable with national or acceptable state verification

( )

06. Designation Fee Payment. After completion of the TSE site survey, the TSE Council will notify the applicant facility of the designation determination by letter. The applicant facility must then pay either the annual

designation fee or the entire three (3) year designation fee. After designation notification and upon the EMS Bureau's receipt of the designation fee, designation is effective. The TSE Council will send a certificate of designation and confirmation of the designation period. Annual designation fees for those facilities paying yearly are due to the EMS Bureau within thirty (30) days of the date of the invoice to maintain designation. Failure to meet this deadline will result in suspension or revocation of designation. ( )

626. -- 629. (RESERVED)

630. TSE SITE SURVEY.
The TSE Council will conduct a site survey of each TSE designated center at least once every three (3) years, unless the center has been verified by a national accrediting body to meet or exceed the standards set in these rules. The TSE Council will schedule the site survey with the designated center in a timely manner. ( )

631. TSE SITE SURVEY -- GENERAL REQUIREMENTS.
The TSE site survey will consist of and consider each facility's application and compliance with the TSE Standards Manual for the specific type of designation being requested. The general requirements in Subsections 631.01 through 635.06 of this rule apply: ( )

01. Survey Team Member Requirements. Survey team members will meet the following inclusion criteria: ( )

a. A physician surveyor must: ( )

i. Be certified by the American Board of Medical Specialties or the American Board of Osteopathic Medicine; ( )

ii. Be board-certified in the specialty area being represented on the review team; ( )

iii. Be currently active, or active in the last twelve (12) months, in trauma, stroke, or emergency cardiac care at a center that is at or above the level being reviewed; ( )

iv. Have no conflict of interest with the facility under review; and ( )

v. Be from outside the region of the center being verified. ( )

b. A nurse surveyor or program manager must: ( )

i. Be currently active, or active in the last twelve (12) months, in trauma, stroke, or emergency cardiac care at a center that is at or above the level being reviewed; ( )

ii. Have no conflict of interest with the facility under review; and ( )

iii. Be from outside the region of the center being verified. ( )

02. Communication Between Surveyors and Facilities. To standardize ethical practice, all communication between surveyors and facilities prior to the survey must be facilitated by TSE program staff. ( )

03. Survey Team Member Notification of Potential Conflict of Interest. Upon being assigned to a site survey team, a potential team member must notify the TSE Council of any potential conflict of interest regarding any financial, professional, or personal bias that may affect the survey of the applicant's facility. ( )

04. Notification to Applicant of Survey Team Members. The TSE Council will provide the applicant with the names of the site survey team once they have been selected and at least thirty (30) calendar days prior to the scheduled survey. ( )

05. Facility Notification to TSE Council of Potential Conflict of Interest. If the applicant believes that a potential surveyor has a financial, professional, or personal bias that may affect the survey, the applicant must

notify the TSE Council in writing no later than seven (7) calendar days after the applicant receives the TSE Council's notification of the proposed survey team. ( )

06. Notification of Decision for Conflict of Interest. The TSE Council will consider the conflict of interest notice and make a decision concerning replacement of the survey team member in question. No person who has a substantial conflict of interest in the operation of any facility under review will participate in the site survey of the applicant. ( )

632. SITE SURVEY -- SURVEY TEAM COMPOSITION.
The TSE Council will select a site survey team based on the applicant's designation application and specifications provided in these rules and the standards published in the TSE Standards Manual. ( )

633. SITE SURVEY -- ADDITIONAL SURVEYS.
The TSE Council may conduct additional, announced or unannounced, site reviews of TSE designated centers or applicants when there is reason to believe that the center is not in compliance with the designation criteria standards of these rules. ( )

634. (RESERVED)

635. DESIGNATION DECISION.

01. Summary Report. The survey team will present a verbal summary of the survey results to the applicant. The survey team will submit in writing to the TSE Council its recommendation on the center's designation upon completion of the site survey. ( )

02. Written Report. The TSE Council will consider all evidence and notify the applicant in writing of its decision within thirty (30) calendar days of receiving the survey team's recommendation. ( )

03. Final Determination. The TSE Council's final determination regarding each application will be based upon consideration of: ( )

a. The application; ( )

b. The evaluation and recommendations of the site survey team; ( )

c. The best interests of patients; and ( )

d. Any unique attributes or circumstances that make the facility capable of meeting special community needs. ( )

04. Provisional Designation. The TSE Council may grant a provisional designation to a facility with deficiencies it deems correctable. A facility receiving a provisional designation must: ( )

a. Resolve the deficiencies within the time specified by the TSE Council; ( )

b. Submit documentation that the deficiency has been resolved; and ( )

c. If necessary, submit to an additional focused site survey and pay the applicable survey fees. ( )

05. Denial. If the TSE Council denies an applicant a designation, the provisions of Title 67, Chapter 52, Idaho Code will apply. ( )

636. -- 639. (RESERVED)

640. WAIVERS.

01. Granting a Waiver. The TSE Council may grant a waiver from one (1) or more designation criteria for a center applying for TSE designation. ( )

02. Waiver Application. A center requesting a waiver must submit a completed TSE Waiver Application Form. The TSE Council may require the applicant to provide additional information, and the application will not be considered complete until all required information is provided. ( )

03. Post Notice. A center requesting a waiver must post a notice of the waiver application at all public entrances to the center and in at least one (1) area that is commonly used by the patients. The notice must: ( )

a. Include a meaningful description of the reason for the waiver; ( )

b. Be posted on the date the waiver application is submitted; ( )

c. Remain posted for a minimum of thirty (30) calendar days; and ( )

d. Describe where and to whom comments may be submitted during the thirty (30) calendar days. ( )

04. Notice Distribution. When the notice is posted, the center must distribute copies of the notice to prehospital emergency medical service agencies active in the community served by the center. ( )

05. Waiver Application Submission. To be placed on the agenda, the completed waiver application must be submitted to the TSE Council at least thirty (30) calendar days before a TSE Council meeting. Applications submitted less than thirty (30) calendar days in advance of a TSE Council meeting will be placed on the next agenda. ( )

06. Waiver Application Distribution. The TSE Council will make available the public notice of the TSE Council meeting regarding the waiver application to all TSE designated centers. ( )

07. Waiver Application Review. The regional TSE committee must review the request and make recommendations to the TSE Council. The TSE Council must decide and notify the facility administrator in writing within thirty (30) calendar days of the TSE Council meeting during which the waiver decision is made. ( )

08. Waiver Conditions. When a waiver is granted, the TSE Council must: ( )

a. Specify the terms and conditions of the waiver; ( )

b. Specify the duration of the waiver; duration will not exceed the designation period for that center or three (3) years, whichever is shorter; and ( )

c. Require the submission of progress reports from the center that was granted a waiver. ( )

09. Waiver Renewal. A center that plans to maintain a waiver beyond its expiration must submit a new waiver application to the TSE Council no less than three (3) months prior to the expiration of the waiver. ( )

10. Waiver Revocation. The TSE Council may revoke or suspend a waiver when it determines: ( )

a. That continuation of the waiver jeopardizes the health, safety, or welfare of the patients; ( )

b. The applicant has provided false or misleading information in the waiver application; ( )

c. The applicant has failed to comply with conditions of the waiver; or ( )

d. That a change in federal or state law prohibits continuation of the waiver. ( )

11. Notification and Appeal. When the TSE Council denies, revokes, or suspends a waiver, the TSE Council must provide the center with a written notification of the action and the basis for the action. The notice will inform the facility of the right to appeal and the appeal procedure under Title 67, Chapter 52, Idaho Code. Notification will be made in writing within thirty (30) calendar days of the TSE Council meeting during which the appeal decision is made. ( )

641. -- 644. (RESERVED)

645. DENIAL AND MODIFICATION.

01. Denial. The TSE Council may deny an initial or renewal application for a center's designation when a center: ( )

a. Does not meet the criteria for designation required in these rules; ( )

b. Application or accompanying documents contain false statements of material facts; ( )

c. Refuses to allow any part of a site survey; ( )

d. Fails to comply with or to successfully complete a plan of correction, or ( )

e. Is substantially noncompliant with any TSE rules. ( )

02. Modification. When a center fails to meet the criteria at the level of designation for which it applied or opts to surrender its designation, the TSE Council may recommend a designation at a lesser level described in Section 647 of these rules, or a complete revocation of state designation. This action, unless agreed to by the applicant, will represent a denial of the application. ( )

03. Notification and Appeal. When the TSE Council denies an application for designation, the TSE Council must provide the center with a written notification of the denial and the basis for the denial. The notice will inform the facility of the right to appeal and the appeal procedure under Title 67, Chapter 52, Idaho Code. ( )

646. REVOCATION AND SUSPENSION.

01. Revocation. The TSE Council may revoke the designation of a center or a waiver when an owner, officer, director, manager, or other employee: ( )

a. Fails or refuses to comply with the provisions of these rules; ( )

b. Fails to make annual designation fee payment for those facilities paying yearly; ( )

c. Makes a false statement of material fact about the center's capabilities or other pertinent circumstances under investigation for any purposes connected with these rules; ( )

d. Prevents, interferes with, or attempts to impede in any way, the work of a TSE Council representative in implementing or enforcing these rules; ( )

e. Falsely advertises, or in any way misrepresents the facility's ability to care for patients based on its designation status; ( )

f. Is substantially noncompliant with these rules and has not rectified such noncompliance; ( )

g. Fails to provide reports required by the Idaho TSE Registry or the EMS Bureau in a timely and complete fashion; or ( )

h. Fails to comply with or complete a plan of correction in the time or manner specified. ( )

02. Suspension. The TSE Council may suspend a center's designation or waiver when it finds, after investigation, that the center has engaged in a deliberate and willful violation of these rules, or that the public's health, safety, or welfare is endangered. ( )

03. Notification and Appeal. When the TSE Council revokes or suspends a center's designation or waiver, it must provide the center with a written notification of the action and the basis for the action. The notice will inform the center of the right to appeal and the appeal procedure under Title 67, Chapter 52, Idaho Code. ( )

647. DESIGNATION AT A LESSER LEVEL.

01. Inability to Meet Criteria. The TSE Council may opt to redesignate a center at a lesser level due to the center's inability to meet current designation criteria, without regard to any waiver previously granted. ( )

02. Notification and Appeal. When the TSE Council decides to redesignate a center, it must provide the center with a written notification of the action and the basis for the action. The notice will inform the center of the right to appeal and the appeal procedure under Title 67, Chapter 52, Idaho Code. ( )

648. -- 699. (RESERVED)

SUBPART G – IDAHO EMERGENCY MEDICAL SERVICES (EMS) PHYSICIAN COMMISSION (Sections 700 - 999)

700. GENERAL PROVISIONS.

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

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

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

701. -- 709. (RESERVED)

710. GENERAL DUTIES OF EMS PERSONNEL.

01. General Duties. General duties of EMS personnel include the following: ( )

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

b. Licensed EMS personnel must only provide patient care for which they have been trained, based on curricula or specialized training approved according to these rules or additional training approved by the hospital or medical clinic supervising physician. ( )

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

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

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

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

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

02. Scope of Practice. ( )

a. The Commission maintains an "EMS Physician Commission Standards Manual" that: ( )

i. Establishes the scope of practice of licensed EMS personnel; and ( )

ii. Specifies the type and degree of medical supervision for specific skills, treatments, and procedures by level of EMS licensure. ( )

b. The Commission will consider the United States Department of Transportation's National EMS Scope of Practice Model when preparing or revising the EMSPC Standards Manual; ( )

c. The scope of practice established by the Commission determines the objectives of applicable curricula and specialized education of licensed EMS personnel; ( )

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

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

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

g. The credentialing of licensed EMS personnel affiliated with an EMS agency, must not exceed the licensure level of that EMS agency; and ( )

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

711. -- 719. (RESERVED)

720. EMS MEDICAL DIRECTOR, HOSPITAL SUPERVISING PHYSICIAN, AND MEDICAL CLINIC SUPERVISING PHYSICIAN QUALIFICATIONS.
The EMS Medical Director, Hospital Supervising Physician, and Medical Clinic Supervising Physician must: ( )

01. Accept Responsibility. Accept responsibility for the medical direction and medical supervision of the activities provided by licensed EMS personnel. ( )

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

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

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

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

02. Approval for EMS Personnel to Function. ( )

a. The explicit approval of the EMS medical director, hospital supervising physician, or medical clinic supervising physician is required for licensed EMS personnel under their supervision to provide medical care. ( )

b. The EMS medical director, hospital supervising physician, or medical clinic supervising physician may credential licensed EMS personnel under their supervision with a limited scope of practice relative to that allowed by the EMS Physician Commission, or with a limited scope of practice corresponding to a lower level of EMS licensure. ( )

03. Restriction or Withdrawal of Approval for EMS Personnel to Function. ( )

a. The EMS medical director, hospital supervising physician, or medical clinic supervising physician can restrict the scope of practice of licensed EMS personnel under their supervision when such personnel fail to meet or maintain proficiencies established by the EMS medical director, hospital supervising physician, or medical clinic supervising physician, or the Idaho EMS Bureau. ( )

b. The EMS medical director, hospital supervising physician, or medical clinic supervising physician can withdraw approval of licensed EMS personnel to provide services, under their supervision, when such personnel fail to meet or maintain proficiencies established by the EMS medical director, hospital supervising physician, or medical clinic supervising physician, or the EMS Bureau. ( )

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

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

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

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

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

08. Develop and Implement Plan for Medical Supervision. The EMS medical director, hospital supervising physician, or medical clinic supervising physician must develop, implement and oversee a plan for supervision of licensed EMS personnel as described in Subsection 722.06 of these rules. ( )

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

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

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

02. Designation of EMS Medical Director. The EMS agency must designate a physician for the medical supervision of licensed EMS personnel affiliated with the EMS agency. ( )

03. Delegated Medical Supervision of EMS Personnel. The EMS medical director can designate other physicians to supervise the licensed EMS personnel in the temporary absence of the EMS medical director. ( )

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

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

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

c. The physician supervising the PA, as defined in IDAPA 24.33.02, "Rules for the Licensure of Physician Assistants," authorizes the PA to provide direct (on-line) supervision; and ( )

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

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

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

06. Medical Supervision Plan. The medical supervision of licensed EMS personnel must be provided in accordance with a documented medical supervision plan that includes direct, indirect, on-scene, educational, and proficiency standards components. The requirements for the medical supervision plan are found in the EMSPC Standards Manual. ( )

07. Out-of-Hospital Medical Supervision Plan Filed with EMS Bureau. The agency EMS medical director must submit the medical supervision plan within thirty (30) days of request to the EMS Bureau in a form described in the standards manual. ( )

a. The agency EMS medical director must identify the designated clinicians to the EMS Bureau annually in a form described in the standards manual. ( )

b. The agency EMS medical director must inform the EMS Bureau of any changes in designated clinicians or of a change in the agency medical director within thirty (30) days of the change(s). ( )

c. The EMS Bureau must provide the Commission with the medical supervision plans within thirty (30) days of request. ( )

d. The EMS Bureau must provide the Commission with the identification of EMS medical directors and designated clinicians annually and upon request. ( )

723. PHYSICIAN SUPERVISION IN HOSPITALS AND MEDICAL CLINICS.

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

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

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

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

05. Designation of Supervising Physician. The hospital or medical clinic administration must designate a physician for the medical supervision of licensed EMS personnel employed or utilized in the hospital or medical clinic. ( )

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

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

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

b. The physician supervising the PA, as defined in IDAPA 24.33.02, "Rules for the Licensure of Physician Assistants," authorizes the PA to provide supervision; and ( )

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

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

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

09. Medical Supervision Plan. The medical supervision of licensed EMS personnel must be provided in accordance with a documented medical supervision plan. The hospital supervising physician or medical clinic supervising physician is responsible for developing, implementing, and overseeing the medical supervision plan, and must submit the plan(s) within thirty (30) days of request by the Commission or the EMS Bureau. ( )

724. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.01.02 – EMERGENCY MEDICAL SERVICES (EMS) – RULE DEFINITIONS

DOCKET NO. 16-0102-2401 (CHAPTER REPEAL)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202, Idaho Code, as well as Sections 56-1003 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:

IDAPA chapters 16.01.02. 16.01.03, 16.01.05, 16.01.07, 16.01.12, 16.02.01, and 16.02.02 are being repealed and consolidated into a singular EMS chapter, 16.01.01.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 4th, 2024, Idaho Administrative Bulletin, Vol. 24-9, page 118.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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 will not be a negative fiscal impact exceeding $10,000 to the state by this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at 208-334-5500.

DATED this 26th day of September, 2024.

Alex J. Adams, PharmD, MPH
Director
Idaho Department of Health & Welfare
450 W. State Street, 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5500 phone
(208) 334-6558 fax
Alex.Adams@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 Section 56-202, Idaho Code, as well as Sections 56-1003 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 September 18th, 2024.

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:

IDAPA chapters 16.01.02. 16.01.03, 16.01.05, 16.01.07, 16.01.12, 16.02.01, and 16.02.02 are being repealed and consolidated into a singular EMS chapter that will be published in this bulletin. The language in chapter 16.01.07 (Personnel Licensure Rules) was updated as part of the Red-Tape Reduction Act.

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

Fees will not be increased as a result of repealing this chapter.

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 will not be a negative fiscal impact exceeding $10,000 to the state by repealing this chapter.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted on chapters 16.01.02. 16.01.03, 16.01.05, 16.01.12, 16.02.01, and 16.02.02 because those chapters are simply being proposed to be repealed and consolidated with all other chapters of EMS. Negotiated rulemaking was conducted for chapter 16.01.07 on April 18th, 2024 and was published on pages 20 through 22 of the April 3rd, 2024 bulletin, Vol. 24-4.

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 Jared Larsen at 208-334-5500.

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 25th, 2024.

DATED this 18th day of July, 2024.

IDAPA 16.01.02 IS PROPOSED TO BE REPEALED IN ITS ENTIRETY.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

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

DOCKET NO. 16-0103-2401 (CHAPTER REPEAL)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202, Idaho Code, as well as Sections 56-1003 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:

IDAPA chapters 16.01.02. 16.01.03, 16.01.05, 16.01.07, 16.01.12, 16.02.01, and 16.02.02 are being repealed and consolidated into a singular EMS chapter, 16.01.01.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 4th, 2024, Idaho Administrative Bulletin, Vol. 24-9, page 119.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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 will not be a negative fiscal impact exceeding $10,000 to the state by this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at 208-334-5500.

DATED this 26th day of September, 2024.

Alex J. Adams, PharmD, MPH
Director
Idaho Department of Health & Welfare
450 W. State Street, 10th Floor
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Boise, ID 83720-0036
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Alex.Adams@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 Section 56-202, Idaho Code, as well as Sections 56-1003 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 September 18th, 2024.

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:

IDAPA chapters 16.01.02. 16.01.03, 16.01.05, 16.01.07, 16.01.12, 16.02.01, and 16.02.02 are being repealed and consolidated into a singular EMS chapter that will be published in this bulletin. The language in chapter 16.01.07 (Personnel Licensure Rules) was updated as part of the Red-Tape Reduction Act.

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

Fees will not be increased as a result of repealing this chapter.

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 will not be a negative fiscal impact exceeding $10,000 to the state by repealing this chapter.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted on chapters 16.01.02. 16.01.03, 16.01.05, 16.01.12, 16.02.01, and 16.02.02 because those chapters are simply being proposed to be repealed and consolidated with all other chapters of EMS. Negotiated rulemaking was conducted for chapter 16.01.07 on April 18th, 2024 and was published on pages 20 through 22 of the April 3rd, 2024 bulletin, Vol. 24-4.

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 Jared Larsen at 208-334-5500.

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 25th, 2024.

DATED this 18th day of July, 2024.

IDAPA 16.01.03 IS PROPOSED TO BE REPEALED IN ITS ENTIRETY.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.01.05 – EMERGENCY MEDICAL SERVICES (EMS) – EDUCATION, INSTRUCTOR, AND EXAMINATION REQUIREMENTS

DOCKET NO. 16-0105-2401 (CHAPTER REPEAL)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202, Idaho Code, as well as Sections 56-1003, and 56-1011 through 56-1023, Idaho Code.

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

IDAPA chapters 16.01.02. 16.01.03, 16.01.05, 16.01.07, 16.01.12, 16.02.01, and 16.02.02 are being repealed and consolidated into a singular EMS chapter, 16.01.01.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 4th, 2024, Idaho Administrative Bulletin, Vol. 24-9, page 120.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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 will not be a negative fiscal impact exceeding $10,000 to the state by this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at 208-334-5500.

DATED this 26th day of September, 2024.

Alex J. Adams, PharmD, MPH
Director
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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 56-202, Idaho Code, as well as Sections 56-1003, and 56-1011 through 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 September 18th, 2024.

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:

IDAPA chapters 16.01.02. 16.01.03, 16.01.05, 16.01.07, 16.01.12, 16.02.01, and 16.02.02 are being repealed and consolidated into a singular EMS chapter that will be published in this bulletin. The language in chapter 16.01.07 (Personnel Licensure Rules) was updated as part of the Red-Tape Reduction Act.

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

Fees will not be increased as a result of repealing this chapter.

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 will not be a negative fiscal impact exceeding $10,000 to the state by repealing this chapter.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted on chapters 16.01.02. 16.01.03, 16.01.05, 16.01.12, 16.02.01, and 16.02.02 because those chapters are simply being proposed to be repealed and consolidated with all other chapters of EMS. Negotiated rulemaking was conducted for chapter 16.01.07 on April 18th, 2024 and was published on pages 20 through 22 of the April 3rd, 2024 bulletin, Vol. 24-4.

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 Jared Larsen at 208-334-5500.

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 25th, 2024.

DATED this 18th day of July, 2024.

IDAPA 16.01.05 IS PROPOSED TO BE REPEALED IN ITS ENTIRETY.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

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

DOCKET NO. 16-0107-2401 (CHAPTER REPEAL)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202, Idaho Code, as well as Sections 56-1003, and 56-1011 through 56-1023, Idaho Code.

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

IDAPA chapters 16.01.02. 16.01.03, 16.01.05, 16.01.07, 16.01.12, 16.02.01, and 16.02.02 are being repealed and consolidated into a singular EMS chapter, 16.01.01.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 4th, 2024, Idaho Administrative Bulletin, Vol. 24-9, page 121.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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 will not be a negative fiscal impact exceeding $10,000 to the state by this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at 208-334-5500.

DATED this 26th day of September, 2024.

Alex J. Adams, PharmD, MPH
Director
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P.O. Box 83720
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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 56-202, Idaho Code, as well as Sections 56-1003, and 56-1011 through 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 September 18th, 2024.

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:

Chapters 16.01.02. 16.01.03, 16.01.05, 16.01.07, 16.01.12, 16.02.01, and 16.02.02 are being repealed and consolidated into a singular EMS chapter that will be published in this bulletin. The language in chapter 16.01.07 (Personnel Licensure Rules) was updated as part of the Red-Tape Reduction Act.

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

Fees will not be increased as a result of repealing this chapter.

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 will not be a negative fiscal impact exceeding $10,000 to the state by repealing this chapter.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted on chapters 16.01.02. 16.01.03, 16.01.05, 16.01.12, 16.02.01, and 16.02.02 because those chapters are simply being proposed to be repealed and consolidated with all other chapters of EMS. Negotiated rulemaking was conducted for chapter 16.01.07 on April 18th, 2024 and was published on pages 20 through 22 of the April 3rd, 2024 bulletin, Vol. 24-4.

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 Jared Larsen at 208-334-5500.

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 25th, 2024.

DATED this 18th day of July, 2024.

IDAPA 16.01.07 IS PROPOSED TO BE REPEALED IN ITS ENTIRETY.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.01.12 – EMERGENCY MEDICAL SERVICES (EMS) – COMPLAINTS, INVESTIGATIONS, AND DISCIPLINARY ACTIONS

DOCKET NO. 16-0112-2401 (CHAPTER REPEAL)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202, Idaho Code, as well as Sections 56-1003, 56-1005, 56-1022, 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:

IDAPA chapters 16.01.02. 16.01.03, 16.01.05, 16.01.07, 16.01.12, 16.02.01, and 16.02.02 are being repealed and consolidated into a singular EMS chapter, 16.01.01.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 4th, 2024, Idaho Administrative Bulletin, Vol. 24-9, page 122.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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 will not be a negative fiscal impact exceeding $10,000 to the state by this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at 208-334-5500.

DATED this 26th day of September, 2024.

Alex J. Adams, PharmD, MPH
Director
Idaho Department of Health & Welfare
450 W. State Street, 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5500 phone
(208) 334-6558 fax
Alex.Adams@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 Section 56-202, Idaho Code, as well as Sections 56-1003, 56-1005, 56-1022, 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 September 18th, 2024.

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:

Chapters 16.01.02. 16.01.03, 16.01.05, 16.01.07, 16.01.12, 16.02.01, and 16.02.02 are being repealed and consolidated into a singular EMS chapter that will be published in this bulletin. The language in chapter 16.01.07 (Personnel Licensure Rules) was updated as part of the Red-Tape Reduction Act.

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

Fees will not be increased as a result of repealing this chapter.

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 will not be a negative fiscal impact exceeding $10,000 to the state by repealing this chapter.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted on chapters 16.01.02. 16.01.03, 16.01.05, 16.01.12, 16.02.01, and 16.02.02 because those chapters are simply being proposed to be repealed and consolidated with all other chapters of EMS. Negotiated rulemaking was conducted for chapter 16.01.07 on April 18th, 2024 and was published on pages 20 through 22 of the April 3rd, 2024 bulletin, Vol. 24-4.

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 Jared Larsen at 208-334-5500.

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 25th, 2024.

DATED this 18th day of July, 2024.

IDAPA 16.01.12 IS PROPOSED TO BE REPEALED IN ITS ENTIRETY.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.02.01 – IDAHO TIME SENSITIVE EMERGENCY SYSTEM COUNCIL

DOCKET NO. 16-0201-2401 (CHAPTER REPEAL)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202, Idaho Code, as well as Sections 56-1007, 56-1024 through 56-1030, and 57-2003, 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:

IDAPA chapters 16.01.02. 16.01.03, 16.01.05, 16.01.07, 16.01.12, 16.02.01, and 16.02.02 are being repealed and consolidated into a singular EMS chapter, 16.01.01.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 4th, 2024, Idaho Administrative Bulletin, Vol. 24-9, page 123.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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 will not be a negative fiscal impact exceeding $10,000 to the state by this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at 208-334-5500.

DATED this 26th day of September, 2024.

Alex J. Adams, PharmD, MPH
Director
Idaho Department of Health & Welfare
450 W. State Street, 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
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(208) 334-6558 fax
Alex.Adams@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 Section 56-202, Idaho Code, as well as Sections 56-1007, 56-1024 through 56-1030, and 57-2003, 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 18th, 2024.

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:

IDAPA chapters 16.01.02. 16.01.03, 16.01.05, 16.01.07, 16.01.12, 16.02.01, and 16.02.02 are being repealed and consolidated into a singular EMS chapter that will be published in this bulletin. The language in chapter 16.01.07 (Personnel Licensure Rules) was updated as part of the Red-Tape Reduction Act.

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

Fees will not be increased as a result of repealing this chapter.

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 will not be a negative fiscal impact exceeding $10,000 to the state by repealing this chapter.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted on chapters 16.01.02. 16.01.03, 16.01.05, 16.01.12, 16.02.01, and 16.02.02 because those chapters are simply being proposed to be repealed and consolidated with all other chapters of EMS. Negotiated rulemaking was conducted for chapter 16.01.07 on April 18th, 2024 and was published on pages 20 through 22 of the April 3rd, 2024 bulletin, Vol. 24-4.

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 Jared Larsen at 208-334-5500.

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 25th, 2024.

DATED this 18th day of July, 2024.

IDAPA 16.02.01 IS PROPOSED TO BE REPEALED IN ITS ENTIRETY.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.02.02 – IDAHO EMERGENCY MEDICAL SERVICES (EMS) PHYSICIAN COMMISSION

DOCKET NO. 16-0202-2401 (CHAPTER REPEAL)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202, Idaho Code, as well as Sections 56-1013, 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:

IDAPA chapters 16.01.02. 16.01.03, 16.01.05, 16.01.07, 16.01.12, 16.02.01, and 16.02.02 are being repealed and consolidated into a singular EMS chapter, 16.01.01.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 4th, 2024, Idaho Administrative Bulletin, Vol. 24-9, page 124.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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 will not be a negative fiscal impact exceeding $10,000 to the state by this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at 208-334-5500.

DATED this 26th day of September, 2024.

Alex J. Adams, PharmD, MPH
Director
Idaho Department of Health & Welfare
450 W. State Street, 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
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Alex.Adams@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 Section 56-202, Idaho Code, as well as Sections 56-1013, 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 September 18th, 2024.

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:

IDAPA chapters 16.01.02. 16.01.03, 16.01.05, 16.01.07, 16.01.12, 16.02.01, and 16.02.02 are being repealed and consolidated into a singular EMS chapter that will be published in this bulletin. The language in chapter 16.01.07 (Personnel Licensure Rules) was updated as part of the Red-Tape Reduction Act.

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

Fees will not be increased as a result of repealing this chapter.

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 will not be a negative fiscal impact exceeding $10,000 to the state by repealing this chapter.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted on chapters 16.01.02. 16.01.03, 16.01.05, 16.01.12, 16.02.01, and 16.02.02 because those chapters are simply being proposed to be repealed and consolidated with all other chapters of EMS. Negotiated rulemaking was conducted for chapter 16.01.07 on April 18th, 2024 and was published on pages 20 through 22 of the April 3rd, 2024 bulletin, Vol. 24-4.

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 Jared Larsen at 208-334-5500.

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 25th, 2024.

DATED this 18th day of July, 2024.

IDAPA 16.02.02 IS PROPOSED TO BE REPEALED IN ITS ENTIRETY.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.02.12 – NEWBORN SCREENING

DOCKET NO. 16-0212-2401 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo and Incorporation By Reference Synopsis (IBRS)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202, Idaho Code, and Sections 39-906, 39-909, and 39-910, Idaho Code.

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

Executive Order 2020-01, Zero Based Regulation, requires agencies to review and rewrite chapters every five (5) years on an approved schedule. The purpose of this proposed rulemaking is to comply with this mandate and is scheduled for presentation to the 2025 Legislature. The rule specifies the tests and procedures that must be performed on newborn infants for early detection of metabolic disorders, endocrine disorders, hemoglobin disorders, cystic fibrosis, critical congenital heart disease, and prevention of infant blindness.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 4th, 2024, Idaho Administrative Bulletin, Vol. 24-9, pages 125 through 131.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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 will not be a negative fiscal impact exceeding $10,000 to the state by this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at 208-334-5500.

DATED this 26th day of September, 2024.

Alex J. Adams, PharmD, MPH
Director
Idaho Department of Health & Welfare
450 W. State Street, 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5500 phone; (208) 334-6558 fax
Alex.Adams@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 Section 56-202, Idaho Code, and Sections 39-906, 39-909, and 39-910, Idaho Code.

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

VIRTUAL TELECONFERENCE Via WebEx
Wednesday, September 18, 2024 **12:00-1:00 p.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=mca1c94cd6d168f5453c5de6efd5a03bb** **Join by meeting number** **Meeting number (access code): 2821 229 7212** **Meeting password: njSjbpUC695 (65752782 when dialing from a phone or video system)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

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: Executive Order 2020-01, Zero Based Regulation, requires agencies to review and rewrite chapters every five (5) years on an approved schedule. The purpose of this proposed rulemaking is to comply with this mandate and is scheduled for presentation to the 2025 Legislature. The rule specifies the tests and procedures that must be performed on newborn infants for early detection of metabolic disorders, endocrine disorders, hemoglobin disorders, cystic fibrosis, critical congenital heart disease, and prevention of infant blindness.

FEE SUMMARY: There will not be a change to the fee structure for newborn screening.

FISCAL IMPACT: There is no anticipated negative fiscal impact with this rule rewrite.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted. However, two public meetings were posted on Townhall Idaho and received public responses on March 14th, 2024, and April 11th, 2024.

INCORPORATION BY REFERENCE: The materials cited are being incorporated by reference as they provide details on industry standards associated with specimen collection, the filter paper collection device, application of blood to the filter paper, and uniform techniques for collecting the best possible specimen for use in dried blood spot specimen screening, and industry standards associated with appropriate pulse-oximetry equipment and uniform screening algorithms to obtain the most accurate results for critical congenital heart disease screening.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jared Larsen at 208-334-5500.

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 25th, 2024.

DATED this 30th day of July, 2024.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0212-2401

16.02.12 – NEWBORN SCREENING

000. LEGAL AUTHORITY.
~~The Idaho Legislature has given the Board of Health and Welfare and the Director of the Department authority to promulgate rules governing the testing of newborn infants for phenylketonuria and other preventable diseases and governing the instillation of an ophthalmic preparation in the eyes of the newborn to prevent Ophthalmia Neonatorum, under~~ Sections 39-906, 39-909, and 39-910, Idaho Code. ~~(3-17-22)~~( )

~~**001. TITLE AND SCOPE.**~~

~~**01. Title**. These rules are titled IDAPA 16.02.12, "Newborn Screening." (3-17-22)~~

~~**02. Scope**. These rules specify the tests and procedures that must be performed on newborn infants for early detection of metabolic disorders, endocrine disorders, hemoglobin disorders, cystic fibrosis, critical congenital heart disease, and prevention of infant blindness. (3-17-22)~~

001. (RESERVED)

002. INCORPORATION BY REFERENCE.
The Department has incorporated by reference the following documents: (3-17-22)

01. Dried Blood Spot Specimen Collection ~~on Filter Paper~~ for Newborn Screening ~~Programs; Approved Standard, Fifth~~ Seventh Edition. The Department has adopted Clinical Laboratory Standards Institute's "Dried Blood Spot Specimen Collection ~~on Filter Paper~~ for Newborn Screening ~~Programs; Approved Standard~~," ~~Fifth Edition, Clinical and Laboratory Standards Institute. 2007 (ISBN 1-56238-644-1)~~ Seventh Edition, 2021 (ISBN 978-68440-108-6), and hereby incorporates this standard by reference. A copy is available for review at the Department, or through the Clinical and Laboratory Standards Institute, 940 West Valley Road, Suite 1400, Wayne, PA 19087-1898, telephone 1-610-688-0100. ~~(3-17-22)~~( )

02. Critical Congenital Heart Defects (CCHDs). The Department has adopted the Critical ~~CHD~~ Congenital Heart Defect Screening Methods as recommended by the American Academy of Pediatrics~~, from "Strategies of Implementing Screening for Critical Congenital Heart Diseases," Kemper, et al., 2011,~~ online resource, and hereby incorporates this material by reference. Copies may be obtained from the Department, see online at: https://www.cdc.gov/ncbddd/heartdefects/hcp.html. ~~(3-17-22)~~( )

003. -- 009. (RESERVED)

010. DEFINITIONS.
The following definitions will apply in the interpretation and enforcement of this chapter: (3-17-22)

01. Critical Congenital Heart Disease (CCHD). CCHD, also known as critical congenital heart defects, is a term that refers to a group of serious heart defects, as defined by the Centers for Disease Control and

Prevention (CDC), that are present from birth. (3-17-22)

02. Department. The Idaho Department of Health and Welfare. (3-17-22)

03. Dried Blood Specimen. A blood specimen obtained from an infant by means of skin puncture, not by means of venipuncture or any other method, that is placed on special filter paper and allowed to dry. (3-17-22)

04. Hyperalimentation. The administration of an amount of nutrients beyond minimum normal requirements of the appetite, in an attempt to replace nutritional deficiencies. (3-17-22)

05. Laboratory. A medical or diagnostic laboratory certified according to the provisions of the Clinical Laboratory Improvement Amendments of 1988 by the United States Department of Health and Human Services. (3-17-22)

06. Newborn Screening. Newborn screening means a laboratory procedure performed on dried blood specimens from newborns to detect those at risk for the diseases specified in Subsection 100.01 of these rules. (3-17-22)

07. Person Responsible for Registering Birth of Child. The person responsible for preparing and filing the certificate of birth is defined in Section 39-255, Idaho Code. (3-17-22)

08. Pulse Oximetry. A non-invasive test that estimates the percentage of hemoglobin in blood that is saturated with oxygen using equipment approved by the U.S. Food and Drug Administration for use with newborn infants. (3-17-22)

09. Test Kit. The materials provided by the laboratory for the purposes of dried blood specimen collection and submission of specimens for newborn screening laboratory procedures. (3-17-22)

011. -- 049. (RESERVED)

050. USE AND STORAGE OF DRIED BLOOD SPECIMENS.

01. Use and Storage of Dried Blood Specimens. Dried blood specimens will be used only for the purpose of testing or re-testing, when necessary, the infant from whom the specimen was taken, and for congenital birth defects. Limited use of specimens for routine calibration of newborn screening laboratory equipment and quality assurance is permissible. ~~(3-17-22)~~( )

~~**02. Prohibited Use of Dried Blood Specimens**. Dried blood specimens may not be used for any purpose other than those described in Subsection 050.01 of this rule without the express written consent of the parent(s) or guardian(s) of the infant from whom the specimen was collected. (3-17-22)~~

~~**03. Storage of Dried Blood Specimens**. Dried blood specimens may be stored at the testing facility for a period not to exceed eighteen (18) months. Acceptable use of stored specimens will be for re-testing the specimen in the event of a symptomatic diagnosis or death of the infant during the storage period. (3-17-22)~~

051. -- 099. (RESERVED)

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

01. Conditions for Which Infants Will Be Tested. All infants born in Idaho must be tested for at least the following conditions: (3-17-22)

a. Biotinidase deficiency; (3-17-22)

b. Congenital hypothyroidism; (3-17-22)

c. Galactosemia; (3-17-22)

d. Maple syrup urine disease; (3-17-22)

e. Phenylketonuria; and (3-17-22)

f. Critical congenital heart disease. (3-17-22)

02. Blood Specimen Collection. (3-17-22)

~~**a.** The dried blood specimen collection procedures must follow the document listed in Subsection 004.01 of these rules.~~ ~~(3-17-22)~~

~~**b.** For infants admitted to the neonatal intensive care unit (NICU), the initial dried blood specimen for newborn screening must be obtained upon admission to the NICU.~~ ~~(3-17-22)~~

~~e~~a. For ~~non premature~~ healthy infants, ~~in hospital,~~ the initial dried blood specimen for newborn screening must be obtained between twenty-four (24) and forty-eight (48) hours of age. ~~(3-17-22)~~( )

b. All infants must be retested. A test kit should be given to the parents or responsible party at the time of discharge from the institution where initial newborn care was rendered, with instructions to have a second dried blood specimen collected. The preferred time for sample collection for healthy infants is between ten (10) and fifteen (15) days of age. ( )

c. For infants admitted to the neonatal intensive care unit (NICU), the initial dried blood specimen for newborn screening must be obtained upon admission to the NICU. Newborns who require a blood transfusion, hyperalimentation, or dialysis should have a dried blood specimen collected for screening prior to these procedures. ( )

d. For low birth weight, sick infants (requiring three (3) or more weeks of hospitalization) and/or NICU infants, the first newborn screen specimen should be collected upon admission to the NICU, the second at twenty-four (24) to forty-eight (48) hours of age, and the third at twenty-eight (28) days or four (4) weeks of age. ( )

~~d~~e. For newborns transferred from one hospital to another, the originating hospital must assure that the dried blood specimen is drawn. If the newborn is ~~too premature or~~ too sick to have a dried blood specimen drawn for screening prior to transfer and a dried blood specimen is not obtained, the originating hospital must document this, and notify the hospital to which the newborn is being transferred that a dried blood specimen for newborn screening has not been obtained. ~~(3-17-22)~~( )

~~e~~f. Prior to the discharge of an infant from the institution where initial newborn care or specialized medical care was rendered, the Administrator of the institution must assure that an adequate dried blood specimen has been collected regardless of the time the infant is discharged from the institution. (3-17-22)

~~f~~g. For births occurring outside of a hospital, the birth attendant is responsible for assuring that an acceptable dried blood specimen is properly collected for newborn screening as stipulated in Section 100 of this rule. (3-17-22)

~~**g.** Newborns who require a blood transfusion, hyperalimentation, or dialysis must have a dried blood specimen collected for screening prior to these procedures.~~ ~~(3-17-22)~~

~~**h.** If a dried blood specimen cannot be obtained for newborn screening before transfusion, hyperalimentation, or dialysis, the hospital must ensure that a repeat dried blood specimen is obtained at the appropriate time when the specimen will reflect the infant's own metabolic processes and phenotype.~~ ~~(3-17-22)~~

~~**i.** All infants must be retested. A test kit must be given to the parents or responsible party at the time of discharge from the institution where initial newborn care was rendered, with instructions to have a second dried~~

~~blood specimen collected. The preferred time for sample collection is between ten (10) and fifteen (15) days of age.~~ ~~(3-17-22)~~

03. Specimen Data Card. The person obtaining the newborn screening specimen ~~must~~ should complete ~~the~~ all demographic information requested on the specimen collection card ~~attached to the sample kit. The First Specimen Card must include the infant's mother's date of birth, address, and phone number. Both the First and Second Specimen's Card must include the items listed in 100.03.a. through 100.03.k. of this rule, optional fields may be completed as needed~~. ~~(3-17-22)~~( )

~~**a.** Name of the infant;~~ ~~(3-17-22)~~

~~**b.** Whether the birth was a single or multiple-infant birth;~~ ~~(3-17-22)~~

~~**c.** Name of the infant's mother;~~ ~~(3-17-22)~~

~~**d.** Gender of the infant;~~ ~~(3-17-22)~~

~~**e.** Method of feeding the infant;~~ ~~(3-17-22)~~

~~**f.** Name of the birthing facility;~~ ~~(3-17-22)~~

~~**g.** Date and time of the birth;~~ ~~(3-17-22)~~

~~**h.** Date and time the specimen was obtained;~~ ~~(3-17-22)~~

~~**i.** Name of the attending physician or other attendant;~~ ~~(3-17-22)~~

~~**j.** Date specimen was collected; and~~ ~~(3-17-22)~~

~~**k.** Name of person collecting the specimen.~~ ~~(3-17-22)~~

04. Specimen Mailing. Within twenty-four (24) hours after collection, the dried blood specimen ~~must~~ should be mailed to the laboratory by first class mail or its equivalent, except when mailing service is not available. When mailing service is not available on weekends and holidays, dried blood specimens ~~must~~ should be mailed to the laboratory on the first available mail pick-up day. The preferred method of mailing, following a weekend or holiday, is by expedited mail service. ~~(3-17-22)~~( )

05. Record Keeping. Maintain a record of all dried blood specimens collected for newborn screening. This record ~~must~~ should indicate: ~~(3-17-22)~~( )

a. Name of the infant; (3-17-22)

b. Name of the attending physician or other attendant; (3-17-22)

c. Date specimen was collected; ~~and~~ ~~(3-17-22)~~( )

d. Name of person collecting specimen~~.~~; and ~~(3-17-22)~~( )

e. Tracking number if courier service is used. ( )

06. Collection Protocol. Ensure that a protocol for collection and submission for newborn screening of adequate dried blood specimens has been developed, documented, and implemented. Individual responsibilities must be clearly defined and documented. The attending physician ~~must~~ or birth attendant should request that the test be done. The ~~hospital~~ facility may make an appropriate charge for this service and should seek reimbursement when available. ~~(3-17-22)~~( )

07. Responsibility for Recording Specimen Collection. (3-17-22)

a. The administrator of the responsible institution, or their designee, must record on the birth certificate whether the dried blood specimen for newborn screening has been collected. (3-17-22)

b. When a birth occurs outside a hospital, the person responsible for registering the birth of the child must record on the birth certificate whether the dried blood specimen for newborn screening has been collected and submitted within twenty-four (24) hours following collection. (3-17-22)

08. Fees. The Department will provide access to newborn screening laboratory services. If the administration of the responsible institution or the person required to register the birth of a child chooses to utilize this service, the Department will collect a fee equal to the cost of the test kit, analytical, and ~~diagnostic~~ follow-up services provided by the laboratory. The fees must be remitted to the Department before the laboratory provides the test kit to those responsible for ensuring the infant is tested according to these rules. ~~(3-17-22)~~( )

101. -- 199. (RESERVED)

200. LABORATORY DUTIES.

01. Participation in Centers for Disease Control and Prevention (CDC) Newborn Screening Quality Assurance Program. All laboratories receiving dried blood specimens for newborn screening on infants born in Idaho ~~must~~ should participate in the Newborn Screening Quality Assurance Program operated by the CDC. ~~(3-17-22)~~( )

02. Specimen Processing. Dried blood specimens for newborn screening ~~must~~ should be processed within twenty-four (24) hours of receipt by the laboratory or before the close of the next business day. ~~(3-17-22)~~( )

03. Result Notification. Normal test results may be reported by mail to the submitter. Other results ~~must~~ should be reported in accordance with Section 300 of these rules. ~~(3-17-22)~~( )

201. -- 299. (RESERVED)

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

01. Follow-Up for Unsatisfactory Specimens. (3-17-22)

a. The laboratory will immediately report any unsatisfactory dried blood specimens to the submitting institution that originated the dried blood specimen or to the healthcare provider responsible for the newborn's care, with an explanation of the results. The laboratory will request a repeat dried blood specimen for newborn screening from the institution or individual submitting the original sample, or from the responsible provider as instructed by the program. ~~(3-17-22)~~( )

b. Upon notification from the laboratory and as instructed by the program, the health care provider responsible for the newborn's care at the time of the report ~~will cause another~~ should collect a repeat dried blood specimen to be appropriately forwarded to the laboratory for screening. ~~(3-17-22)~~( )

02. Follow-Up of Presumptive Positive Results. The laboratory will report positive or suspicious results on an infant's dried blood specimen to the attending physician or midwife, or, if there is none or the physician or midwife is unknown, to the person who registered the infant's birth, and make recommendations on the necessity of follow-up testing. (3-17-22)

03. Positive Case Notification. Confirmed positive cases of biotinidase deficiency, congenital hypothyroidism, galactosemia, maple syrup urine disease, and phenylketonuria must be reported as described in IDAPA 16.02.10, "Idaho Reportable Diseases." (3-17-22)

301. NEWBORN CRITICAL CONGENITAL HEART DISEASE (CCHD) SCREENING.

01. Pulse Oximetry for the Screening of CCHD. ~~(3-17-22)~~

~~**a.** For births occurring in a hospital, the administrator of the institution or their designee must assure that all infants who meet the CDC criteria for CCHD screening are screened following the algorithm on the CDC website at: https://www.cdc.gov/ncbddd/heartdefects/hcp.html.~~ ~~(3-17-22)~~

~~**b.**~~ For births occurring outside of a hospital, the birth attendant must assure that screening for congenital heart disease is conducted through the use of pulse oximetry ~~no sooner than~~ between twenty-four (24) hours after birth and no later than forty-eight (48) hours after birth following the algorithm on the CDC website at: https://www.cdc.gov/ncbddd/heartdefects/hcp.html. ~~(3-17-22)~~( )

02. Responsibility of Recording CCHD Screening Results. (3-17-22)

a. For births occurring in a hospital, the administrator of the responsible institution or their designee must record the pulse oximetry results on the birth certificate and whether the CCHD screening was determined as "passed" or "failed" following the algorithm on the CDC website at: https://www.cdc.gov/ncbddd/heartdefects/hcp.html, or "not screened." (3-17-22)

b. For births occurring outside of a hospital, the birth attendant or their designee must record the pulse oximetry results on the birth certificate and whether the CCHD screening was determined as "passed" or "failed" following the algorithm on the CDC website at: https://www.cdc.gov/ncbddd/heartdefects/hcp.html, or "not screened." (3-17-22)

03. Follow Up for Abnormal CCHD Screening Results. (3-17-22)

a. For births occurring in a hospital, the administrator of the responsible institution or their designee must make a referral for further evaluation of the newborn whose CCHD results are abnormal and inform the parent or legal guardian of the need for appropriate intervention. (3-17-22)

b. For births occurring outside of a hospital, the person performing the screening is responsible for making an immediate referral for further evaluation of the newborn whose CCHD results are abnormal and informing the parent or legal guardian of the need for appropriate intervention. (3-17-22)

302. -- 399. (RESERVED)

400. SUBSTANCES THAT FULFILL REQUIREMENTS FOR OPHTHALMIC PREPARATION.
Only those germicides ~~proven to be~~ effective in preventing ophthalmia neonatorum and recommended for use in its prevention by the ~~U.S. Department of Health and Human Services (including the U.S. Public Health Service, the Center for Disease Control and Prevention, and the U.S. Food and Drug Administration)~~ Centers for Disease Control and Prevention, the American Academy of Pediatrics, or the U.S. Preventative Services Task Force will satisfy the requirements established herein, under Section 39-903, Idaho Code. ~~(3-17-22)~~( )

401. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.02.13 – STATE OF IDAHO DRINKING WATER LABORATORY CERTIFICATION PROGRAM

DOCKET NO. 16-0213-2401 (ZBR CHAPTER REWRITE, FEE RULE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo, Incorporation By Reference Synopsis (IBRS), & Cost/Benefit Analysis (CBA)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202, Idaho Code, and Sections 56-1003 and 56-1007, Idaho Code.

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

This rule has been rewritten in accordance with Executive Order 2020-01: Zero-Based Regulation. The goals for this chapter rewrite are to eliminate unnecessary text, improve readability using plain language, lessen requirements for microbiology supervisors to reflect more simplified methods used as the industry standard, update notification requirements, and to change certification fees to prioritize Idaho laboratories.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 4th, 2024, Idaho Administrative Bulletin, Vol. 24-9, pages 132-144.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

Section 56-1007, Idaho Code, authorizes the Department to charge and collect reasonable fees, established by rule, for any services provided by the Department. The fee schedule in this chapter of rule was set in 2011 and is being updated to help support increased costs to the program. We are proposing that the annual base certification fee for Idaho drinking water labs performing chemistry testing increase from $50 to $100 per chemistry discipline. The $20 per analyte per method fee will remain unchanged. Idaho drinking water labs performing microbiology testing will move from a base fee plus per analyte per method structure to a flat annual fee of $150. The move to the flat fee is to simplify the payment structure, currently almost all microbiology labs pay an itemized invoice with three separate charges to meet compliance testing requirements. The annual base certification fee for out of state chemistry laboratories is being increased from $50 to $200 per discipline. The annual flat certification fee for out of state microbiology laboratories will be $300.

The total estimated increase in receipts due to these fee updates is approximately $8,300, based on the number of currently certified drinking water laboratories. The laboratory participants in our negotiated rulemaking sessions did not express concerns about the updated fee schedule.

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

There is no anticipated negative fiscal impact exceeding $10,000 as a result of this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at 208-334-5500.

DATED this 17th day of October, 2024.

Alex J. Adams, PharmD, MPH
Director
Idaho Department of Health & Welfare
450 W. State Street, 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5500 phone; (208) 334-6558 fax
Alex.Adams@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 Section 56-202, Idaho Code, and Sections 56-1003 and 56-1007, Idaho Code.

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

VIRTUAL TELECONFERENCE Via WebEx
Tuesday, September 10, 2024 **9:00 a.m.-10:00 a.m. (MT)**
Join from the meeting link https://idhw.webex.com/idhw/j.php?MTID=ma3c307672a041148dc08efcd77923e8b **Join by meeting number** **Meeting number (access code): 2819 079 1078** **Meeting password: s3En9r93AcR (73369793 when dialing from a phone or video system)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

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

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

This rule has been rewritten in accordance with Executive Order 2020-01: Zero-Based Regulation. The goals for this chapter rewrite are to eliminate unnecessary text, improve readability using plain language, lessen requirements for microbiology supervisors to reflect more simplified methods used as the industry standard, update notification requirements, and to change certification fees to prioritize Idaho laboratories.

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

Section 56-1007, Idaho Code, authorizes the Department to charge and collect reasonable fees, established by rule, for any services provided by the Department. The fee schedule in this chapter of rule was set in 2011 and is being updated to help support increased costs to the program. We are proposing that the annual base certification fee for Idaho drinking water labs performing chemistry testing increase from $50 to $100 per chemistry discipline. The $20 per analyte per method fee will remain unchanged. Idaho drinking water labs performing microbiology testing will move from a base fee plus per analyte per method structure to a flat annual fee of $150. The move to the flat fee is to simplify the payment structure, currently almost all microbiology labs pay an itemized invoice with three separate charges to meet compliance testing requirements. The annual base certification fee for out of state chemistry laboratories is being increased from $50 to $200 per discipline. The annual flat certification fee for out of state microbiology laboratories will be $300.

The total estimated increase in receipts due to these fee updates is approximately $8,300, based on the number of currently certified drinking water laboratories. The laboratory participants in our negotiated rulemaking sessions did not express concerns about the updated fee schedule.

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:

There is no negative impact on the state General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the May 1st, 2024, Idaho Administrative Bulletin, Volume 24-5, pages 196 and 197.

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

The Manual for the Certification of Laboratories Analyzing Drinking Water is the federal resource that the Environmental Protection Agency utilizes to define quality standards for laboratories testing drinking water in support of the Safe Drinking Water Act. This reference sets the minimum requirements to ensure that laboratories can provide high quality, legally defensible, analytical data at the local, state, and national level. Incorporating this reference allows us to eliminate most of the text in the existing rule and just focus on Idaho specific requirements.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jared Larsen at 208-334-5500.

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 25th, 2024.

DATED this 18th day of July, 2024.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0213-2401

16.02.13 – ~~STATE OF IDAHO~~ DRINKING WATER LABORATORY CERTIFICATION PROGRAM

000. LEGAL AUTHORITY.
~~Under~~ Section 56-1003 and 56-1007, 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. Under Section 56-1007, Idaho Code, the Department is authorized to charge and collect fees for services rendered by the Department.~~ ~~(3-15-22)~~( )

001. ~~TITLE AND~~ SCOPE.

~~01.~~ ~~Title~~. ~~These rules are titled IDAPA 16.02.13, "State of Idaho Drinking Water Laboratory Certification Program."~~ ~~(3-15-22)~~

~~02.~~ ~~Scope~~. ~~These rules establish a process for certification and standards of operation for laboratories certified by the State of Idaho to test drinking water~~To define laboratory certification requirements for testing drinking water compliance samples. ~~(3-15-22)~~( )

002. INCORPORATION BY REFERENCE.

~~01.~~ ~~Selected Sections from the Code of Federal Regulations, Title 40, Part 141 – National Primary Drinking Water Regulations, July 1, 2010 Edition~~. ~~40 CFR 141 and 143 may be accessed in electronic format at https://ecfr.io/Title-40/ecfrv25#0. The following sections from the Code of Federal Regulations are hereby incorporated by reference:~~ ~~(3-15-22)~~

~~**a.** 40 CFR 141.6 (h), effective dates;~~ ~~(3-15-22)~~

~~**b.** 40 CFR 141.27, alternate testing program;~~ ~~(3-15-22)~~

~~**c.** 40 CFR 141.21(f)(3), total coliform rule;~~ ~~(3-15-22)~~

~~**d.** 40 CFR 141.23, inorganic methods;~~ ~~(3-15-22)~~

~~**e.** 40 CFR 141.24, organic methods;~~ ~~(3-15-22)~~

~~**f.** 40 CFR 141.25, methods for radioactivity;~~ ~~(3-15-22)~~

~~**g.** 40 CFR 141.131, disinfection by-products;~~ ~~(3-15-22)~~

~~**h.** 40 CFR 141.74(a), surface water treatment rule;~~ ~~(3-15-22)~~

~~**i.** 40 CFR 141.89, lead and copper;~~ ~~(3-15-22)~~

~~**j.** 40 CFR 141.402(c)(2), ground water;~~ ~~(3-15-22)~~

~~**k.** 40 CFR 141.704, long-term surface water treatment rule 2;~~ ~~(3-15-22)~~

~~**l.** 40 CFR 141.803, aircraft drinking water rules;~~ ~~(3-15-22)~~

~~**m.** 40 CFR 141, Appendix A to Subpart C, expedited method approval; and~~ ~~(3-15-22)~~

~~**n.** 40 CFR 143.4, secondary contaminants.~~ ~~(3-15-22)~~

0~~2~~1. Manual for the Certification of Laboratories Analyzing Drinking Water EPA 815-R-05-004, Fifth Edition, January 2005, including Supplement 1 EPA 815-F-08-006, June 2008, and Supplement 2 EPA 815-F-12-006, November 2012~~. The Manual for the Certification of Laboratories Analyzing Drinking Water EPA~~

~~815-R-05-004, Fifth Edition, January 2005, including Supplement 1 EPA 815-F-08-006, June 2008, is hereby incorporated by reference. It may be a~~Accessed in electronic format at https://www.epa.gov/dwlabcert/laboratory-certification-manual-drinking-water. ~~(3-15-22)~~( )

003. -- 009. (RESERVED)

010. DEFINITIONS.

01. Department~~Analyst~~. ~~A person responsible for testing, quality control, and reporting of analytical results~~. The Idaho Department of Health and Welfare. ~~(3-15-22)~~( )

~~**02. Board**. The Idaho Board of Health and Welfare.~~ ~~(3-15-22)~~

~~**03. Certification Authority for the State of Idaho (CA)**. The CA has signature authority for all certification decisions as required for primacy in 40 CFR 142.10 (b)(3)(i). The Bureau Chief of the Idaho Bureau of Laboratories is the certification authority for the State of Idaho.~~ ~~(3-15-22)~~

~~**04. Certification Officer (CO)**. The CO is the person responsible for on-site evaluations and providing technical support and guidance to a certified drinking water laboratory (CDWL).~~ ~~(3-15-22)~~

~~**05. Certified Drinking Water Laboratory (CDWL)**. A facility that examines drinking water for the purpose of identifying or measuring microbiological, chemical, radiological, or physical parameters, and is certified by the State of Idaho.~~ ~~(3-15-22)~~

02. Discipline. A drinking water program designed to test inorganic chemistry, microbiology, organic chemistry, or radiochemistry analytes. ( )

~~**06. Department**. The Idaho Department of Health and Welfare.~~ ~~(3-15-22)~~

03. Maximum Contaminant Level (MCL). The maximum permissible level of a contaminant in a public water system. ( )

04. Regulatory Agency. The Idaho Department of Environment Quality ( )

05. Subcontracting. The procedure where a certified laboratory sends samples to another laboratory that is certified or has been granted reciprocity to test compliance samples from Idaho. ( )

~~**07. Department of Environmental Quality (DEQ)**. The state agency that has primacy and is primarily responsible for administrating and enforcing regulations related to environmental quality.~~ ~~(3-15-22)~~

~~**08. Director**. The Director of the Idaho Department of Health and Welfare, or their designee.~~ ~~(3-15-22)~~

~~**09. Discipline**. Areas of certification for the testing of drinking water, i.e., microbiology, radiochemistry, inorganic chemistry, and organic chemistry.~~ ~~(3-15-22)~~

~~**10. Drinking Water Coordinator (DWC)**. The drinking water coordinator is an Environmental Health Specialist at a public health district assigned to monitor public water systems.~~ ~~(3-15-22)~~

~~**11. Idaho Bureau of Laboratories (IBL)**. The IBL is a bureau in the Division of Public Health in the Idaho Department of Health and Welfare.~~ ~~(3-15-22)~~

~~**12. LIMS**. Laboratory Information Management System.~~ ~~(3-15-22)~~

~~**13. Laboratory Supervisor**. A person who directs the day-to-day activities of a CDWL.~~ ~~(3-15-22)~~

~~**14. Maximum Contaminant Level (MCL)**. The maximum permissible level of a contaminant in~~

~~water that is delivered to any user of a public water system.~~ ~~(3-15-22)~~

~~**15. On-Site Evaluation**. The physical, quality control, and data audit of a laboratory, including all aspects of operation related to the testing of drinking water samples.~~ ~~(3-15-22)~~

~~**16. Primacy**. The responsibility for ensuring that Safe Drinking Water Act (SDWA) laws are implemented and the authority to enforce a law and related regulations (40 CFR 142.2) applicable to public water systems within the state.~~ ~~(3-15-22)~~

~~**17. Proficiency Test (or Testing) (PT)**. Sample(s) provided to demonstrate that a laboratory can successfully analyze the sample(s) within the acceptance limits specified in the regulations. The qualitative or quantitative composition of the reference material is unknown to the laboratory at the time of the analysis.~~ ~~(3-15-22)~~

~~**18. Public Water System (PWS)**. A system for the provision to the public of water for human consumption through pipes or other constructed conveyances, if such system has at least fifteen (15) service connections, regardless of the number of water sources or configuration of the distribution system, or regularly serves an average of at least twenty-five (25) individuals daily at least sixty (60) days out of the year.~~ ~~(3-15-22)~~

~~**19. Quality Assurance (QA)**. An integrated system of management activities that involves planning, quality control, quality assessment, reporting, and quality improvement to ensure a product or service meets defined standards of quality with a stated level of confidence.~~ ~~(3-15-22)~~

~~**20. Quality Control (QC)**. The overall system of technical activities whose purpose is to measure and control the quality of a product or service so that it meets the needs of the users. QC also includes operational techniques and activities that are used to fulfill the requirement of quality.~~ ~~(3-15-22)~~

~~**21. Quality Assurance Plan (QA Plan)**. A comprehensive plan detailing the aspects of quality assurance required to adequately fulfill the needs of a program. This document is required before a laboratory can be certified or reciprocity is granted.~~ ~~(3-15-22)~~

~~**22. Reciprocity**. An extension of certification by the CA to an accredited or certified out-of-state laboratory based upon satisfactory review of documentation that demonstrates compliance with these rules.~~ ~~(3-15-22)~~

~~**23. Regulatory Agency**. The Idaho Department of Environment Quality (DEQ).~~ ~~(3-15-22)~~

~~**24. Regulatory Authority (RA)**. The assigned drinking water Analyst III at a regional DEQ office.~~ ~~(3-15-22)~~

~~**25. Standard Operating Procedure (SOP)**. A written document that describes the method of an operation, analysis, or action whose techniques and procedures are thoroughly prescribed and that is officially approved as the method for performing a routine or repetitive test.~~ ~~(3-15-22)~~

~~**26. Standard Methods (SM)**. SM refers to a standard method of water testing published in the Standard Methods for the Examination of Water and Wastewater, as incorporated by reference under Section 004 of these rules.~~ ~~(3-15-22)~~

~~**27. Subcontracting**. The procedure whereby a laboratory certified by the State of Idaho may send samples to another laboratory that is certified or has been granted reciprocity by the State of Idaho for analysis.~~ ~~(3-15-22)~~

011. -- 099. (RESERVED)

REQUIREMENTS FOR CERTIFICATION OF DRINKING WATER LABORATORIES (Sections 100-199)

100. APPLICATION FOR CERTIFICATION.

~~**01. Required Information on Application**. An application for first time certification for microbiology, inorganic chemistry, organic chemistry, or radiochemistry must be submitted to the CA on a form provided by the IBL. The following information must be included: name, location, and contact information of the drinking water laboratory, name of the owner, listing of methods/analytes for which certification is requested, documentation of the education, experience, and training of the laboratory supervisor for each discipline for which certification is being requested. (3-15-22)~~

~~**02. Time Frame for Renewal of Application for Reciprocity**. Applications for renewal of reciprocity must be received by the IBL at least thirty (30) days before the current certificate expires. (3-15-22)~~

~~**03. Reapplication for Additional Analytes or to Change Methods**. An in-state laboratory seeking to change methods or to add analytes utilizing the same method for which the laboratory is currently certified must submit a written application requesting the change in certification and include a copy of the SOP with QC requirements specific to the method. (3-15-22)~~

~~**04. Reapplication for Certification**. A laboratory that has been downgraded to provisional or has been decertified for an analyte or method, or both, must provide written documentation to the CO of the corrective actions within the specified period. A laboratory that has been decertified in entirety must re-apply following the same procedure as a laboratory applying for first time certification. (3-15-22)~~

~~**05. Reciprocity for Out State Laboratories**. Each out-of state laboratory seeking reciprocity with Idaho must submit the same information as an in-state drinking water laboratory applying for first time certification. (3-15-22)~~

01. Approved Form. An application for drinking water certification, listing methods approved by the regulatory agency, must be submitted annually on a form approved by the department. ( )

02. Time Frame for Renewal of Application. Applications for renewal and supporting documentation requested by the department must be received by the department at least thirty (30) days before the current certificate expires. ( )

03. Reapplication for Additional Analytes or to Change Methods. A laboratory seeking to change methods or to add analytes prior to annual reapplication must submit an amended application and provide supporting documentation requested by the department. Laboratories submitting an amended application will be subject to an additional base fee charge. ( )

101. CERTIFICATION FEES.

01. Idaho Chemistry Laboratory Fees. Laboratories requesting chemistry certification will be charged a base fee of one hundred dollars ($100) per discipline and twenty dollars ($20) per analyte per method. Certification is valid for one (1) year from the date of issuance. ( )

02. Idaho Microbiology Laboratory Fee. Laboratories requesting microbiology certification will be charged a fee of one hundred fifty dollars ($150). Certification is valid for one (1) year from the date of issuance. ( )

03. Out of State Chemistry Laboratory Fees. Out of state laboratories requesting chemistry certification will be charged a base fee of two hundred dollars ($200) per discipline and twenty dollars ($20) per analyte per method. Certification is valid for one (1) year from the date of issuance. ( )

04. Out of State Microbiology Laboratory Fee. Out of state laboratories requesting microbiology certification will be charged a fee three hundred dollars ($300). Certification is valid for one (1) year from the date of issuance. ( )

05. New Laboratory Non-Refundable Application Fee. New laboratories requesting certification will be charged a non-refundable application fee of two hundred fifty dollars ($250) per discipline listed and the

completed application form. ( )

102. -- 109. (RESERVED)

110. ON-SITE AUDIT.
Qualified representatives of the department are authorized to audit the premises and operations of all certified laboratories to determine the adequacy of the laboratory to perform drinking water compliance testing. On-site audits must occur a minimum of every three (3) years or more frequently at the discretion of the department. Departmental representatives will issue a written report of audit findings, list items requiring a laboratory response, and specify the response timeframe required to maintain certification. ( )

~~**01. Annual Base Fee**. All CDWLs must pay an annual base fee of fifty dollars ($50) per discipline and twenty dollars ($20) per analyte per method for which certification is requested. Certification is valid for one (1) year from the date of issuance. (3-15-22)~~

~~**02. Non-Refundable Application Fee**. Each new laboratory that is seeking certification or reciprocity must include a non-refundable application fee of two hundred dollars ($200) per discipline with the application. (3-15-22)~~

~~**102. TYPES OF CERTIFICATION.**~~

~~**01. Certified**. A certified laboratory meets the regulatory performance criteria described in these rules. (3-15-22)~~

~~**02. Provisionally Certified**. A provisionally certified laboratory has deficiencies, but demonstrates the ability to consistently produce valid data within the acceptance limits in these rules. (3-15-22)~~

~~**03. Not Certified**. A laboratory with the status of "not certified" can not produce consistently valid data, or is not following method protocol, or both. Such laboratories cannot analyze compliance samples. (3-15-22)~~

~~**04. Interim Certification**. The CA may grant interim certification to a laboratory if the laboratory has appropriate instrumentation, is using approved methods, has adequately trained personnel to perform the analyses, and has satisfactorily analyzed PT samples for the contaminants involved. The CO will review the laboratory's quality control data before granting this type of certification and will conduct an on-site evaluation as soon as possible. (3-15-22)~~

~~**05. Reciprocity**. Reciprocity may be granted by the CA to out-of-state laboratories if such laboratories are certified or accredited by an approved regulatory agency and meet the regulatory performance criteria described in these rules. (3-15-22)~~

~~**103. SUBCONTRACTING.**~~

~~**01. List of Subcontractors**. Laboratories who subcontract work must maintain a list of subcontractors and documentation of the subcontracting laboratories' certification or reciprocity with the State of Idaho. (3-15-22)~~

~~**02. Identification Requirements for Subcontracting Laboratory**. The laboratory performing the subcontracted analysis must be identified by name and EPA identification number on the final report. (3-15-22)~~

~~**03. Availability of the Report from the Subcontracting Laboratory**. The report from the subcontracting laboratory must be available to the client upon request. (3-15-22)~~

~~**04. Availability of all Subcontracting Laboratory Records**. All subcontracting laboratory records must be available to the COs. (3-15-22)~~

~~**104. -- 109. (RESERVED)**~~

~~**110. ON-SITE EVALUATION.**~~

~~**01. On-Site Audits and Evaluations**. COs will perform audits of the premises and operations of new laboratories or laboratories requesting continuing certification for the purpose of determining if there is enough security to maintain the integrity of the samples and data. The frequency of the on-site evaluation is at the discretion of the CA or a minimum of every three (3) years. In addition, the CO will evaluate the: (3-15-22)~~

~~**a.** Physical set up of the laboratory; (3-15-22)~~

~~**b.** Quality assurance program; (3-15-22)~~

~~**c.** Personnel qualifications; (3-15-22)~~

~~**d.** Equipment considerations; and (3-15-22)~~

~~**e.** Adequacy of data handling. (3-15-22)~~

~~**02. Written Report of Findings from the On-Site Evaluation**. The CO will generate a written report of findings from the on-site evaluation. The report will detail areas requiring a written response and specify the length of time the laboratory has to respond. The length of time for the laboratory to respond will be proportional the number and severity of deviations. If the conditions observed during an on-site evaluation are such that an immediate down grade or decertification is warranted the laboratory will be notified by certified mail within thirty (30) days by the CA. - (3-15-22)~~

111. -- 1~~1~~29. **(RESERVED)**

130. REPORTING, NOTIFICATION, AND DISTRIBUTION OF LABORATORY RESULTS.

01. Submission of Test Results in Approved Format. Test results must be submitted in a format approved by the regulatory agency. Test results must be reported to the regulatory agency, or designee, no later than ten (10) business days after the completion of testing or upon receipt of results from subcontract laboratories. ( )

02. Notification of High Chemical Contaminant Levels. As soon as feasible, the laboratory must notify the regulatory agency, or designee, of any nitrate and nitrite level exceeding the current MCL. Notification must also be made for any other regulated chemical or radiological contaminant that exceeds four (4) times the MCL. Notification requirements apply to any samples subcontracted to another laboratory. ( )

03. Notification of Positive Microbiological Results. The laboratory must notify the regulatory agency, or designee, of any total coliform positive result by the end of the day unless the positive result is obtained after the regulatory agency is closed and the regulatory agency does not have either an after-hours phone line or an alternative notification procedure, in which case the laboratory must notify the regulatory agency before the end of the next business day. ( )

~~**120. PERSONNEL QUALIFICATIONS.**~~

~~**01. General Supervisor Qualifications**. (3-15-22)~~

~~**a.** A supervisor must be on site frequently enough to satisfactorily perform the required duties outlined below. The CO must be notified if the supervisor is unable to be on-site for a period greater than three (3) consecutive weeks. (3-15-22)~~

~~**b.** Supervisors are responsible for ensuring that all laboratory personnel have demonstrated proficiency for assigned functions and that all data reported by the laboratory meet the required quality assurance criteria and regulatory requirements. (3-15-22)~~

~~**c.** If a formal complaint is received from the regulatory agency, then the CO will notify the responsible laboratory supervisor and request a report describing the incident, the probable cause, and the corrective action to be taken to ensure the situation is resolved. The incident report must be received by the CA within thirty~~

~~(30) days of the laboratory being notified of the problem. The CO in conjunction with the CA will evaluate the response and if found to be acceptable, no further action will be required of the laboratory. If the response is incomplete, the CO will provide in writing the additional steps that must be completed for certification status to remain uninterrupted.~~ ~~(3-15-22)~~

~~**d.** No drinking water supervisor will be responsible for the supervision of more than two (2) certified drinking water laboratories unless specifically approved by the CA.~~ ~~(3-15-22)~~

~~**e.** If a microbiology supervisor is not available, a consultant having the same qualifications may be utilized. The laboratory must submit the academic qualifications and work experience of the potential consultant to the CA. In addition, the laboratory must define and submit a list of the specific functions the consultant will be performing along with a schedule of routine visits. If the information is found to be acceptable, the CA will notify the laboratory director or owner in writing. A record of all consultant visits and communications must be maintained and be available for review during the on-site evaluation. The record must include a brief description of on-site findings and include any telephone or electronic consultation. Each entry must be dated and signed by the consultant.~~ ~~(3-15-22)~~

~~**02. Supervisor Qualifications by Discipline**.~~ ~~(3-15-22)~~

~~**a.** The supervisor of a microbiology laboratory must have a bachelor's degree from an accredited college in microbiology, biology, or equivalent. Supervisors who have a degree in a subject other than microbiology must have had at least two (2) college-level microbiology courses in which environmental microbiology was part of the curriculum. In addition, the supervisor must have a minimum of two (2) weeks training at a federal agency, state agency, or academic institution in the microbiological analysis of drinking water or eighty (80) hours of on-the-job-training in water microbiology at a certified laboratory, or other comparable training acceptable to the CA.~~ ~~(3-15-22)~~

~~**b.** The supervisor of a chemistry laboratory must have at least a bachelor's degree from an accredited college with a major in chemistry or equivalent and at least one (1) year of experience in the analysis of drinking water. In addition, the supervisor must have a working knowledge of quality assurance principles.~~ ~~(3-15-22)~~

~~**c.** The supervisor of a radiochemistry laboratory must have at least a bachelor's degree from an accredited college with a major in chemistry, or equivalent, and should have at least one (1) year of experience in the measurement of radioactive analytes in drinking water. In addition, the supervisor must have a working knowledge of QA and QC principles as applied to all radiochemical practices and procedures conducted in the laboratory.~~ ~~(3-15-22)~~

~~**03. Analyst or Equivalent Job Title**.~~ ~~(3-15-22)~~

~~**a.** An analyst performing microbiological testing must have a minimum of a high school education or equivalent, at least three (3) months of bench experience in environmental microbiological testing, and thirty (30) days on the job training in drinking water microbiology under the direction of an experienced analyst. If an analyst has a bachelor's degree in microbiology, or related field, the three (3) month bench training may be shortened to thirty (30) hours at the discretion of the laboratory supervisor. Before analyzing compliance samples, the analyst must demonstrate competency by successfully completing a PT.~~ ~~(3-15-22)~~

~~**b.** Analysts in each of the chemical disciplines should have at least a bachelor's degree with a major in chemistry, or equivalent, and at least one (1) year of experience in the analysis of drinking water for the discipline in which they are working. If the analyst is responsible for the operation of analytical instrumentation, they must have completed specialized training offered by the manufacturer or another qualified training facility or have successfully served an apprenticeship under an experienced analyst. The duration of this apprenticeship should be proportional to the sophistication of the instrument. Data produced by analysts and instrument operators while in the process of obtaining the required training or experience are acceptable only when reviewed and validated by a fully qualified analyst or the laboratory supervisor. Documentation of training must be maintained for each analyst and available for evaluation by the CO.~~ ~~(3-15-22)~~

~~**04. Chemistry Technician**. Technicians in each of the chemical disciplines must have at least a high school diploma or equivalent, have completed a method-training program under an experience analyst, and have six~~

(6) months bench experience in the analysis of drinking water. The method-training record for each analyst should be recorded in a training file and available for evaluation by the CO. (3-15-22)

121. -- 129. (RESERVED)

130. REPORTING, NOTIFICATION, AND DISTRIBUTION OF LABORATORY RESULTS.

01. Submission of Test Results in Approved Format. The drinking water supervisor in each of the disciplines of certification is responsible for submission of all test results performed on samples submitted by PWSs, including subcontracted samples, in a format approved by the DEQ Drinking Water Program. Reports must be submitted to the appropriate regulatory authority or drinking water coordinator in a timely manner not to exceed ten (10) business days after the completion of testing or upon receipt of results from subcontract laboratories. (3-15-22)

02. Notification of High Contaminant Levels. The chemistry supervisor or designee must notify the appropriate regulatory agency or drinking water coordinator by phone as soon as feasible of any nitrate and nitrite level exceeding the current MCL including subcontracted samples. Notification must also be made when any other regulated chemical or radiological contaminant exceeds four (4) times the MCL. (3-15-22)

03. Notification of Positive Microbiological Results. The microbiological supervisor or designee is responsible for an immediate telephone notification to the appropriate regulatory agency in the case of a positive result for a microbiological test. If the RA or DWC is not available, the results must be given to the person designated by the RA or DWC to take the information. (3-15-22)

131. -- 139. (RESERVED)

140. LABORATORY QUALITY ASSURANCE.

01. The QA Plan. Each laboratory certified or having reciprocity with the State of Idaho must have and adhere to a QA plan. Laboratories seeking certification will be required to submit such a plan for review as part of the application process. (3-15-22)

02. Required Items for the QA Plan. The EPA Manual for the Certification of Laboratories Analyzing Drinking Water lists the items that must be included: (3-15-22)

a. Laboratory organization and responsibility; (3-15-22)

b. SOPs with dates of last revision; (3-15-22)

c. Laboratory sample receipt and handling procedure; (3-15-22)

d. Instrument calibration procedures; (3-15-22)

e. Analytical procedures; (3-15-22)

f. Data reduction, validation, reporting and verification; (3-15-22)

g. Type of quality control (QC) checks and frequency of use; (3-15-22)

h. List of schedules of internal and external system and data quality audits and inter-laboratory comparisons; (3-15-22)

i. Preventive maintenance procedures and schedules; (3-15-22)

j. Corrective action contingencies; and (3-15-22)

k. Record keeping procedures. (3-15-22)

03. Chain-of-Custody Procedures. Each laboratory must have a procedure in place in the event the submitter requires an evidence chain-of-custody. (3-15-22)

04. Maintenance of Records. Each laboratory must: (3-15-22)

a. Maintain a record keeping system that allows the history of the sample and associated data to be readily understood through documentation. This would include access to LIMS, both present and prior systems, all electronic data including backup, QC documents and all associated calculations, maintenance records including replacement history of instruments, submission forms, submission forms to subcontracting laboratories, final reports from subcontracting laboratories, and final reports generated by the certified laboratory. (3-15-22)

b. Retain all records for a minimum of five (5) years from generation of the last entry in the records. (3-15-22)

c. Notify public water system clients before disposing of records. (3-15-22)

d. Be aware of and adhere to specific record retention as required for specific analytes or disciplines. (3-15-22)

05. Proficiency Testing (PT). Proficiency test samples must be successfully analyzed annually per analyte per method for which the laboratory is certified. All PT samples must be obtained from an approved supplier, and must be analyzed in the same manner as routine samples by the primary analyst assigned to the specific analysis. If testing is rotated among a number of analysts the supervisor will be responsible for determining who completes the PT. Records must include the name of the analyst who completed the testing. The results of the PT must be sent directly from the supplier to the CO. The methods listed on the laboratory's certificate must be the methods used for PT samples. (3-15-22)

141. – 149. (RESERVED)

150. EVALUATION.

01. Documentation of Corrective Action. If a CDWL is found to be noncompliant, it will be notified in writing by the CA of the number and seriousness of the deviations. The noncompliant laboratory will be required to submit documentation of correction to the CA or their designee within the time limit specified by the CA. (3-15-22)

02. Adequacy of Corrective Action. Upon receipt of documentation of corrective action, the CO in conjunction with the CA will review the response to determine the adequacy of the corrective action taken. The laboratory will be eligible for certification if the response is found to be complete. If the response is incomplete or inadequate, the laboratory will be notified in writing of the additional changes required along with a specified time for completion. (3-15-22)

03. Unacceptable PT Result. In the event of an unacceptable PT, the laboratory must submit an incident report to the CO that includes a description of the incident and corrective action taken. A second PT must be completed within sixty (60) days of the laboratory being notified of the failure. If the second PT is successfully analyzed no further action will be taken. If a second PT is not analyzed or if the second PT is also unacceptable, the laboratory will be downgraded in accordance with Section 210 of these rules. (3-15-22)

04. Continued Certification of Other Tests. A CDWL that has an unacceptable PT result per analyte per method may remain certified for performance of all tests for which satisfactory performance has been demonstrated through the annual successful PT testing. (3-15-22)

151. – 199. (RESERVED)

REQUIREMENTS FOR DRINKING WATER LABORATORIES TO MAINTAIN, DOWNGRADE, OR REVOKE CERTIFICATION
(Sections 200-299)

200. MAINTENANCE OF CERTIFICATION.
In order to maintain certification, drinking water laboratories must be able to demonstrate they continue to meet all of the following requirements. (3-15-22)

01. Successful Completion of PT Samples. Each year, each laboratory must successfully complete a PT per analyte per method for which the laboratory is seeking to maintain certification. (3-15-22)

02. Use of Specified Methods. Each laboratory must be able to demonstrate it is using the methods specified in the drinking water regulations. (3-15-22)

03. Maintain Required Standard of Quality. The CO must be satisfied the laboratory is maintaining the required standard of quality for certification. This is based on the results of the PT testing, on-site evaluations, and any feedback from regulatory agencies. (3-15-22)

04. Notification of Major Changes. The laboratory must notify the CA in writing within thirty (30) days of major changes that could affect the accuracy and precision of testing. A major change includes the loss of a laboratory supervisor, equipment failure or breakdown, or change in location or ownership. (3-15-22)

201. -- 209. (RESERVED)

210. CRITERIA AND PROCEDURES FOR DOWNGRADING OR REVOKING CERTIFICATION STATUS.

01. Reasons a Laboratory May be Downgraded to Provisionally Certified Status. A laboratory may be downgraded to provisionally certified status for an analyte or method for any of the following reasons: (3-15-22)

a. Failure to analyze a PT annually within acceptance limits specified in the regulations as demonstrated by a failure of a second PT; (3-15-22)

b. Failure to submit an incident report after failing a PT or to analyze a second PT; (3-15-22)

c. Failure to notify the CA within thirty (30) days of major changes; (3-15-22)

d. Failure to maintain the required standard of quality based upon observations made by the CO during an on-site evaluation; or (3-15-22)

e. Failure to report compliance data to the regulatory agency in a timely manner. (3-15-22)

02. Procedure for Downgrading to Provisionally Certified Status. (3-15-22)

a. The CA will notify the laboratory director or owner by certified mail of the intent to downgrade the laboratory to provisional certification per analyte per method within thirty (30) days of learning of any of the items listed under Subsection 210.01 of this rule. The laboratory will be given be given thirty (30) days from the date of receipt to develop a written corrective action plan and submit it with all supporting documentation to the CA. This information will be reviewed and evaluated for adequacy. The laboratory will be notified by certified mail if the response is acceptable or if additional corrective action must be taken. The CO will document that the corrective action plan has been implemented during the next on-site evaluation. (3-15-22)

b. If a laboratory fails a second PT, the CA will downgrade the laboratory to provisionally certified status for that analyte or method and notify the laboratory by certified mail. (3-15-22)

c. A provisionally certified laboratory has three (3) months to correct the problem in a manner that is acceptable to the CA. If the downgrading of certification is based on the results of PT testing, the reason for the error must be identified and corrected. A third PT must be successfully analyzed. A provisionally certified laboratory may continue to analyze samples for compliance purposes, but must notify its clients of the downgraded status of

~~certification and provide that information in writing on all reports.~~ ~~(3-15-22)~~

~~**d.** An out-of-state laboratory that has reciprocity with Idaho and is downgraded to provisional status by either the accreditation agency or certification authority of the home state must notify the CA of the change within thirty (30) days of the downgrade.~~ ~~(3-15-22)~~

~~**03. Criteria for Revoking Certification Status**.~~ ~~(3-15-22)~~

~~**a.** A laboratory must be downgraded from certified, provisionally certified, or interim certified status to "not certified" for a particular analyte or method for the following reasons:~~ ~~(3-15-22)~~

~~i. Reporting PT data from another laboratory as its own;~~ ~~(3-15-22)~~

~~ii. Falsification of data or other deceptive practices;~~ ~~(3-15-22)~~

~~iii. Failure to use the analytical methodology specified in the regulations; and~~ ~~(3-15-22)~~

~~iv. For provisionally certified laboratories, failure to correct the identified deficiencies that lead to the downgrading of certification status.~~ ~~(3-15-22)~~

~~**b.** Reciprocity of out-of-state laboratories who do not notify the CA of any changes in the status of certification or accreditation will automatically be revoked.~~ ~~(3-15-22)~~

~~**04. Procedure for Revocation**.~~ ~~(3-15-22)~~

~~**a.** The CA will notify the laboratory in writing of the intent to revoke certification. The laboratory will have thirty (30) days from the time of the notification to provide a written response.~~ ~~(3-15-22)~~

~~**b.** If the laboratory responds with an acceptable written corrective action plan, including documentation of implementation, the revocation will be suspended.~~ ~~(3-15-22)~~

~~**c.** If the response is unacceptable, incomplete, or both, certification will be revoked. If the laboratory does not respond, certification will be revoked. The laboratory will be notified in writing of the revocation.~~ ~~(3-15-22)~~

~~**05. Upgrading or Reinstatement of Certification**. A laboratory seeking an upgrade of certification must request this change in writing and provide documentation that the deficiencies that led to the provisional certification have been corrected. In addition, an on-site evaluation and successful completion of an additional PT may be required. A laboratory seeking certification after a revocation must follow the same procedure as a new laboratory seeking initial certification.~~ ~~(3-15-22)~~

~~211~~131. -- 999. (RESERVED)

IDAPA 16 – IDAHO DEPARTMENT OF HEALTH AND WELFARE

16.03.09 – MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-2401 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo and Incorporation By Reference Synopsis (IBRS)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

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) 56-202, Idaho Code, and Sections 56-264, 56-265, and 56-1610, 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:

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language. The changes in text from the proposed rule to the adopted rule are as a result of responses received from stakeholders during the public comment period, as well as to correct errors noted after publication of the proposed rule.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the September 4th, 2024, Idaho Administrative Bulletin, Vol. 24-9, pages 145-302.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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 anticipated fiscal impact to the state General Fund or any other fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at (208) 334-5500.

DATED this 15th day of October, 2024.

Alex J. Adams, PharmD, MPH
Director
Idaho Department of Health & Welfare
450 W. State Street, 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5500 phone; (208) 334-6558 fax
Alex.Adams@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 Section 56-202, Idaho Code, and Sections 56-264, 56-265, and 56-1610, Idaho Code.

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

VIRTUAL TELECONFERENCE Via WebEx

Tuesday, September 17, 2024
1:00pm- 2:00pm (MT)

Join from the meeting link
https://idhw.webex.com/idhw/j.php?MTID=m292b238a95c19e7f077494c941daf3f7

Join by meeting number
Meeting number (access code): **2826 650 5576**
Meeting password: **jbJ5KKrrW26**
Meeting password from phone: **52555577**

Join by phone
+1-415-527-5035 United States Toll
+1-303-498-7536 United States Toll (Denver)

VIRTUAL TELECONFERENCE Via WebEx

Friday, September 20, 2024
2:30pm- 3:30pm (MT)

Join from the meeting link
https://idhw.webex.com/idhw/j.php?MTID=m9e9e8b604ab7fcd24631e522770ffdd9

Join by meeting number
Meeting number (access code): **2819 457 8744**
Meeting password: **ZrXA4fmkT42**
Meeting password from phone: **97924365**

Join by phone
+1-415-527-5035 United States Toll
+1-303-498-7536 United States Toll (Denver)

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:

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language.

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

Fees will not be increased as a result of this rule change.

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:

There is no anticipated fiscal impact to the state General Fund or any other fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the May 1st, 2024, Idaho Administrative Bulletin, Volume 24-5, pages 198 through 199.

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

The "Estimated Useful Lives of Depreciable Hospital Assets" is incorporated by reference to support financial operations and reimbursement. A copy of the document is available from the copyright holder, the American Hospital Association.

The "Provider Reimbursement Manual (PRM)" is incorporated by reference to support financial operations and reimbursement. The document is available at https://www.cms.gov/medicare/regulations-guidance/manuals/paper-based-manuals.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jared Larsen at 208-334-5500.

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 25th, 2024.

DATED this 22nd day of July, 2024.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0309-2401

Italicized red text that is *double underscored* indicates amendments to the proposed text as adopted in the pending rule.

16.03.09 – MEDICAID BASIC PLAN BENEFITS

000. LEGAL AUTHORITY.

01. Rulemaking Authority. The Idaho Department of Health and Welfare has the authority to promulgate public assistance rules under Section 56-202(b), 56-264, 56-265, and 56-1610, Idaho Code. (3-17-22)

~~**02. General Administrative Authority**. Titles XIX and XXI of the Social Security Act, as amended, and the companion federal regulations, are the basic authority for administration of the federal program. General administrative duties for the Department are found under Section 56-202, Idaho Code.~~ (3-17-22)

~~**03. Administration of the Medical Assistance Program.**~~ (3-17-22)

~~**a.** Section 56-203(7), Idaho Code, empowers the Department to define persons entitled to medical assistance.~~ (3-17-22)

~~**b.** Section 56-203(9), Idaho Code, empowers the Department to identify the amount, duration, scope of care, and services to be purchased as medical assistance on behalf of individuals eligible to receive benefits under the Medical Assistance Program.~~ (3-17-22)

~~**c.** Sections 56-250 through 56-257, and 56-260 through 56-266, Idaho Code, establish minimum standards that enable these rules.~~ (3-17-22)

~~**04. Fiscal Administration.**~~ (3-17-22)

~~**a.** Fiscal administration of these rules is authorized by Titles XIX and XXI of the Social Security Act, as well as 42 CFR Part 447 and the Provider Reimbursement Manual (PRM) Part I and Part II found in CMS Publication 15-1 and 15-2. Provisions of the PRM, as incorporated in Section 004 of these rules, apply unless otherwise provided for in these rules.~~ (3-17-22)

~~**b.** Title 56, Chapter 1, Idaho Code, establishes standards for provider payment for certain Medicaid providers.~~ (3-17-22)

001. ~~TITLE AND~~ SCOPE.

~~**01. Title**. The title of these rules is IDAPA 16.03.09, "Medicaid Basic Plan Benefits."~~ (3-17-22)

02. ~~Scope~~. ~~This chapter of~~These rules contain~~s~~ the general provisions regarding the administration of ~~the Medical Assistance Program~~ Medicaid. All goods and services not specifically included in this chapter are excluded from coverage under the Medicaid Basic Plan. ~~A guide to covered services is found under Section 399 of these rules.~~ These rules also contain requirements for provider procurement and ~~provider~~ reimbursement.
~~(3-17-22)~~( )

~~**002. WRITTEN INTERPRETATIONS.**~~
~~This agency may have written statements that pertain to the interpretations of the rules of this chapter. These documents are available for public inspection.~~ (3-17-22)

002. – 003. (RESERVED)

004. INCORPORATION BY REFERENCE.

The ~~following are~~ Department has incorporated by reference ~~in this chapter of rules~~ the following: ~~(3-17-22)~~( )

~~**01. American Speech-Language-Hearing Association (ASHA): Medicaid Guidance for Speech-Language Pathology Services**. The American Speech-Language-Hearing Association (2004) Medicaid Guidance~~

~~for Speech-Language Pathology Services: Addressing the "Under the Direction of" Rule technical report is available on the internet at: https://www.asha.org/. The report may also be obtained at the ASHA National Office, 2200 Research Boulevard, Rockville, MD 20850-3289, telephone (301) 296-5700.~~ ~~(3-17-22)~~

~~**02. DSM-5-TR**. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) Arlington, VA, American Psychiatric Association, 2022. A copy of the manual is available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702.~~ ~~(7-1-24)~~

0~~3~~1. **Estimated Useful Lives of Depreciable Hospital Assets, ~~2004~~ 2023 Revised Edition~~, Guidelines Lives~~**. Thi~~s~~e document may be obtained from the American Hospital ~~Publishing, Inc., 211 East Chicago Avenue~~ Association, 155 North Wacker Drive, Ste. 400, Chicago, IL, 606~~11~~06. ~~(3-17-22)~~( )

~~**04. Medicare Durable Medical Equipment Medicare Administrative Contractor Jurisdiction D Supplier Manual 2016, As Amended (CMS/Medicare DME Coverage Manual)**. Since the supplier manual is amended on a quarterly basis by CMS, the current year's manual is being incorporated by reference, as amended, to allow for the incorporation of the most recent amendments to the manual. The full text of the CMS/Medicare DME Coverage Manual is available via the Internet at https://med.noridianmedicare.com/web/jddme/education/supplier-manual.~~ ~~(3-17-22)~~

0~~5~~2. **Provider Reimbursement Manual (PRM)**. The Provider Reimbursement Manual (PRM), Part I and Part II (CMS Publication 15-1 and 15-2), is available ~~on the CMS website~~ at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html. ~~(3-17-22)~~( )

~~**06. Travel Policy and Procedures**. The text of "State Travel Policy and Procedures," Appendices A and B, January 17, 2023, is available at the Office of the State Controller, 700 W. State St., 5th Fl., Box 83720, Boise, Idaho 83720-0011 or at https://www.sco.idaho.gov/LivePages/state-travel-policy-and-procedures.aspx.~~ ~~(7-1-24)~~

005. -- 007. (RESERVED)

008. ~~AUDIT, INVESTIGATION, AND ENFORCEMENT.~~(RESERVED)
~~The Department may audit, investigate, and take enforcement action under IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct."~~ ~~(7-1-24)~~

009. BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Background Checks. Background checks are required for ~~certain types of~~ specific providers under these rules. Providers who are required to have a background check and their contractors must comply with IDAPA 16.05.06, "Criminal History and Background Checks." ~~(7-1-24)~~( )

02. Department-Issued Variances to Requirements for a Clearance. (7-1-24)

a. Notwithstanding ~~those~~ provider types required to obtain a clearance or enhanced clearance under these rules or under IDAPA 16.05.06, "Criminal History and Background Checks," the Department may allow variances to clearance requirements under certain circumstances. Providers who are subject to a background check must still complete ~~and notarize~~ an application for a background check. ~~(7-1-24)~~( )

b. In cases where the application process results in a denial ~~rather than a clearance, and the denial is~~ due to the applicant's prior convictions for disqualifying drug and alcohol-related offenses, the applicant may, with prior written approval of the Department, deliver covered Medicaid Peer Support and Recovery Coaching services. ~~(3-17-22)~~( )

~~**c.** A variance may be granted on a case by case basis upon review by the Department of any underlying facts and circumstances in each individual case. The Department will establish the process for the administrative review which will be conducted separate from the background check unit. During the Department's review, the following factors may be considered:~~ ~~(7-1-24)~~

~~i. The severity or nature of the crimes or other findings; (3-17-22)~~

~~ii. The period of time since the incidents occurred; (3-17-22)~~

~~iii. The number and pattern of incidents being reviewed; (3-17-22)~~

~~iv. Circumstances surrounding the incidents that would help determine the risk of repetition; (3-17-22)~~

~~v. The relationship between the incidents and the position sought; (3-17-22)~~

~~vi. Activities since the incidents, such as continuous employment, education, participation in treatment, completion of a problem-solving court or other formal offender rehabilitation, payment of restitution, or any other factors that may be evidence of rehabilitation; (3-17-22)~~

~~vii. A pardon granted by a state governor or the President of the United States; (7-1-24)~~

~~viii. The falsification or omission of information on the self-declaration form and other supplemental forms submitted; and (3-17-22)~~

~~ix. Any other factor deemed relevant to the review. (3-17-22)~~

~~**d.** A variance granted under these rules is not a criminal history and background check clearance and does not set a precedent for subsequent application for variance. The Department may revoke a variance when it identifies a risk to participants' health and safety. Providers who have been granted a variance must still meet all other Department requirements for Medicaid coverage and reimbursement of Peer Support and Recovery Coaching services, and are prohibited from delivering any other covered Medicaid service without the required clearance or Department enhanced clearance. (3-17-22)~~

~~**03. Availability to Work or Provide Service**. (3-17-22)~~

~~**a.** The employer may allow an individual to provide care or services on a provisional basis once the application for a 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. (7-1-24)~~

~~**b.** Those individuals licensed or certified by the Department are not available to provide services or receive licensure or certification until the background check is completed and a clearance issued by the Department. (7-1-24)~~

043. ~~Additional Criminal~~Subsequent Convictions, Charges, or Investigations. Once ~~an individual has received a~~ clearances are received, any ~~additional~~ subsequent criminal, adult, or child protection convictions, charges, or investigations must be immediately reported by the agency to the Department ~~when the agency learns of the conviction~~. ~~(7-1-24)~~( )

054. Providers Subject to Background Check Requirements. ~~The following providers must receive a clearance:~~ ~~(7-1-24)~~( )

a. Contracted Non-Emergency Medical Transportation (NEMT) Providers. All staff of ~~transportation~~ NEMT providers having contact with participants except for ~~i~~Individuals~~s~~ ~~e~~Contracted NEMT ~~as transportation~~ providers defined in ~~Subsection 870.02 of~~ these rules. ~~(7-1-24)~~( )

b. Provider types deemed by the Department to be at high risk for fraud, waste, and abuse under ~~Subsection 200.02 of~~ these rules and 42 CFR 455~~.434~~ Subpart E. ~~(7-1-24)~~( )

010. DEFINITIONS: A THROUGH H.

For the purposes of these rules, the following terms are used as defined below: (3-17-22)

~~01. Abortion. The medical procedure necessary for the termination of pregnancy endangering the life of the woman, or the result of rape or incest, or determined to be medically necessary in order to save the health of the woman.~~ ~~(3-17-22)~~

021. **Amortization**. The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. (3-17-22)

032. **Ambulatory Surgical Center (ASC)**. Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, and which is certified by the U.S. Department of Health and Human Services as an ASC. (3-17-22)

043. **Audit**. An examination of provider records on the basis of which an opinion is expressed representing the compliance of a provider's financial statements and records with Medicaid ~~law,~~ regulations~~, and rules~~. ~~(3-17-22)~~( )

054. **Auditor**. The individual or entity designated by the Department to conduct the audit of a provider's records. (3-17-22)

~~06. Audit Reports.~~ ~~(3-17-22)~~

~~a. Draft Audit Report. A preliminary report of the audit finding sent to the provider for the provider's review and comments.~~ ~~(3-17-22)~~

~~b. Final Audit Report. A final written report containing the results, findings, and recommendations, if any, from the audit of the provider, as approved by the Department.~~ ~~(3-17-22)~~

~~c. Interim Final Audit Report. A written report containing the results, findings, and recommendations, if any, from the audit of the provider, sent to the Department by the auditor.~~ ~~(3-17-22)~~

~~07. Bad Debts. Amounts due to provider as a result of services rendered, but which are considered uncollectible.~~ ~~(3-17-22)~~

085. **Basic Plan**. The ~~medical assistance~~ Medicaid benefits included under this chapter of rules. ~~(3-17-22)~~( )

~~09. Buy-In Coverage. The amount the State pays for Medicare Part B of Title XVIII of the Social Security Act on behalf of eligible participants.~~ ~~(3-17-22)~~

~~10. Certified Registered Nurse Anesthetist (CRNA). A Licensed Registered Nurse qualified by advanced training in an accredited program in the specialty of nurse anesthesia to manage the care of the patient during the administration of anesthesia in selected surgical situations.~~ ~~(3-17-22)~~

~~11~~06. **Claim**. An itemized bill for services rendered to one (1) participant by a provider and submitted to the Department for payment. (3-17-22)

~~12. CFR. Code of Federal Regulations.~~ ~~(3-17-22)~~

~~13. Clinical Nurse Specialist (CNS). A licensed registered nurse who meets all the applicable requirements to practice as clinical nurse specialist according to the regulations in the state where services are provided.~~ ~~(3-17-22)~~

~~14~~07. **CMS**. Centers for Medicare and Medicaid Services. (3-17-22)

~~15~~08. **CMS/Medicare DME Coverage Manual**. Medicare Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Jurisdiction D Supplier Manual. (3-17-22)

~~**16. Co-Payment**. The amount a participant is required to pay to the provider for specified services.~~ ~~(3-17-22)~~

~~17~~09. **Cost Report**. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. (3-17-22)

1~~8~~0. **Customary Charges**. Customary charges are the rates charged to Medicare participants and ~~to~~ other paying patients ~~liable for such charges,~~ as reflected in the facility's records. Those charges are adjusted downward, when the provider does not impose such charges on most patients liable for payment on a charge basis or, when the provider fails to make reasonable collection efforts. The reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt as described in ~~Chapter 3, Sections 310 and 312,~~ the PRM. ~~(3-17-22)~~( )

1~~9~~1. **Department**. The Idaho Department of Health and Welfare or a person authorized to act on its behalf ~~of the Department~~. ~~(3-17-22)~~( )

~~20~~12. **Director**. The Director of the ~~Idaho~~ Department ~~of Health and Welfare~~ or their designee. ~~(3-17-22)~~( )

~~2~~13. **Dual Eligibles**. Medicaid participants who are also eligible for Medicare. (3-17-22)

~~22~~14. **Durable Medical Equipment (DME)**. Equipment and appliances that: (3-17-22)

a. Are primarily and customarily used to serve a medical purpose; (3-17-22)

b. Are generally not useful to an individual in the absence of a disability, illness, or injury; (3-17-22)

c. Can withstand repeated use; (3-17-22)

d. Can be reusable or removable; (3-17-22)

e. Are suitable for use in any setting in which normal life activities take place; and (3-17-22)

f. Are reasonable and medically necessary for the treatment of a disability, illness, or injury ~~for a Medicaid participant~~. ~~(3-17-22)~~( )

~~**23. Emergency Medical Condition**. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:~~ ~~(3-17-22)~~

~~**a.** Placing the health of the individual, or, with respect to a pregnant woman, the health of the woman or unborn child, in serious jeopardy.~~ ~~(3-17-22)~~

~~**b.** Serious impairment to bodily functions.~~ ~~(3-17-22)~~

~~**c.** Serious dysfunction of any bodily organ or part.~~ ~~(3-17-22)~~

~~**24. EPSDT**. Early and Periodic Screening, Diagnostic, and Treatment services.~~ ~~(3-17-22)~~

~~25~~15. **Facility**. Facility refers to a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities. (3-17-22)

~~**26. Federally Qualified Health Center (FQHC)**. An entity that meets the requirements of 42 U.S.C Section 1395x(aa)(4). The FQHC may be located in either a rural or urban area designated as a shortage area or in an area that has a medically underserved population.~~ ~~(3-17-22)~~

~~27~~16. **Fiscal Year**. An accounting period that consists of twelve (12) consecutive months. (3-17-22)

~~28~~17. **Healthy Connections**. The primary care case management model of managed care under Idaho Medicaid. (3-17-22)

~~29. Home Health Services. Services and items that are: (3-17-22)~~

~~a. Ordered by a physician or licensed practitioner of the healing arts as part of a home health plan of care; (3-17-22)~~

~~b. Performed by a licensed or qualified professional; (3-17-22)~~

~~c. Typically received by a Medicaid participant at the participant's place of residence; and (3-17-22)~~

~~d. Reasonable and medically necessary for the treatment of a disability, illness, or injury for a Medicaid participant. (3-17-22)~~

~~30. Hospital. A hospital as defined in Section 39-1301(a), Idaho Code. (3-17-22)~~

~~31. Hospital-Based Facility. A nursing facility that is owned, managed, or operated by, or is otherwise a part of a licensed hospital. (3-17-22)~~

011. DEFINITIONS: I THROUGH O.

01. **Idaho Medicaid Provider Handbook**. A document that contains policy for the implementation and operations of the Medicaid program. ( )

0~~1~~2. **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)**. An entity licensed as an ICF/IID and federally certified to provide care to Medicaid and Medicare participants with developmental disabilities. (7-1-24)

0~~2~~3. **Idaho Behavioral Health Plan (IBHP)**. A ~~prepaid ambulatory health plan (~~PA~~I~~HP~~)~~ that provides ~~outpatient~~ behavioral health coverage for Medicaid ~~eligible children and adults~~ participants. ~~Outpatient b~~Behavioral health services include mental health and substance use disorder treatment and case management services. The ~~coordination and~~ provision of behavioral health services as authorized through the IBHP contract are provided to ~~qualified, enrolled~~ participants by a ~~statewide~~ network of ~~professionally licensed and certified~~ behavioral health providers. ~~(7-1-24)~~( )

~~03. Idaho Infant-Toddler Program (ITP). Serves children from birth through the end of their 36th month of age who meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C. (7-1-24)~~

~~04. In-Patient Hospital Services. Services that are ordinarily furnished in a hospital for the care and treatment of an in-patient under the direction of a physician or dentist except for those services provided in mental hospitals. (3-17-22)~~

0~~5~~4. **Intermediary**. Any organization that administers Title XIX or Title XXI; in this case the Department of Health and Welfare. (3-17-22)

~~06. Intermediate Care Facility Services. Services furnished in an intermediate care facility as defined in 42 CFR 440.150, but excluding services provided in a Christian Science Sanatorium. (7-1-24)~~

0~~7~~5. **Legal Representative**. A parent ~~with custody of a minor child, one who holds a legally executed and effective power of attorney for health decisions,~~ or a court-appointed guardian ~~whose powers include the power~~ or custodian legally authorized to make health care decisions for a participant. ~~(3-17-22)~~( )

~~**08. Legend Drug**. A drug that requires, by federal regulation or state rule, the order of a licensed medical practitioner before dispensing or administration to the patient.~~ ~~(3-17-22)~~

0~~9~~6. **Level of Care**. The classification in which a participant is placed, based on severity of need for institutional care. (3-17-22)

~~**10. Licensed, Qualified Professionals**. Individuals licensed, registered, or certified by national certification standards in their respective discipline, or otherwise qualified within the state of Idaho.~~ ~~(3-17-22)~~

~~**11. Licensed Practitioner of the Healing Arts**. The term includes the following practitioner types: certified registered nurse anesthetists (CRNA), nurse practitioners (NP), nurse midwives (NM), clinical nurse specialists (CNS), and physician assistants (PA), as defined in these rules.~~ ~~(7-1-24)~~

~~12~~07. **Lock-In Program**. An administrative sanction, required of a participant found to have misused the services provided by the ~~Medical Assistance~~ Medicaid Program. The participant is required to select one (1) provider in the identified area(s) of misuse to serve as the primary provider. ~~(3-17-22)~~( )

~~**13. Locum Tenens/Reciprocal Billing**. The practice of a physician to retain a substitute physician when the regular physician is absent for reasons such as illness, pregnancy, vacation, or continuing medical education. The substitute physician is called the "Locum Tenens" physician. Reimbursement to a Locum Tenens physician will be limited to a period of ninety (90) continuous days. Reciprocal billing occurs when a substitute physician covers the regular physician during an absence or on an on-call basis a period of fourteen (14) continuous days or less.~~ ~~(3-17-22)~~

~~14~~08. **Medical Assistance**. Payments for part or all of the cost of services, capitation payments, or managed care costs funded by Titles XIX or XXI of the federal Social Security Act. ~~(7-1-24)~~( )

~~**15. Medicaid**. Idaho's Medical Assistance Program.~~ ~~(3-17-22)~~

~~16~~09. **Medicaid-Related Ancillary Costs**. Services considered to be ancillary by Medicare cost reporting principles. Medicaid-related ancillary costs will be determined by apportioning direct and indirect costs associated with each ancillary service to Medicaid participants by dividing Medicaid charges into total charges for that service. The resulting percentage, when multiplied by the ancillary service cost, will be considered Medicaid-related ancillaries. (7-1-24)

1~~7~~0. **Medical Necessity (Medically Necessary)**. A service is medically necessary if: (3-17-22)

a. It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; ~~and~~ ~~(3-17-22)~~( )

b. There is no other equally effective course of treatment available or suitable for the participant requesting the service that is more conservative or substantially less costly; (3-17-22)

c. It meets any applicable Department criteria. Services that do not meet criteria require a prior authorization; ( )

~~e~~**d.** Medical services must be: (3-17-22)

i. Of a quality that meets professionally-recognized standards of health care; and (3-17-22)

ii. Substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the Department upon request. (3-17-22)

1~~8~~1. **Medical Supplies**. Healthcare-related items that are consumable, disposable, or cannot withstand repeated use by more than one (1) individual, are suitable for use in any setting in which normal life activities take place, and are reasonable and medically necessary for the treatment of a disability, illness, or injury for a Medicaid participant. (3-17-22)

~~19. Medicare Durable Medical Equipment Medicare Administrative Contractor Jurisdiction D Supplier Manual (CMS/Medicare DME Coverage Manual). A publication incorporated in Section 004 of these rules that contains information on DME supplier enrollment, documentation, claim submission, coverage, appeals, and overpayments. (7-1-24)~~

~~20. Nurse Midwife (NM). An advanced practice registered nurse who meets all the applicable requirements to practice as a nurse midwife according to state regulations where the services are provided. (7-1-24)~~

~~2~~12. **Nominal Charges**. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the services provided. (3-17-22)

~~22. Non-Legend Drug. Any drug the distribution of which is not subject to the ordering, dispensing, or administering by a licensed medical practitioner. (3-17-22)~~

~~23. Non-Physician Practitioner (NPP). A non-physician practitioner, previously referred to as a midlevel practitioner, comprises the following practitioner types: certified registered nurse anesthetists (CRNA), nurse practitioners (NP), nurse midwives (NM), clinical nurse specialists (CNS), pharmacist (RPh), and physician assistants (PA), as defined in these rules. (3-17-22)~~

~~24. Nurse Practitioner (NP). A person who meets all the applicable requirements to practice as a nurse practitioner according to state regulations where the services are provided. (7-1-24)~~

~~25. Nursing Facility (NF). An institution, or distinct part of an institution, that is primarily engaged in providing skilled nursing care and related services for participants. It is an entity licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare participants. Participants must require medical or nursing care, or rehabilitation services for injuries, disabilities, or sickness. (3-17-22)~~

~~26. Ordering, Rendering, Prescribing Providers. Providers who order services, refer for services or prescribe services, products, or prescription drugs for Medicaid participants. (3-17-22)~~

~~27~~13. **Orthotic**. Pertaining to or promoting the support of an impaired joint or limb. (3-17-22)

~~28. Outpatient Hospital Services. Preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to a patient not in need of inpatient hospital care. (3-17-22)~~

~~29~~14. **Out-of-State Care**. Medical service that is not provided in Idaho or bordering counties is considered out-of-state. Bordering counties outside Idaho are considered out-of-state for the purpose of authorizing long term care. (3-17-22)

012. DEFINITIONS: P THROUGH Z.

01. Participant. A person eligible for and enrolled in ~~the Idaho Medical Assistance Program~~ Medicaid. ~~(3-17-22)~~( )

02. Patient. The person undergoing treatment or receiving services from a provider. (3-17-22)

~~03. Pharmacist. A person who meets all the applicable requirements to practice as a licensed pharmacist according to state regulations where the services are provided. (7-1-24)~~

~~04. Physician. A person possessing a Doctor of Medicine (MD) degree or a Doctor of Osteopathy (DO) degree, and within the State or United States territory services are provided is either licensed to practice medicine, is a resident enrolled in a postgraduate medical training program, is a licensed international medical graduate, or is a licensed bridge year physician. (7-1-24)~~

~~05. Physician Assistant (PA). A person who meets all the applicable requirements to practice as a~~

~~licensed PA according to state regulations where the services are provided.~~ ~~(7-1-24)~~

0~~6~~3. **Plan of Care**. A written description of medical, remedial, habilitative, 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. (7-1-24)

0~~7~~4. **Prepaid Ambulatory Health Plan (PAHP)**. Under 42 CFR 438.2~~, an entity that provides medical services to enrollees under contract with the Department on the basis of prepaid capitation payments, or other arrangements that do not use State Plan payment rates. The PAHP does not provide or arrange for, and is not responsible for the provision of any inpatient hospital or institutional services for its enrollees, and does not have a comprehensive risk contract~~. ~~(7-1-24)~~( )

05. Prepaid Inpatient Health Plan (PIHP). As defined under 42 CFR 438.2. ( )

0~~8~~6. **Private Rate**. Rate most frequently charged to private patients for a service or item. (3-17-22)

07. Prior Authorization. Prior authorization means a written, faxed, or electronic approval from the Department that permits payment or coverage of a medical item or service that is covered only by such authorization. ( )

0~~9~~8. **Prosthetic Device**. Replacement, corrective, or supportive devices~~ prescribed by a physician or other licensed practitioner of the healing arts profession within the scope of their practice as defined by state law~~ to: ~~(3-17-22)~~( )

a. Artificially replace a missing portion of the body; or (3-17-22)

b. Prevent or correct physical deformities or malfunctions; or (3-17-22)

c. Support a weak or deformed portion of the body. (3-17-22)

d. Computerized communication devices are not included in this definition~~ of a prosthetic device~~. ~~(3-17-22)~~( )

~~1~~0**9. Provider**. Any individual~~,~~ acting in concert with Section 200 including, but not limited to certified registered nurse anesthetists, nurse practitioners, nurse midwives, clinical nurse specialists, pharmacists, physician assistants, and physicians. Alternatively, a partnership, association, corporation, or organization~~, public or private,~~ that furnishes medical goods or services in compliance with these rules~~ and who has applied for and received a Medicaid provider number and who has entered into a written provider agreement with the Department under Section 205 of these rules~~. ~~(7-1-24)~~( )

~~**11. Provider Agreement**. A written agreement between the provider and the Department, entered into under Section 205 of these rules.~~ ~~(7-1-24)~~

1~~2~~0**. Provider Reimbursement Manual (PRM)**. A federal publication that specifies accounting treatments and standards for the Medicare program, CMS Publications 15-1 and 15-2, that are incorporated in Section 004 of these rules. (7-1-24)

~~**13. Psychologist, Licensed**. A person licensed to practice psychology according to state regulations where the services are provided.~~ ~~(7-1-24)~~

~~**14. Psychologist Extender**. A person who practices psychology under the supervision of a licensed psychologist who meets state regulations where the services are provided.~~ ~~(7-1-24)~~

~~**15. Public Provider**. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality.~~ ~~(3-17-22)~~

~~**16. Qualified Interpreter**. A person who meets the definition of qualified interpreter under 28 CFR~~

~~35.104.~~ ~~(7-1-24)~~

1~~7~~1. **Quality Improvement Organization (QIO)**. An organization that performs utilization and quality control review of health care furnished to Medicare and Medicaid participants. ~~A QIO is formerly known as a Peer Review Organization (PRO).~~ ~~(3-17-22)~~( )

1~~8~~2. **Related Entity**. An organization with which the provider is associated or affiliated to a significant extent, or has control of, or is controlled by, that furnishes the services, facilities, or supplies for the provider. (3-17-22)

~~**19.** **Registered Nurse (RN)**. A person who meets all the applicable requirements and is licensed to practice as an RN according to state regulations where the services are provided.~~ ~~(7-1-24)~~

13. **Retrospective Review**. A review of an item or service after it has been provided. The review determines if the item or service was medically necessary and conforms to Idaho Medicaid requirements. Claims that have already received payment may be subject to recoupment as detailed in IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse, and Misconduct," if they are not medically necessary. ( )

~~20~~14. **Rural Health Clinic (RHC)**. An ~~outpatient~~ entity that meets the requirements of 42 USC Section 1395x(aa)(2). ~~It is primarily engaged in furnishing physicians and other medical and health services in rural, federally defined, medically underserved areas, or designated health professional shortage areas.~~ ~~(7-1-24)~~( )

~~**21.** **Rural Hospital Based Nursing Facilities**. Hospital based nursing facilities not located within a metropolitan statistical area (MSA) as defined by the United States Bureau of Census.~~ ~~(3-17-22)~~

~~22~~15. **Social Security Act**. 42 USC 101 et seq., authorizing, in part, federal grants to the states for medical assistance to low-income persons who meet certain criteria. (3-17-22)

~~23~~16. **State Plan**. The contract between the state and federal government under 42 USC Section 1396a(a). (3-17-22)

~~24~~17. **Supervision**. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (3-17-22)

~~25~~18. **Title XVIII**. Title XVIII of the Social Security Act, known as ~~Medicare,~~ Health Insurance for The ~~a~~Aged~~, blind,~~ and ~~d~~Disabled ~~individuals~~ or Medicare and administered by the federal government. ~~(3-17-22)~~( )

~~26~~19. **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. (3-17-22)

2~~7~~0. **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. (3-17-22)

2~~8~~1. **Third Party**. Includes a person, institution, corporation, or public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a medical assistance participant. (7-1-24)

2~~9~~2. **Transportation**. The physical movement of a participant to and from a medical appointment or service by the participant, another person, taxi, or common carrier. (7-1-24)

~~**013. MEDICAL CARE ADVISORY COMMITTEE (MCAC).**~~
~~The Director of the Department will appoint a MCAC to advise on health and medical services.~~ ~~(7-1-24)~~

~~**01.** **Membership**. The MCAC will include the following:~~ ~~(7-1-24)~~

~~**a.** Licensed physicians and other health professionals familiar with the medical needs of low-income individuals and the resources available and required for their care; and~~ ~~(7-1-24)~~

~~**b.** Members of stakeholder organizations and Medicaid participants. (7-1-24)~~

~~**02. Organization**. The MCAC will: (7-1-24)~~

~~**a.** Consist of not more than twenty-two (22) members; (7-1-24)~~

~~**b.** Be appointed by the Director to the MCAC to serve three (3) year terms, whose terms are to overlap; (7-1-24)~~

~~**c.** Elect a chairman and a vice-chairman to serve a two (2) year term; (7-1-24)~~

~~**d.** Meet at least quarterly; and (3-17-22)~~

~~**e.** Submit an activity report and recommendations to the Director at least annually. (7-1-24)~~

~~**03. Policy Function**. The MCAC must be given opportunity to participate in medical assistance policy development and program administration. (7-1-24)~~

~~**04. Staff Assistance**. The MCAC must be provided staff assistance from within the Department and independent technical assistance as needed to enable them to make effective recommendations, and will be provided with travel and per diem costs, where necessary. (7-1-24)~~

014~~3~~. -- 099. (RESERVED)

GENERAL PARTICIPANT PROVISIONS
(Sections 100-199)

~~**100. ELIGIBILITY FOR MEDICAL ASSISTANCE.**~~
~~IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," are applicable in determining eligibility for medical assistance. (7-1-24)~~

10~~1~~0. -- 124. (RESERVED)

125. MEDICAL ASSISTANCE PROCEDURES.

01. ~~Issuance of~~ Identification Cards. ~~When a person is determined eligible for medical assistance, t~~The Department will issue a Medicaid identification card to ~~the~~ eligible participants which will contain the name of the participant and their Medicaid identification number. When requested, the Department will give providers ~~of medical services~~ eligibility information regarding participants so ~~that~~ services may be provided. Each Field Office will have information available for participants regarding the amount, duration, and scope of available care and services, the manner in which care and services may be secured, and how to use the identification card.
~~(3-17-22)~~( )

~~**02. Identification Card Information**. An identification card will be issued to each participant and will contain the following information: (3-17-22)~~

~~**a.** The name of the participant to whom the card was issued; and (3-17-22)~~

~~**b.** The participant's Medicaid identification number; and (3-17-22)~~

~~**c.** The card number. (3-17-22)~~

~~**03. Information Available for Participants**. The following information will be available at each Field Office for use by each medical assistance participant: (3-17-22)~~

~~**a.** The amount, duration and scope of the available care and services; and~~ ~~(3-17-22)~~

~~**b.** The manner in which the care and services may be secured; and~~ ~~(3-17-22)~~

~~**c.** How to use the identification card.~~ ~~(3-17-22)~~

126. -- 149. (RESERVED)

150. CHOICE OF PROVIDERS.

~~**01. Service Selection**. Each p~~Participants may obtain any services available from any participating ~~institution, agency, pharmacy, or practitioner~~ provider of their choice, unless enrolled in Healthy Connections ~~or a Prepaid Ambulatory Health Plan~~, a Managed Care Organization, ~~(~~PAHP~~)~~, or PIHP that limits provider choice, or a lock-in program. This~~, however,~~ does not prohibit the Department from establishing the fees that will be paid to providers ~~for furnishing medical and remedial care available~~ under ~~the Medical Assistance Program~~ Medicaid, or from setting standards relating to the qualifications of providers ~~of such care~~. ~~(3-17-22)~~( )

~~**02. Lock-In Option**.~~ ~~(3-17-22)~~

~~**a.** The Department may implement a total or partial lock-in program for any participant found to be misusing the Medical Assistance Program according to provisions in Sections 910 through 918 of these rules.~~ ~~(3-17-22)~~

~~**b.** In situations where the participant has been restricted to a participant lock-in program, that participant may choose the physician and pharmacy of their choice. The providers chosen by the lock-in participant will be identified in the Department's Eligibility Verification System (EVS). This information will be available to any Medicaid provider who accesses the EVS.~~ ~~(3-17-22)~~

151. -- 159. (RESERVED)

160. RESPONSIBILITY FOR KEEPING APPOINTMENTS.
~~The p~~Participants ~~is solely~~ are responsible for making and keeping ~~an~~ appointments with the provider. The Department will not reimburse providers when participants do not attend scheduled appointments. Providers ~~may~~ cannot bill participants for missed appointments. ~~(3-17-22)~~( )

161. -- ~~164.~~ ~~(RESERVED)~~

~~165. COST SHARING.~~

~~**01. Co-Payments**. When a participant accesses certain services inappropriately, the provider can require the participant to pay a co-payment as described in IDAPA 16.03.18, "Medicaid Cost Sharing."~~ ~~(3-17-22)~~

~~**02. Premiums**. A participant can be required to share in the cost of basic plan benefits in the form of a premium as described in IDAPA 16.03.18, "Medicaid Cost Sharing."~~ ~~(3-17-22)~~

~~166. —~~199. (RESERVED)

GENERAL PROVIDER PROVISIONS
(Sections 200-299)

200. INDIVIDUAL PROVIDERS – REQUIREMENTS.

01. Provider Eligibility. Be licensed or registered as required by the applicable jurisdiction for the profession, have a National Provider Identification or Medicaid provider number, and enter into a written provider agreement with the Department. ( )

02. Network Limitation. The Department may contract with a limited number of providers of certain

Medicaid services. ( )

03. Practice Authority. Provide services within the practice authority for the applicable profession consistent with the laws and regulations of the state where services are provided. ( )

04. Standard of Care. Provide services within the accepted standard of care that would be provided in the same or similar setting by a reasonable and prudent provider with similar education, training, and experience as determined by the applicable oversight authority. ( )

05. Express Exclusions. Not perform any service that is expressly prohibited by state or federal regulations. Further no reimbursement will be provided for any service that is expressly excluded by a provider in these rules. ( )

20~~0~~1. PROVIDER APPLICATION PROCESS.

01. ~~Provider~~ Application. Providers who meet Medicaid enrollment requirements may apply for Idaho Medicaid provider status with the Department. All ~~healthcare~~ providers ~~who are~~ eligible for a National Provider Identifier (NPI) must apply using that identifying number. For providers not eligible for an NPI, the Department will assign a provider number upon approval of the application. ~~(3-17-22)~~( )

~~**02. Screening Levels**. In accordance with 42 CFR 455.450, the Department will assign risk levels of "limited," "moderate," or "high" to defined groups of providers. These assignments and definitions will be published in the provider handbook. (3-17-22)~~

~~**03. Medicare Enrollment Requirement for Specified Providers**. The following providers must enroll as Medicare providers or demonstrate enrollment with another state's Medicaid agency prior to enrollment or revalidation as an Idaho Medicaid provider. (3-17-22)~~

~~**a.** Any providers classified in the "moderate" or "high" categorical risk level, as defined in the provider handbook. (3-17-22)~~

~~**b.** Any provider type classified as an institutional provider by Medicare. (3-17-22)~~

0~~4~~2. Disclosure of Information ~~by P~~Providers and Fiscal Agents~~**~~. All enrolling providers and ~~their fiscal agents~~ any additional disclosable party must comply with the disclosure requirements ~~as stated~~ in 42 CFR 455, Subpart B, "Disclosure of Information by Providers and Fiscal Agents." ~~(3-17-22)~~( )

0~~5~~3. Denial of Provider Agreement. The Department may deny provider status by refusing a request to enter into a provider agreement, refusing to extend an existing agreement, or refusing to enter into additional agreements with any ~~individual or entity~~ provider. Denial ~~R~~reasons ~~for denying provider status~~ include those described in IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct~~,~~." ~~Section 265.~~ ~~(3-17-22)~~( )

0~~6~~4. Mandatory Denial of Provider Agreement. ~~The Department will deny a r~~Request for a provider agreement are denied when: ~~(3-17-22)~~( )

a. The provider fails to meet the qualifications required by rule or by any applicable licensing board; (3-17-22)

b. The provider was a managing employee, or had an ownership interest, as defined in 42 CFR Section 455.101, in any entity ~~that was~~ and: ( )

i. ~~p~~Previously found by the Department to have engaged in fraudulent ~~conduct,~~ or abusive conduct related to the Medicaid program~~,~~; ~~or has~~ ( )

ii. ~~d~~Demonstrated an inability to comply with the requirements related to the provider status for which application is made, including submitting false claims or violating provisions of any provider agreement;

~~(3-17-22)~~( )

c. ~~The provider was a managing employee, or had an ownership interest, as defined in 42 CFR Section 455.101, in any entity that f~~Failed to repay the Department for any overpayments~~,~~ or ~~to repay claims previously found by the Department to have been paid improperly~~ improper claims, whether the failure resulted from refusal, bankruptcy, or otherwise, unless prohibited by law; ~~(3-17-22)~~( )

d. The provider employs as a managing employee, contracts for any management services, shares any ownership interests, or would be considered a related party to any individual or entity identified in Subsections 200.0~~6~~5.a. through 200.0~~6~~5.~~e~~b. of this rule. ~~(3-17-22)~~( )

e. The provider fails to comply with any applicable requirement under 42 CFR 455. (3-17-22)

f. The provider is precluded from enrollment due to a temporary moratorium issued by the Secretary of Health and Human Services ~~in accordance with~~ under 42 CFR 455.470. ~~(3-17-22)~~( )

g. The provider is currently suspended or terminated from Medicare or Medicaid in any state~~, or has been terminated from Medicare or Medicaid in any state~~. ~~(3-17-22)~~( )

20~~1~~2. -- 204. (RESERVED)

205. ~~AGREEMENTS WITH~~ PROVIDER~~S~~ AGREEMENTS.

01. ~~In~~ General. All individuals or ~~organizations~~ entities must enter into a written provider agreement accepted by the Department prior to receipt of any reimbursement for services. Agreements may contain any terms or conditions deemed appropriate by the Department. All provider agreements must be signed by ~~the provider or by an owner or officer~~ an authorized representative who has the legal authority to bind the provider in the agreement. ~~(3-17-22)~~( )

02. Federal Disclosure Requirements. ~~To~~ Providers must comply with the disclosure requirements in 42 CFR 455, Subpart B~~, each provider, other than an individual practitioner or a group of practitioners, must disclose to the Department:~~. ~~(3-17-22)~~( )

~~**a.** The full name and address of each individual who has either direct or indirect ownership interest in the disclosing entity or in any subcontractor of five percent (5%) or more prior to entering into an agreement or at the time of survey and certification; and~~ ~~(3-17-22)~~

~~**b.** Whether any person named in the disclosure is related to another person named in the disclosure as a spouse, parent, or sibling.~~ ~~(3-17-22)~~

03. ~~Provider Agreement~~ Enforcement Actions and Terminations. ~~Provider agreements may be terminated with or without cause. Terminations for cause may be appealed as a contested case in accordance with the IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings."~~ The Department may~~, at its discretion,~~ take any of the following actions for cause based on the ~~provider's~~ conduct ~~or the conduct~~ of the provider, or its employees or agents, or when the provider fails to comply with any term or provision of the provider agreement, or any applicable state or federal regulation: ~~(3-17-22)~~( )

a. Require corrective actions ~~as described~~ in IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct," Section 270. ~~(3-17-22)~~( )

b. Require a corrective action plan to be submitted by the provider to address noncompliance with the provider agreement; (3-17-22)

c. Reduce, limit, or suspend payment of claims pending the submission, acceptance, or completion of a corrective action plan; (3-17-22)

d. Limit or suspend provision of services to participants who have not previously established services

with the provider pending the submission, acceptance, or completion of a corrective action plan; or (3-17-22)

e. Terminate the provider's agreement. (3-17-22)

~~**04**~~i. ~~**Termination of Provider Agreements.** Due to the need to respond quickly to state and federal mandates, as well as the changing needs of the State Plan, t~~The Department may terminate provider agreements with or without cause by giving written notice to the provider as set forth in the agreement. ~~If an agreement does not provide a notice period, the period is twenty-eight (28) days.~~ ( )

ii. Terminations without cause may result from elimination or change of programs or requirements, or the provider's inability to continue providing services due to the actions of another agency or board. Terminations without cause are not subject to contested case proceedings since the action will either affect a class of providers, or will result from the discretionary act of another regulatory body. If an agreement does not provide a notice period, the period is twenty-eight (28) days. ~~(3-17-22)~~( )

iii. Terminations for cause may be appealed. ( )

04. Crossover Only Providers. Providers of professional services may enroll as crossover only providers that bill for dual eligible participants' Medicare coinsurance and deductible. Crossover only providers act as non-billing ORPs for all other participants. ( )

05. Non-billing ORP. Providers may enroll as non-billing ORPs, provided they follow Sections 200 and 205 of these rules. Non-billing ORPs are not eligible for reimbursement and are otherwise not Medicaid providers. ( )

206. INDIVIDUAL PROVIDERS – GENERAL APPROACH.
An individual provider must meet all the following conditions: ( )

01. Provider Eligibility. Be licensed or registered by the applicable licensing board of the profession, apply for and receive a Medicaid provider number, and enter into a written provider agreement with the Department. ( )

02. Practice Authority. Provide services within the practice authority for the applicable profession consistent with the laws and regulations of the state and the applicable licensing board of the profession. ( )

03. Standard of Care. Provide services within the accepted standard of care that would be provided in the same or similar setting by a reasonable and prudent provider with similar education, training, and experience as determined by the applicable licensing board of the profession. ( )

04. Express Exclusions. Not perform any service that is expressly prohibited by state or federal law. Further, no reimbursement will be provided for any service that is expressly excluded to be performed by a provider. ( )

20~~6~~7. -- 209. (RESERVED)

210. CONDITIONS FOR PAYMENT.

01. Participant Eligibility. The Department will reimburse providers for medically ~~care and~~ necessary services~~, regardless of the current eligibility status of the medical assistance participant in the month of payment, provided~~ when a complete and properly submitted claim for payment has been received and each of the following conditions are met: ~~(3-17-22)~~( )

~~**a.** The participant was found eligible for medical assistance for the month, day, and year during which the medical care and services were rendered; (3-17-22)~~

~~**b**~~**a.** The participant received ~~such medical care and~~ services no earlier than the third month before ~~the month in which~~ an application was made on ~~such~~ the participant's behalf; ~~(7-1-24)~~( )

eb. The provider verified the participant's eligibility on the date the of service was rendered and can provide proof of the eligibility verification; and (7-1-24)( )

c. Services provided after the participant's date of death cannot be reimbursed; and ( )

d. Not more than twelve (12) months have elapsed since the month of the latest participant services for which such payment is being made. Medicare cross-over claims are excluded from the twelve (12) month submittal limitation. When a participant is determined retroactively eligible, the Department will reimburse providers for services within the period of retroactive eligibility, if a claim is submitted within twelve (12) months of the participant's eligibility determination. (3-17-22)( )

02. Time LimitsComply With All Applicable Regulations. The time limit set forth in Subsection 210.01.d. of this rule does not apply with respect to retroactive eligibility adjustment. When participant eligibility is determined retroactively, the Department will reimburse providers for services within the period of retroactive eligibility if a claim for those services is submitted within twelve (12) months of the date of the participant's eligibility determination. (3-17-22)( )

03. Acceptance of State Payment. By participating in the Medical Assistance Program Medicaid, providers agree to accept, as payment in full, the amounts paid by the Department for covered services to Medicaid participants. Providers also agree to provide all materials and services without unlawfully discriminating on the grounds of race, age, sex, creed, color, national origin, or physical or intellectual disability. Participants cannot be billed for covered services. Providers may only bill participants for non-covered services when the participant is notified in writing before the service is provided that it is non-covered and its cost. (3-17-22)( )

04. Payment in Full. If a provider accepts Medicaid payment for a covered service, the Medicaid payment must be accepted as full payment for that service, and the participant cannot be billed for the difference between the billed amount and the Medicaid allowed amount. (3-17-22)

054. Medical Care Provided Outside the State of Idaho. Out-of-state medical care is subject to the same utilization review and other Medicaid coverage requirements and restrictions as medical care received within the state of Idaho. (3-17-22)

065. Ordering, Prescribing, and Referring Providers. Any service or supply ordered, prescribed, or referred by a physician or other qualified professional provider who is not an enrolled Medicaid provider will not be reimbursed by the Department. (3-17-22)( )

076. Referrals From Participant's Assigned Primary Care Provider. Medicaid services may require a referral from the participant's assigned primary care provider. Services requiring a referral are listed in the Idaho Medicaid Provider Handbook. Services provided without a referral, when one is required referral, are not covered and are subject to sanctions, and recoupment, or both. The Department may change the services that require a referral after appropriate notification of Medicaid-eligible individuals and providers as specified in Section 563 of these rules. (3-17-22)( )

07. Prior Authorizations. The Department may require a prior authorization for any service. Unless otherwise specified: ( )

a. Medicaid payment will be denied for the medical item or service or portions thereof that were provided prior to the submission of a valid prior authorization request. An exception may be allowed on a case-by-case basis, when events beyond the provider's control prevented the request's submission. ( )

b. The provider cannot bill the Medicaid participant for services not reimbursed by Medicaid solely because the authorization was not requested or obtained in a timely manner. ( )

c. An item or service will be deemed prior approved where the participant was not eligible for Medicaid when the service was provided, but was subsequently determined eligible under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled," or IDAPA 16.03.01, "Eligibility for Health Care Assistance for

Families and Children," and the medical item or service provided is authorized by the Department. ( )

d. A Notice of Decision approving or denying a requested item will be issued to the participant by the Department. The participant has twenty-eight (28) days from the date of the denial to request a fair hearing on the decision. ( )

08. Follow-up Communication ~~with Assigned Primary Care Provider~~. Medicaid services may require timely follow-up communication with the participant's assigned primary care provider. Services requiring post-service communication with the primary care provider and time frames for that communication are listed in the Idaho Medicaid Provider Handbook. Services provided without timely communication of care outcomes~~, when communication is required,~~ are not covered and ~~are~~ subject to sanctions~~,~~ and recoupment~~, or both. The Department may change the services that require communication of care outcomes after appropriate notification of Medicaid-eligible individuals and providers as specified in Section 563 of these rules.~~ ~~(7-1-24)~~( )

~~**09. Virtual Care**. Services delivered via virtual care under Title 54, Chapter 57, Idaho Code, must be identified as such under billing requirements published in the Idaho Medicaid Provider Handbook. Virtual care services billed without being identified as such are not covered. Virtual care services may be reimbursed within limitations defined by the Department in the Idaho Medicaid Provider Handbook. Fee-for-service reimbursement is not available for asynchronous services except remote monitoring.~~ ~~(7-1-24)~~

~~**10. Services Subject to Electronic Visit Verification (EVV)**. Services requiring EVV compliance are subject to quality review. Services billed without the minimum essential EVV elements, under Section 1903(l)(2) of the Social Security Act, may be denied, delayed, or subject to sanctions or recoupment, or both, under IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct."~~ ~~(7-1-24)~~

211. -- 214. (RESERVED)

215. THIRD PARTY LIABILITY.

01. Determining Liability ~~of Third Parties~~. The Department will take reasonable measures to determine any legal liability of third parties for ~~medical care and~~ services rendered to a participant. ~~(3-17-22)~~( )

02. ~~Third Party Liability as a~~ Current Resource. The Department is to treat any third party liability as a current resource ~~when such liability is found to exist~~ and payment by the third party has been made or will be made within a reasonable time. ~~(3-17-22)~~( )

03. Withholding Payment. The Department ~~must~~ will not withhold payment ~~on behalf of a participant~~ because of the liability of a third party when ~~such~~ liability~~, or the amount thereof,~~ cannot be currently established or is not currently available to pay the participant's medical expense. ~~(3-17-22)~~( )

04. Seeking Third Party Reimbursement. The Department will seek reimbursement from a third party when ~~the party's~~ liability ~~is established after reimbursement to the provider is made, and in any other case in which the liability of a third party~~ existed, but was not treated as a current resource, with the exceptions provided ~~in Subsection 215.05 of~~ under this rule. ~~(3-17-22)~~( )

a. The Department will seek reimbursement from a participant ~~when a participant's liability is established after reimbursement to the provider is made; and~~ ~~(3-17-22)~~

~~**b.**~~ ~~I~~in any ~~other~~ situation in which the participant has received direct payment from any third party resource and ~~has~~ not forwarded the money to the Department for services ~~or items~~ received. ~~(3-17-22)~~( )

05. Billing Third Parties First. Medicaid providers must bill all other sources of direct third party payment, with the following exceptions: (3-17-22)

a. When the resource is a court-ordered absent parent and there are no other viable resources available, the claims will be ~~paid~~ reimbursed and the resources billed by the Department; ~~(3-17-22)~~( )

b. Preventive pediatric care including early and periodic screening, ~~and diagnosis.~~ diagnostic, and treatment ~~Screening and diagnosis program~~ services which includes: ~~(3-17-22)~~( )

i. ~~Regularly scheduled~~Well Child examinations ~~and evaluations of the general physical, dental, and mental health, growth, development, and nutritional status of~~ for children under age twenty-one (21), years when provided according to guidance ~~for child wellness exams published~~ in the Idaho Medicaid ~~General~~ Provider ~~and Participant~~ Handbook; ~~(3-17-22)~~( )

~~ii.~~ ~~Immunizations recommended by the American Academy of Pediatrics immunization schedule;~~ ~~(3-17-22)~~

ii~~i~~. Diagnosis services to identify the nature of an illness or other problem by examination of the symptoms. (3-17-22)

c. When prior authorization has been approved ~~according to Section 883 of~~ under these rules, treatment services to control, correct, or ameliorate health problems found through diagnosis and screenings; ~~(3-17-22)~~( )

d. If the claim is for preventative pediatric care ~~as described in Subsection 215.05.b of~~ under this rule, the Department will make payment for the service provided in its fee schedule and will seek reimbursement from the third party ~~according to~~ under 42 U.S.C. 1396a(a)(25)(E). ~~(3-17-22)~~( )

06. Accident Determination. When the participant's Medicaid card indicates private insurance or when the diagnosis indicates an accident for which private insurance is often carried, ~~or both,~~ the claim will be suspended or denied until ~~it can be determined that there is no other source of payment~~ third party liability determination can occur. ~~(3-17-22)~~( )

07. Third Party Payments. The Department will pay the provider the lowest amount of the following: (3-17-22)

a. The provider's actual charge for the service; or (3-17-22)

b. The maximum allowable charge for the service as established by the Department in its pricing file. ~~If the service or item does not have a specific price on file, the provider must submit supporting documentation to the Department. Reimbursement will be based on the documentation~~; or ~~(3-17-22)~~( )

c. The third party-allowed amount minus the third party payment, or the patient liability as indicated by the third party. (3-17-22)

08. Subrogation of Third Party Liability. In all cases where the Department will be required to pay ~~medical expenses~~ for a participant ~~and that participant~~ who is entitled to recover any ~~or all such~~ medical expenses from any third party, the Department will be subrogated to the rights of the participant to the extent of the amount of ~~medical assistance~~ Medicaid benefits paid by the Department ~~as the result of the occurrence giving rise to the claim against the third party~~. ~~(3-17-22)~~( )

a. If litigation or a settlement in such a claim is pursued by the ~~medical assistance~~ Medicaid participant, the participant must notify the Department. ~~(3-17-22)~~( )

b. If the participant recovers funds, ~~either by settlement or judgment,~~ from ~~such~~ a third party, the participant must repay the amount of benefits paid by the Department ~~on their behalf~~. ~~(3-17-22)~~( )

09. Subrogation of Legal Fees. (3-17-22)

a. If a ~~medical assistance~~ participant incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the Department is subrogated, the amount which the Department is entitled to recover, or any lesser amount which the Department may agree to accept ~~in compromise of its claim~~, will be reduced by ~~an amount which bears the same relation to~~ the total amount of attorney fees and court costs ~~actually~~

paid by the participant ~~as the amount actually recovered by the Department, exclusive of the reduction for attorney fees and court costs, bears to the total amount paid by the third party to the participant~~. ~~(3-17-22)~~( )

b. If a settlement or judgment is received by the participant that does not specify which portion ~~of the settlement or judgment~~ is for payment of medical expenses, it will be presumed that the settlement or judgment applies first to the medical expenses ~~incurred by the participant~~ in an amount equal to ~~the expenditure for benefits~~ that paid by the Department ~~as a result of the payment or payments to the participant~~. ~~(3-17-22)~~( )

216. -- ~~224.~~ ~~(RESERVED)~~

~~225. REPORTING TO THE INTERNAL REVENUE SERVICE (IRS).~~
~~In accordance with 26 U.S.C 6041, the Department must provide annual information returns to the IRS showing aggregate amounts paid to providers identified by name, address, and social security number or employer identification number.~~ ~~(3-17-22)~~

~~226.~~ 229. (RESERVED)

230. GENERAL PAYMENT PROCEDURES.

01. Provided Services. (3-17-22)

~~a.~~ ~~Each participant may consult a participating physician or provider of their choice for care and receive covered services by presenting their identification card to the provider, subject to restrictions imposed by participation in Healthy Connections or enrollment in a PAHP.~~ ~~(7-1-24)~~

~~b~~a. ~~The p~~Providers must obtain the required information from the Electronic Verification System (EVS) by using the Medicaid number on the identification card ~~from the Electronic Verification System (~~EVS~~)~~ and transfer the required information onto the appropriate claim form. Where the EVS indicates ~~that~~ a participant is enrolled in Healthy Connections, the provider must comply with referral or follow-up communication requirements under ~~Section 210 of~~ these rules. ~~(7-1-24)~~( )

~~e~~b. Upon providing the care and services to a participant, the provider or their agent must submit a properly completed claim to the Department including their usual and customary charge, which is the lowest charge by the provider to the general public for the same service including advertised specials. ~~(3-17-22)~~( )

~~d~~c. The Department is to process each claim received and make payment directly to the provider. (3-17-22)

~~e~~d. The Department will not supply claim forms. Forms needed to comply with the Department's unique billing requirements are included in the Idaho Medicaid Provider Handbook. (7-1-24)

02. ~~Individual~~ Provider Reimbursement. ( )

a. The Department will ~~not~~ pay the ~~individual~~ provider ~~more than~~ the lowest of: ~~(3-17-22)~~( )

~~a~~i. The provider's actual charge for service; or (3-17-22)

~~b~~ii. The maximum allowable charge for the service as established by the Department on its pricing file~~,~~ ~~if the service or item does not have a specific price on file, the provider must submit documentation to the Department and reimbursement will be based on the documentation~~ and Idaho Medicaid Provider Handbook; or ~~(3-17-22)~~( )

~~c~~iii. The Medicaid-allowed amount minus the Medicare payment or the Medicare co-insurance and deductible amounts added together when a participant has both Medicare and Medicaid. (3-17-22)

b. Services and items without a Medicare price on file are priced for the maximum allowable charge at the Department's discretion per the following: ( )

i. Historical cost or regional reimbursement data. ( )

ii. Percent of charge. ( )

iii. A copy of the manufacturer's suggested retail pricing (MSRP) or an invoice or quote from the manufacturer or wholesaler. Reimbursement will be seventy-five percent (75%) of MSRP or quote. If the pricing documentation is an invoice for items, reimbursement will be at cost plus ten percent (10%), plus shipping. ( )

vi. An invoice with the usual and customary charges of the provider, and documentation in the form of operation reports, chart notes or medical records. ( )

v. Home and community-based services are priced in accordance with approved service criteria. ( )

03. Services Normally Billed Directly to the Patient. If a provider ~~delivers~~ bills services ~~and it is customary for the provider to bill patients~~ directly ~~for such services~~ to patients, the provider must ~~complete the appropriate~~ submit a claim form ~~and submit it~~ to the Department for reimbursement. ~~(3-17-22)~~( )

04. Reimbursement for Other Noninstitutional Services. The Department will reimburse for all noninstitutional services ~~that are not included in other Department rules~~ unless otherwise specified, ~~but~~ as allowed ~~under Idaho's Medical Assistance Program~~ under 42 CFR Section 447.325. ~~(7-1-24)~~( )

05. Cost Reporting. Providers subject to filing a Medicaid cost report must use the Department designated reporting forms, unless the Department provides an exception. Requests to use alternate forms must be sent to the Department in writing, with samples attached, ninety (90) days prior to the report due date. Requests are not a reason for late filing. ( )

06. Cost Settlement. Following receipt of the finalized Medicare cost report and the timely receipt of other information requested by the Department to fairly cost settle with the provider, a certified letter with return receipt requested will be sent to the provider that 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. 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. ( )

a. The Department will make every effort to issue a notice of program reimbursement within twelve (12) months of receipt of the cost report. ( )

b. 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. ( )

0~~5~~7. Review of Records. ~~(3-17-22)~~

~~a.~~ The Department, the U.S. Department of Health and Human Services, and the Bureau of Compliance have the right to review records of providers and related entities receiving Medicaid reimbursement ~~for covered services~~. These reviews may be conducted for audit purposes outside of processes in IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct." ~~(7-1-24)~~( )

~~b~~**a.** The review of ~~participants'~~ medical and financial records must be conducted for the purposes of determining: ~~(3-17-22)~~( )

i. ~~The necessity for the c~~Care was necessary; or ~~(3-17-22)~~( )

ii. ~~That t~~Treatment was rendered under accepted medical standards of practice; or ~~(7-1-24)~~( )

iii. ~~That charges were not in excess of t~~The provider~~'s~~ billed their usual and customary rates; ~~or~~ ~~(3-17-22)~~( )

iv. Verification of actual costs for providing services; ( )

v. Provider's compliance with the provider agreement, reporting form instructions, and applicable regulations; ( )

vi. Reimbursement rates or settlements; or ( )

~~i~~vii. ~~That f~~Fraudulent or abusive treatment and billing practices are not taking place. ~~(3-17-22)~~( )

~~e~~**b.** Refusal of a provider to permit the Department to review records pertinent to ~~medical assistance~~ Medicaid will constitute grounds for: ~~(3-17-22)~~( )

i. Withholding provider payments ~~to the provider~~ until access to the requested information is granted; or ~~(3-17-22)~~( )

ii. Suspending the provider~~'s number~~. ~~(3-17-22)~~( )

~~**06. Lower of Cost or Charges**. Payment to providers, other than public providers furnishing such services free of charge or at nominal charges to the public, is the lesser of the reasonable cost of such services or the customary charges with respect to such services. Public providers that furnish services free of charge, or at a nominal charge, are reimbursed fair compensation that is the same as reasonable cost.~~ ~~(3-17-22)~~

0~~7~~8. **Procedures for Medicare Cross-Over Claims**. (3-17-22)

a. If a ~~medical assistance~~ Medicaid participant is eligible for Medicare, the provider must first bill Medicare for the services ~~rendered to the participant~~ before billing the Department. ~~(3-17-22)~~( )

b. If a provider accepts a Medicare assignment, the Department will ~~pay the provider for the services, up to the Medicaid allowable amount minus the Medicare payment, and~~ forward ~~the~~ payment to the provider automatically based upon the Medicare Summary Notice (MSN) ~~information~~ that is received from the Medicare Part B Carrier ~~on a weekly basis~~. ~~(7-1-24)~~( )

c. If a provider does not accept a Medicare assignment, an MSN must be ~~attached to the appropriate claim form and~~ submitted with a claim to the Department. ~~The Department will pay the provider for the services, up to the Medicaid allowable amount minus the Medicare payment.~~ ~~(3-17-22)~~( )

d. For all other services, an MSN must be ~~attached to the appropriate claim form and~~ submitted to the Department with a claim. ~~The Department will pay the provider for the services up to the Medicaid allowable amount minus the Medicare payment.~~ ~~(3-17-22)~~( )

e. The Department will pay the provider for the services up to the Medicaid allowable amount minus the Medicare payment. ( )

0~~8~~9. ~~**Services Reimbursable After the**~~ **Appeals Process**. Reimbursement for services originally ~~identified~~ denied by the Department ~~as not medically necessary~~ will be made if such decision is reversed by the appeals process ~~required in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings."~~ ~~(3-17-22)~~( )

231. HANDLING OF OVERPAYMENTS AND UNDERPAYMENTS FOR SPECIFIED PROVIDERS.

~~The provisions in Subsections 231.01 and 231.02~~This section of ~~this~~ rule appl~~y~~ies only to hospitals, FQHCs, RHCs and Home Health providers. ~~(3-17-22)~~( )

01. Interest Charges ~~on Overpayments and Underpayments~~. ~~The~~ Medicaid ~~program~~ will charge interest on overpayments, and pay interest on underpayments, as follows: ~~(3-17-22)~~( )

a. ~~Interest After Sixty Days of Notice.~~ If full repayment from the indebted party is not received within sixty (60) days after the provider has received the Department reimbursement notice, interest will accrue from the date of receipt ~~of the Department reimbursement notice~~, and will be charged on the unpaid settlement balance for each thirty (30) day period that payment is delayed. Periods of less than thirty (30) days will be treated as a full thirty (30) day period, and the thirty (30) day interest charge will be applied to any unpaid balance. Each payment will be applied first to accrued interest, then to the principal. Interest accrued on overpayments and interest on funds borrowed by a provider to repay overpayments are not an allowable interest expense. ~~(3-17-22)~~( )

b. ~~Waiver of Interest Charges.~~ When the Department determines an overpayment exists, it may waive interest charges if ~~it determines that~~ the administrative costs of collecti~~o~~n~~g them~~ exceed the charges. ~~(3-17-22)~~( )

c. ~~Rate of Interest.~~ The interest rate on overpayments and underpayments will be the statutory rate ~~as set forth in~~ under Section 28-22-104(1), Idaho Code, compounded monthly. ~~(3-17-22)~~( )

d. Retroactive Adjustment. The balance and interest will be retroactively adjusted to equal the amounts that would have been due based on any changes that occur as a result of the final determination in the administrative appeal and judicial appeal process. Interest penalties will only appl~~ied~~y to unpaid amounts and will be subordinated to final interest determinations made in the judicial review process. ~~(3-17-22)~~( )

02. Recovery Methods ~~for Overpayments~~. One (1) of the following ~~methods~~ will be used for recovery of overpayments: ~~(3-17-22)~~( )

a. ~~Lump Sum Voluntary Repayment.~~ Upon receipt of the notice of program reimbursement, the provider voluntarily refunds, in a lump sum, the entire overpayment to the Department. ~~(3-17-22)~~( )

b. ~~Periodic Voluntary Repayment.~~ The provider ~~must~~ may: ~~(3-17-22)~~( )

i. Request in writing that recovery of the overpayment be made over a period of twelve (12) months or less; and (3-17-22)

ii. ~~Adequately~~Submit documentation ~~the request by~~ demonstrating that the financial integrity of the provider would be irreparably compromised if repayments occurred over a shorter period of time ~~than requested~~. ~~(3-17-22)~~( )

c. ~~Department Initiated Recovery. The~~If the provider does not respond to the notice of program reimbursement within thirty (30) days of receiving the notice, the Department will initiate recovery of the entire unpaid balance ~~of the overpayment of any settlement amount in which the provider does not respond to the notice of program reimbursement within thirty (30) days of receiving the notice~~ in addition to accrued interest. ~~(3-17-22)~~( )

d. ~~Recovery from Medicare Payments.~~ The Department can request that Medicare payments be withheld ~~in accordance with~~ under 42 CFR Section 405.377. ~~(3-17-22)~~( )

232. -- ~~234.~~ ~~(RESERVED)~~

~~235. PATIENT "ADVANCE DIRECTIVES."~~

~~01. Provider Participation~~. ~~Hospitals, nursing facilities, providers of home health care services (home health agencies, federally qualified health clinics, rural health clinics), hospice providers, and personal care RN supervisors must:~~ ~~(7-1-24)~~

~~a.~~ ~~Provide all adults receiving medical care written and oral information (the information provided~~

must contain all material found in the Department's approved Advance Directive Registration Form) which defines their rights under state law to make decisions concerning their medical care. (7-1-24)

i. The provider must explain that the participant has the right to make decisions regarding their medical care which includes the right to accept or refuse treatment. If the participant has any questions regarding treatment, the facility or agency will notify the physician of those concerns. Their physician can answer any questions they may have about the treatment. (3-17-22)

ii. The provider will inform the participant of their rights to formulate advance directives, such as "Living Will" or "Durable Power of Attorney For Healthcare," or both. (7-1-24)

iii. The provider must comply with Subsection 235.02 of this rule. (3-17-22)

b. Provide all adults receiving medical care written information on the providers' policies concerning the implementation of the participant's rights regarding "Durable Power of Attorney for Healthcare," "Living Will," and the participant's right to accept or refuse medical and surgical treatment. (7-1-24)

c. Document in the participant's medical record whether the participant has executed an advance directive ("Living Will" or "Durable Power of Attorney for Healthcare," or both), or have a copy of the Department's approved Advance Directive Registration Form attached to the patient's medical record which has been completed acknowledging whether the patient/resident has executed an advance directive ("Living Will" or "Durable Power of Attorney for Healthcare," or both). (7-1-24)

d. The provider cannot condition the provision of care or otherwise discriminate against an individual based on whether that participant has executed an advance directive. (7-1-24)

e. If the provider cannot comply with the patient's "Living Will" or "Durable Power of Attorney for Healthcare," or both, as a matter of conscience, the provider will assist the participant in transferring to a facility or agency that can comply. (7-1-24)

f. Provide education to their staff and the community on issues concerning advance directives. (3-17-22)

02. When Advance Directives Must Be Given. Hospitals, nursing facilities, providers of home health care (home health agencies, federally qualified health centers, rural health clinics), hospice agencies, and personal care RN supervisors, must give information concerning "advance directives" to adult participants in the following situations: (7-1-24)

a. Hospitals must give the information at the time of the participant's admission as an inpatient unless Subsection 235.03 of this rule applies. (3-17-22)

b. Nursing facilities must give the information at the time of the participant's admission as a resident. (3-17-22)

c. Home health providers must give the information to the participant in advance of the participant coming under the care of the provider. (3-17-22)

d. The personal care RN supervisors will inform the participant when the RN completes the RN Assessment and Care Plan. The RN supervisor will inform the Qualified Intellectual Disabilities Professional (QIDP) and the personal care attendant of the participants decision regarding "advance directives." (7-1-24)

e. A hospice provider must give information at the time of initial receipt of hospice care by the participant. (3-17-22)

03. Information Concerning Advance Directives at the Time an Incapacitated Individual Is Admitted. An individual may be admitted to a facility in a comatose or otherwise incapacitated state and be unable to receive information or articulate whether they have executed an advance directive. In this case, to the extent that a

~~facility issues materials about policies and procedures to the families or to the surrogates or other concerned persons of the incapacitated patient under state law, it must also include the information concerning advance directives. This does not relieve the facility from its obligation to provide this information to the patient once they are no longer incapacitated.~~ ~~(7-1-24)~~

~~**04. Provider Agreement**. A "Memorandum of Understanding Regarding Advance Directives" is incorporated within the provider agreement. By signing the Medicaid provider agreement, the provider is not excused from its obligation regarding advance directives under Section 1902(a) of the Social Security Act, as amended by Section 4751 of OBRA 1990.~~ ~~(7-1-24)~~

~~**236. -- 244. (RESERVED)**~~

~~**245. PROVIDERS OF SCHOOL-BASED SERVICES.**~~
~~Only school districts and charter schools can be reimbursed for the services described in Sections 850 through 856 of these rules.~~ ~~(3-17-22)~~

~~**246. -- 249. (RESERVED)**~~

~~**250. 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.~~ ~~(3-17-22)~~

~~**251. --**~~**299. (RESERVED)**

GENERAL REIMBURSEMENT PROVISIONS FOR INSTITUTIONAL PROVIDERS
(Sections 300-389)

~~**300. COST REPORTING.**~~
~~The provider's Medicaid cost report must be filed using the Department designated reporting forms, unless the Department has approved an exception. The request to use alternate forms must be sent to the Department in writing, with samples attached, a minimum of ninety (90) days prior to the due date for the cost report. The request for approval of alternate forms cannot be used as a reason for late filing.~~ ~~(3-17-22)~~

~~**301. -- 304. (RESERVED)**~~

~~**305. REIMBURSEMENT SYSTEM AUDITS.**~~

~~**01. Scope of Reimbursement System Audits**. The Department reserves the right to audit financial and other records of the provider, and, when warranted, the records of entities related to the provider. Audits consist of the following types of records:~~ ~~(3-17-22)~~

~~**a.** Cost verification of actual costs for providing goods and services;~~ ~~(3-17-22)~~

~~**b.** Evaluation of provider's compliance with the provider agreement, reporting form instructions, and any applicable law, rule, or regulation;~~ ~~(3-17-22)~~

~~**c.** Effectiveness of the service to achieve desired results or benefits; and~~ ~~(3-17-22)~~

~~**d.** Reimbursement rates or settlement calculated under this chapter.~~ ~~(3-17-22)~~

~~**02. Exception to Scope for Audits and Investigations**. Audits as described in these rules do not apply to the audit processes used in conducting investigations of fraud and abuse under IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct."~~ ~~(3-17-22)~~

30~~6~~0. -- 329. **(RESERVED)**

330. PROVIDER'S RESPONSIBILITY TO MAINTAIN RECORDS.

~~The p~~Providers must maintain ~~financial and other~~ records in sufficient detail to allow the Department to audit them as described in ~~Section 305 of~~ these rules. ~~(3-17-22)~~( )

01. Expenditure Documentation. Documentation of expenditures must include the amount, date, purpose, payee, and the invoice or other verifiable evidence supporting the expenditure. (3-17-22)

02. Cost Allocation Process. Costs such as depreciation or amortization of assets and indirect expenses are allocated to activities or functions based on the original identity of the costs. Documentation to support basis for allocation must be available for verification. The assets referred to in this Section of rule are economic resources of the provider recognized and measured in conformity with generally accepted accounting principles. (3-17-22)

03. Revenue Documentation. Documentation of revenues must include the amount, date, purpose, and source of the revenue. (3-17-22)

04. Availability of Records. Records must be available for and subject to audit by the auditor, with or without prior notice, during any working day between the hours of 8:00 a.m. and 5:00 p.m. at the provider's principal place of business ~~in the state of Idaho~~. ~~(3-17-22)~~( )

a. ~~The p~~Providers ~~is~~ will be given the opportunity to provide documentation before the interim final audit report is issued. ~~(3-17-22)~~( )

b. ~~The p~~Providers ~~is~~ are not allowed to submit additional documentation in support of cost items after the issuance of the interim final audit report. ~~(3-17-22)~~( )

05. Retention of Records. Providers will retain ~~R~~records required ~~in Subsections 330.01 through 330.03 of~~ under this rule ~~must be retained by the provider~~ for a period of five (5) years from the date of the final payment under the provider agreement. Failure to retain records for the required period can void the Department's obligation to make payment for ~~the goods or~~ services. ~~(3-17-22)~~( )

331. -- 339. (RESERVED)

340. DRAFT AUDIT REPORT.
Following completion of the audit field work and before issuing the interim final audit report to the Department, the auditor will issue a draft audit report and forward a copy to the provider for review and comment. (3-17-22)

01. Review Period. ~~The p~~Providers will have a period of ~~sixty~~ forty-five (~~60~~45) days, beginning on the date of transmittal, to review and provide additional comments or evidence ~~pertaining to the draft audit report~~. The review period may be extended, to a maximum of an additional fifteen (15) days past the original due date, when ~~the~~ a provider: ~~(3-17-22)~~( )

a. Requests an extension prior to the expiration of the original review period; and (3-17-22)

b. Clearly demonstrates the need for additional time to properly respond. (3-17-22)

02. Evaluation of Provider's Response. The auditor will evaluate the provider's response ~~to the draft audit report~~ and will ~~delete,~~ modify~~, or reaffirm~~ the original findings, as deemed appropriate, in preparing the interim final audit report. ~~(3-17-22)~~( )

341. FINAL AUDIT REPORT.
The auditor will incorporate the provider's response and an analysis of the response into the interim final report ~~as appendices~~ and transmit it to the Department. The Department will issue a final audit report and a notice of program reimbursement, if applicable, that sets forth settlement amounts due to the Department or the provider~~. The final audit report and notice of program reimbursement, if applicable,~~ and will take into account the findings made in the interim final audit report and the response of the provider to the draft audit report ~~(3-17-22)~~( )

342. -- 359. (RESERVED)

360. RELATED PARTY TRANSACTIONS.

01. Principle. ~~Costs applicable to services, facilities and supplies furnished to the provider by organizations or persons related to the provider by common ownership, control, etc., are allowable at the cost to the related party. Such costs are allowable to the extent that they relate to patient care, are reasonable, ordinary, and necessary, and are not in excess of those costs incurred by a prudent cost-conscious buyer.~~ ~~(3-17-22)~~

~~02.~~ ~~Cost Allowability - Regulation~~. ~~Allowability of costs~~ applicable to services, facilities and supplies furnished by entities related to the provider is subject to the regulations ~~prescribing the treatment of specific items as outlined~~ in 42 CFR 413.17, et al., and the Providers Reimbursement Manual~~, PRM Chapter 10 and other applicable chapters of the PRM~~ (PMR). ~~(3-17-22)~~( )

~~361. APPLICATION.~~

0~~1~~2. Determination of Common Ownership or Control ~~in the Provider Organization and Supply Organization~~. In determining whether a provider organization is related to a supplying organization as defined under 42 CFR 413.17, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other. ~~(3-17-22)~~( )

~~a.~~ ~~Common Ownership Rule. A determination as to whether an individual(s) possesses ownership or equity in the provider organization and the supplying organization, so that the organizations will be considered to be related by common ownership, will be made on the basis of the facts and circumstances in each case.~~ ~~(3-17-22)~~

~~b.~~ ~~Control Rule. The term "control" includes any kind of control whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control that is decisive, not its form or the mode of its exercise.~~ ~~(3-17-22)~~

0~~2~~3. Cost to Related Organizations. The charges to the provider from related organizations may not exceed the billing to the related organization for these services. (3-17-22)

0~~3~~4. Costs Not Related to Patient Care. All home office costs not related to patient care are not allowable under the Program. (3-17-22)

0~~4~~5. Interest Expense. ~~Generally, i~~Interest expense on loans between related entities will not be reimbursable~~. See~~ under PMR Chapters 2, 10, and 12, PRM~~, for specifics~~. ~~(3-17-22)~~( )

~~362. EXCEPTION TO THE RELATED ORGANIZATION PRINCIPLE.~~
~~An exception is provided to the general rule applicable to related organizations. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of the intermediary:~~ ~~(3-17-22)~~

~~01. Supplying Organization~~. ~~That the supplying organization is a bona fide separate organization;~~ ~~(3-17-22)~~

~~02. Nonexclusive Relationship~~. ~~That a substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control and there is an open, competitive market.~~ ~~(3-17-22)~~

0~~3~~6. ~~Lease or Rentals of Hospital~~Exception. An exception to the general principle applicable to related organizations applies if the provider demonstrates they meet the requirements in 42 CFR 413.17(d). The exception is not applicable to sales, lease or rentals of hospitals~~. These transactions would~~, which do not meet the requirement that there be an open, competitive market for the facilities furnished ~~as described in Sections 1008 and 1012,~~ under the PRM. ~~(3-17-22)~~( )

a. ~~Rentals.~~ Rental expense for transactions between related entities will not be recognized. Costs of ownership will be allowed. ~~(3-17-22)~~( )

b. ~~Purchases.~~ When a facility is purchased from a related entity, the purchaser's depreciable basis must not exceed the seller's net book value ~~as described in Section 1005,~~ under the PRM. ~~(3-17-22)~~( )

363~~3~~1. -- 389. (RESERVED)

EXCLUDED SERVICES
(Section 390)

390. SERVICES, TREATMENTS, AND PROCEDURES NOT COVERED BY ~~MEDICAL ASSISTANCE~~ MEDICAID.
~~The following services, treatments, and procedures are not covered for payment by the Medical Assistance Program:~~ ~~(3-17-22)~~

01. Service Categories Not Covered. The following service categories are not covered for payment by ~~the Medical Assistance Program~~ Medicaid: ~~(3-17-22)~~( )

a. Acupuncture services; (3-17-22)

b. Naturopathic services; (3-17-22)

c. Bio-feedback therapy; (3-17-22)

d. Group hydrotherapy; ~~and~~ ~~(3-17-22)~~( )

e. Fertility-related services, including testing~~.~~ ; ~~(3-17-22)~~( )

f. Vocational services; ( )

g. Educational services; ( )

h. Recreational services; ( )

i. Duplicative services; ( )

j. Housing except when approved for a medical institution; and ( )

k. Food except the home-delivered meals benefit in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ( )

02. Types of Treatments and Procedures Not Covered. The costs of ~~physician~~ provider and hospital services for the following types of treatments and procedures are not covered for payment by ~~the Medical Assistance Program~~ Medicaid: ~~(3-17-22)~~( )

a. Elective medical and surgical treatment, except for family planning services, without Departmental approval. Procedures that are generally accepted by the medical community and are medically necessary may not require prior approval and may be eligible for payment; (3-17-22)

b. ~~Cosmetic surgery, excluding~~ Services for convenience, comfort, or cosmetic reasons except when allowed elsewhere in rule. Hospice services, and reconstructive surgery that has prior approval by the Department are covered benefits; ~~(3-17-22)~~( )

~~**c.** Acupuncture; (3-17-22)~~

~~**d.** Bio-feedback therapy; (3-17-22)~~

~~**e**~~**c.** Laetrile therapy; (3-17-22)

~~f. Procedures and testing for the inducement of fertility. This includes artificial inseminations, consultations, counseling, office exams, tuboplasties, and vasovasostomies;~~ ~~(3-17-22)~~

~~g~~d. New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and that are excluded by the Medicare program or major commercial carriers; (3-17-22)

~~h~~e. Drugs supplied to patients for self-administration other than those allowed under ~~the conditions of Section 662 of~~ these rules; ~~(3-17-22)~~( )

~~i. Services provided by psychologists and social workers who are employees or contract agents of a physician, or a physician's group practice association except for psychological testing on the order of the physician;~~ ~~(3-17-22)~~

~~j~~f. The treatment of complications, consequences, or repair of any medical procedure where the original procedure was not covered by ~~the Medical Assistance Program~~ Medicaid, unless the resultant condition is life-threatening as determined by the Department; ~~(3-17-22)~~( )

~~k~~g. Medical transportation costs incurred for travel to medical facilities for the purpose of receiving a noncovered medical service; (3-17-22)

~~l. Eye exercise therapy; or~~ ~~(3-17-22)~~

~~m~~h. Surgical procedures on the cornea for myopia~~.~~; or ~~(3-17-22)~~( )

i. Services as detailed in Section 56-270 *[56-2731]*, Idaho Code. ( )

03. Experimental Treatments or Procedures. ~~Treatments and procedures used solely to gain further evidence or knowledge or to test the usefulness of a drug or type of therapy are not covered for payment by the Medical Assistance Program. This includes both the~~ Experimental treatments ~~or~~ and procedures ~~itself~~, and the costs for all follow-up medical treatment directly associated with such a procedure are not covered. Treatments and procedures are deemed experimental ~~are not covered for payment by the Medical Assistance Program~~ under the following circumstances: ~~(3-17-22)~~( )

a. The treatment or procedure is in Phase I clinical trials ~~in which the study drug or treatment is given to a small group of people for the first time to evaluate its safety, determine a safe dosage range, and identify side effects~~; ~~(3-17-22)~~( )

b. There is inadequate available clinical ~~or pre-clinical~~ data to provide a reasonable expectation that the trial treatment or procedure will be at least as effective as non-investigational therapy; or ~~(3-17-22)~~( )

c. Expert opinion suggests that additional information is needed to assess the safety or efficacy of the proposed treatment or procedure. (3-17-22)

391. INVESTIGATIONAL PROCEDURES OR TREATMENTS.
The Department may cover investigational procedures or treatments on a case-by-case basis for life-threatening conditions when no other treatment options are available. For these cases, a focused case review is completed by the Department. The Department will determine coverage based on this review. ( )

01. Focused Case Review. A focused case review consists of assessment of: ( )

a. Health benefit to the participant; ( )

b. Risk to the participant; ( )

c. Standard treatment for the participant's condition, including alternative treatments; ( )

d. Specific inclusion or exclusion by Medicare national coverage guidelines; ( )

e. Phase of the clinical trial of the proposed procedure or treatment; ( )

f. Guidance regarding the proposed procedure or treatment by national organizations; ( )

g. Pertinent clinical data and peer-reviewed literature; and ( )

f. Ethics Committee review, if appropriate. ( )

02. Additional Clinical Information. If there is insufficient information from the focused case review to render a coverage decision, the Department may seek an independent professional opinion. ( )

391~~1~~2. -- 398~~8~~9. (RESERVED)

~~399. COVERED SERVICES UNDER BASIC PLAN BENEFITS.~~

~~Individuals who are eligible for Medicaid Basic Plan Benefits are eligible for the following benefits, subject to the coverage limitations contained in these rules. Those individuals eligible for services under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," are also eligible for the services covered under this chapter of rules, unless specifically exempted.~~ ~~(3-17-22)~~

~~01. Hospital Services~~. ~~The range of hospital services covered is described in Sections 400 through 449 of these rules.~~ ~~(3-17-22)~~

~~a.~~ ~~Inpatient and outpatient Hospital Services are described in Sections 400 through 416.~~ ~~(3-17-22)~~

~~b.~~ ~~Reconstructive Surgery services are described in Sections 420 through 426.~~ ~~(3-17-22)~~

~~c.~~ ~~Surgical procedures for weight loss are described in Sections 430 through 436.~~ ~~(3-17-22)~~

~~d.~~ ~~Investigational procedures or treatments are described in Sections 440 through 446.~~ ~~(3-17-22)~~

~~02. Ambulatory Surgical Centers~~. ~~Ambulatory Surgical Center services are described in Sections 450 through 499 of these rules.~~ ~~(3-17-22)~~

~~03. Physician Services and Abortion Procedures~~. ~~Physician services and abortion procedures are described in Sections 500 through 519 of these rules.~~ ~~(3-17-22)~~

~~a.~~ ~~Physician services are described in Sections 500 through 506.~~ ~~(3-17-22)~~

~~b.~~ ~~Abortion procedures are described in Sections 510 through 516.~~ ~~(3-17-22)~~

~~04. Other Practitioner Services~~. ~~Other practitioner services are described in Sections 520 through 559 of these rules.~~ ~~(3-17-22)~~

~~a.~~ ~~Non-physician practitioner services are described in Sections 520 through 526.~~ ~~(3-17-22)~~

~~b.~~ ~~Chiropractic services are described in Sections 530 through 536.~~ ~~(3-17-22)~~

~~c.~~ ~~Podiatrist services are described in Sections 540 through 545.~~ ~~(3-17-22)~~

~~d.~~ ~~Licensed midwife (LM) services are described in Sections 546 through 552.~~ ~~(3-17-22)~~

~~e.~~ ~~Optometrist services are described in Sections 553 through 556.~~ ~~(3-17-22)~~

~~05. Primary Care Case Management~~. ~~Primary care case management services are described in~~

Sections 560 through 579 of these rules. (3-17-22)

a. Healthy Connections services are described in Sections 560 through 566. (3-17-22)

06. **Prevention Services**. The range of prevention services covered is described in Sections 570 through 649 of these rules. (3-17-22)

a. Children's habilitation intervention services are described in Sections 570 through 577. (3-17-22)

b. Child Wellness Services are described in Sections 580 through 584. (3-17-22)

c. Adult Physical Services are described in Sections 590 through 596. (3-17-22)

d. Screening mammography services are described in Sections 600 through 606. (3-17-22)

e. Diagnostic Screening Clinic services are described in Sections 610 through 614. (3-17-22)

f. Additional Assessment and Evaluation services are described in Section 615. (3-17-22)

g. Health Questionnaire Assessment is described in Section 618. (3-17-22)

h. Preventive Health Assistance benefits are described in Sections 620 through 626. (3-17-22)

i. Nutritional services are described in Sections 630 through 636. (3-17-22)

j. Diabetes Education and Training services are described in Sections 640 through 646. (3-17-22)

07. **Laboratory and Radiology Services**. Laboratory and radiology services are described in Sections 650 through 659 of these rules. (3-17-22)

08. **Prescription Drugs**. Prescription drug services are described in Sections 660 through 679 of these rules. (3-17-22)

09. **Family Planning**. Family planning services are described in Sections 680 through 689 of these rules. (3-17-22)

10. **Outpatient Behavioral Health Services**. Community based outpatient services for behavioral health treatment are described in Sections 707 through 711 of these rules. (3-17-22)

11. **Inpatient Psychiatric Hospital Services**. Inpatient Psychiatric Hospital services are described in Sections 700 through 706. (3-17-22)

12. **Home Health Services**. Home health services are described in Sections 720 through 729 of these rules. (3-17-22)

13. **Therapy Services**. Occupational therapy, physical therapy, and speech-language pathology services are described in Sections 730 through 739 of these rules. (3-17-22)

14. **Audiology Services**. Audiology services are described in Sections 740 through 749 of these rules. (3-17-22)

15. **Durable Medical Equipment and Supplies**. The range of covered durable medical equipment and supplies is described in Sections 750 through 779 of these rules. (3-17-22)

a. Durable Medical Equipment and supplies are described in Sections 750 through 756. (3-17-22)

b. Prosthetic and orthotic services are described in Sections 770 through 776. (3-17-22)

~~**16. Vision Services**. Vision services are described in Sections 780 through 789 of these rules. (3-17-22)~~

~~**17. Dental Services**. Medicaid dental services are covered under a selective contract as described in Section 800 through 819 of these rules. (3-17-22)~~

~~**18. Essential Providers**. The range of covered essential services is described in Sections 820 through 859 of these rules. (3-17-22)~~

~~**a.** Rural health clinic services are described in Sections 820 through 826. (3-17-22)~~

~~**b.** Federally Qualified Health Center services are described in Sections 830 through 836. (3-17-22)~~

~~**c.** Indian Health Services Clinic services are described in Sections 840 through 846. (3-17-22)~~

~~**d.** School-Based services are described in Sections 850 through 857. (3-17-22)~~

~~**19. Transportation**. The range of covered transportation services is described in Sections 860 through 879 of these rules. (3-17-22)~~

~~**a.** Emergency transportation services are described in Sections 860 through 866. (3-17-22)~~

~~**b.** Non-emergency medical transportation services are described in Sections 870 through 876. (3-17-22)~~

~~**20. EPSDT Services**. EPSDT services are described in Sections 880 through 889 of these rules. (3-17-22)~~

~~**21. Specific Pregnancy-Related Services**. Specific pregnancy-related services are described in Sections 890 through 899 of these rules. (3-17-22)~~

COVERED SERVICES
(Sections 400-899)

SUB AREA: HOSPITAL SERVICES
(Sections 400-449)

400. 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 that are not available, or when catastrophic events prevent the scheduled discharge of an inpatient. (3-17-22)

02. Allowable Costs. The current year's Medicaid apportionment of a hospital's allowable costs determined at final or interim settlement if cost settlements are applicable, or determined using the version of the cost report used for prospective payment system (PPS) rate setting, 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. (3-17-22)

~~**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. (3-17-22)~~

043. 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. (3-17-22)

~~**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 and applied to Medicaid discharges. 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. (3-17-22)~~

064. Charity Care. Charity care is care provided to individuals who have no source of payment, third-party or personal resources. (3-17-22)

~~**07. Children's Hospital**. A Medicare-certified hospital as set forth in 42 CFR Section 412.23(d). (3-17-22)~~

085. Critical Access Hospitals (CAH). A rural hospital with twenty-five (25) or less beds as set forth in 42 CFR Section 485.620. (3-17-22)

096. Current Year. Any hospital cost reporting period for which reasonable cost is being determined will be termed the current year. (3-17-22)

~~1~~07. Inpatient Services Customary Hospital Charges. Customary inpatient hospital charges reflect the regular rates for inpatient 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. ~~Effective for service dates beginning July 1, 2021 reimbursement will be as follows: (3-17-22)~~( )

a. All in-state providers not described in b-d below will be paid a final prospective payment rate using the All Patient Refined Diagnosis Related Group (APR-DRG) classification system as described in Section 401 of these rules. (3-17-22)

b. Idaho state-owned hospitals and the Department of Veteran's Affairs Medical Center will be reimbursed at one hundred percent (100%) of allowable cost using a retrospective cost settlement upon receipt of a final Medicare cost report. (3-17-22)

c. In-state and those out-of-state within thirty five (35) miles of the Idaho border, ~~Critical Access Hospitals (~~CAHs~~)~~ will be reimbursed at one hundred one percent (101%) of allowable cost using a retrospective cost settlement upon receipt of a final Medicare cost report. ~~(3-17-22)~~( )

d. All out-of-state providers not described in a through c above will be paid a final prospective payment rate with no retrospective cost settlement using the All Patient Refined Diagnosis Related Group (APR-DRG) classification system as described in Section 401 of these rules. The out-of-state APR-DRG rates were developed to provide a combined cost coverage of eighty-seven percent (87%) when all out-of-state providers are averaged together in keeping with Section 56-265(6)(b), Idaho Code. (3-17-22)

~~11~~08. Outpatient Services Customary Hospital Charges. Customary outpatient hospital charges reflect the regular rates for 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. ~~Effective for service dates beginning July 1, 2021, reimbursement will be as follows: (3-17-22)~~( )

a. Idaho state-owned hospitals and the Department of Veteran's Affairs Medical Center will be reimbursed at one hundred percent (100%) of allowable cost. (3-17-22)

b. In-state and those out-of-state within thirty five (35) miles of the Idaho border, CAHs will be reimbursed at one hundred one percent (101%) of allowable cost. ~~(3-17-22)~~( )

c. All hospitals that are not described in a through b above will be subject to the outpatient reimbursement parameters outlined in the Medicaid Provider Agreement and Section 56-265, Idaho Code. (3-17-22)

~~12~~09. **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. (3-17-22)

~~13~~10. **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 405.06 of these rules. (3-17-22)

~~14~~11. **Disproportionate Share Threshold**. The disproportionate share threshold is: (3-17-22)

a. The arithmetic mean plus one (1) standard deviation of the Medicaid Utilization Rates of all Idaho Hospitals; or (3-17-22)

b. A Low-Income Revenue Rate exceeding twenty-five percent (25%). (3-17-22)

~~15. **Excluded Units**. Excluded units are distinct units in hospitals that are certified by Medicare according to 42 CFR Sections 412.25, 412.27 and 412.29 for exclusion from the Medicare prospective payment system. (3-17-22)~~

~~16~~12. **Hospital Inflation Index**. An index calculated through Department studies and used to adjust inpatient operating cost limits and interim rates for the current year. (3-17-22)

~~17~~13. **Low-Income Revenue Rate**. The Low Income Revenue Rate is the sum of the following fractions, expressed as a percentage, calculated as follows: (3-17-22)

a. Total Medicaid inpatient and outpatient 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 ~~(3-17-22)~~( )

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. (3-17-22)

~~18~~14. **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. (3-17-22)

~~19~~15. **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 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.~~ ~~(3-17-22)~~( )

~~20~~16. **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. (3-17-22)

~~2~~17. **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). (3-17-22)

~~22. 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.~~ ~~(3-17-22)~~

~~23. 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 that 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.~~ ~~(3-17-22)~~

~~24~~18. **Reasonable Costs**. Reasonable costs include all necessary and ordinary costs incurred in rendering the services related to patient care that a prudent and cost-conscious hospital would pay for a given item or service. (3-17-22)

~~25~~19. **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~~ both inpatient and outpatient costs of uninsured patients will be considered. ~~(3-17-22)~~( )

~~26~~20. **Upper Payment Limit**. The Upper Payment Limit for hospital services is defined in the Code of Federal Regulations. (3-17-22)

~~27. Prior Service Period Claims Subject to Future Cost Settlement. For providers subject to cost settlement, claims from prior service periods that were not captured in a prior cost settlements will be cost settled in the current year using cost-to-charge ratios and routine cost per diems from the Medicare cost report currently being settled.~~ ~~(3-17-22)~~

401. HOSPITAL REIMBURSEMENT – PROSPECTIVE PAYMENT SYSTEMS.
Providers identified in Section 400.10.a. and 400.10.d will be reimbursed for inpatient services using an All Patient Refined Diagnosis Related Group (APR-DRG) as outlined in the Medicaid Provider Agreement ~~otherwise beginning with service periods on or after July 1, 2021~~. ~~(3-17-22)~~( )

402. INPATIENT HOSPITAL SERVICES: COVERAGE AND LIMITATIONS.
The policy, rules, and regulations to be followed ~~will be those cited in~~ are 42 CFR 456.50 through 42 CFR 456.145. All hospital services must conform to federal and state laws and regulations. ~~Services must be medically necessary as defined in Section 011 of these rules.~~ ~~(3-17-22)~~( )

01. Initial Length of Stay. Prior authorization requirement for an initial length of stay will be established by the Department, or its designee, in the Idaho Medicaid Provider Handbook for hospitals not reimbursed under DRG methodologies. (3-17-22)

02. Extended Stay. The Department, or its designee, will establish authorization requirements in the Idaho Medicaid Provider Handbook for hospitals not reimbursed under DRG methodologies. An authorization is necessary when the appropriate care of the participant indicates the need for hospital days in excess of the initial length of stay, or previously approved extended stay. (3-17-22)

03. Exceptions and Limitations. The following exceptions and limitations apply to in-patient hospital services for hospitals not reimbursed under DRG methodologies: (3-17-22)

a. Payment for accommodations is limited to the hospital's all-inclusive rate. The all-inclusive rate is a flat fee charge incurred on a daily basis that covers both room and board. (3-17-22)

b. The Department will not authorize reimbursement above the all-inclusive rate unless the attending ~~physician~~ provider orders a room that is not an all-inclusive rate room for the patient because of medical necessity. ~~(3-17-22)~~( )

04. Diagnosis Related Group Review and Audits. All services performed under DRG are subject to QIO reviews, retrospective reviews, and audits. The Department reserves the right to execute reviews as described in the Idaho Medicaid Provider Handbook as amended. (3-17-22)

403. INPATIENT HOSPITAL SERVICES: PROCEDURAL REQUIREMENTS.

~~**01. Prior Authorization**. Some services may require a prior authorization from the Department or its designee. Documentation for the request must include the most recent plan of care and adequate documentation to demonstrate continued medical necessity. The Department will set additional documentation requirements in the Idaho Medicaid Provider Handbook to ensure quality of care and integrity of services. (3-17-22)~~

02~~1~~. Certification of ~~Need~~ Medical Necessity. At the time of admission, the physician must certify that inpatient services are necessary. Recertification must occur at least every sixty (60) days inpatient hospital services are required, but may be required more frequently as determined by the Department. ~~(3-17-22)~~( )

03~~2~~. Individual Plan of Care. The individual plan of care is a written plan developed for the participant upon admission to a hospital and updated at least every sixty (60) days, but may be required more frequently as determined by the Department. The plan must include: (3-17-22)

a. Diagnoses, symptoms, complaints, and complications indicating the need for admission; (3-17-22)

b. A description of the functional level of the individual; (3-17-22)

c. Any orders for medications, treatments, rehabilitative services, activities, social services, or diet; and (3-17-22)

d. Plans for continuing care or discharge, as appropriate. (3-17-22)

04~~3~~. Request for Extended Stay. To qualify for reimbursement, authorization must be obtained from the Department, or its designee. The request should be made before the initial length of stay or previously authorized extended stay ends, and submitted as designated by the Department~~, or its designee~~. Documentation for the request should include the most recent plan of care. The Department will set additional documentation requirements in the Idaho Medicaid Provider Handbook to ensure quality of care and integrity of services. ~~(3-17-22)~~( )

404. INPATIENT HOSPITAL SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
In addition to the provider enrollment agreement, each claim submitted by a hospital constitutes an agreement by which the hospital agrees to accept and abide by the Department's rules. Only a Medicare certified hospital, licensed by the state in which it operates, may enroll in the Idaho Medicaid program. Hospitals not participating as a Medicaid swing-bed provider, which are licensed for long-term care or as a specialty hospital that provides a nursing home level of care, will be reimbursed as a nursing facility. Hospitals not eligible for enrollment which render emergency care will be paid rates established in these rules. (3-17-22)

405. 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 Medicaid reimbursement for services established in accordance with the procedures detailed under this 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. ~~(3-17-22)~~( )

01. Payment Procedures. The following procedures are applicable to in-patient hospitals: (3-17-22)

a. The participant's admission and length of stay may be subject to prior authorization, concurrent

review, continued stay review, 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 a 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 402 of these 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 this rule.~~ ~~(3-17-22)~~( )

i. All admissions for hospitals not reimbursed under DRG methodologies 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. (3-17-22)

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, "Contested Case Proceedings and Declaratory Rulings."~~ ~~(3-17-22)~~( )

~~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.~~ ~~(3-17-22)~~

b. In reimbursing licensed hospitals, the Department will pay the lesser of customary hospital charges or Medicaid reimbursement 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 that would be determined as reasonable cost using the Title XVIII standards and principles. (3-17-22)

~~**02. Hospital Penalty Schedule**. The following applies for hospitals not reimbursed under DRG methodologies:~~ ~~(3-17-22)~~

~~**a.** A request for a preadmission or continued stay QIO review, or for both, 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.~~ ~~(3-17-22)~~

~~**b.** A request for a preadmission or continued stay QIO review, or for both, 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.~~ ~~(3-17-22)~~

~~**c.** A request for a preadmission or continued stay QIO review, or for both, 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.~~ ~~(3-17-22)~~

~~**d.** A request for a preadmission or continued stay QIO review, or for both, 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.~~ ~~(3-17-22)~~

~~**e.** A request for a preadmission or continued stay QIO review, or for both, 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.~~ ~~(3-17-22)~~

03. 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/IID rates are excluded from this calculation.~~ ~~(3-17-22)~~( )

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. ~~(3-17-22)~~( )

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 (3-17-22)

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. (3-17-22)

04. Reimbursement for Services. Routine services ~~as addressed~~ in Subsection 405.05 of this rule include all medical care, supplies, and services that are included in the calculation of nursing facility property and non-property 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. ~~(3-17-22)~~( )

05. 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~~ for participants in licensed hospital "swing-beds" who require nursing facility level of care. ~~(3-17-22)~~( )

~~**a.** Facility Requirements. The Department will approve hospitals for nursing facility care provided to eligible participants under the following conditions: (3-17-22)~~

~~i. The Department's Licensure and Certification Section finds the hospital in conformance with the requirements of 42 CFR 482.58 "Special Requirements" for hospital providers of long-term care services ("swing-beds"), or 42 CFR 485.645 Special requirements for CAH providers of long-term services ("swing beds") as applicable; and (3-17-22)~~

~~ii. The hospital is approved by the Medicare program for the provision of "swing-bed" services; and (3-17-22)~~

~~iii. The facility does not have a twenty-four (24) hour nursing waiver granted under 42 CFR 488.54(c); and (3-17-22)~~

~~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 (3-17-22)~~

~~v. The hospital must be licensed for less than one hundred (100) beds as defined by 42 CFR 482.58(a)(1) for swing-bed purposes; and (3-17-22)~~

~~vi. Nursing facility services in swing beds must be rendered in beds used interchangeably to furnish hospital or nursing facility-type services. (3-17-22)~~

~~b~~**a.** Participant Requirements. The Department will reimburse hospitals for participants under the following conditions: (3-17-22)

i. The participant is determined to be entitled to such services in accordance with IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled"; and (3-17-22)

ii. The participant is authorized for payment in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 222.02. (3-17-22)

~~c~~**b.** Reimbursement for "Swing-Bed" Patient Days. The Department will reimburse swing-bed hospitals on a per diem basis utilizing a rate established as follows: (3-17-22)

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/IID facilities' rates are excluded from the calculations.~~ ~~(3-17-22)~~( )

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. ~~(3-17-22)~~( )

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. (3-17-22)

iv. Routine services include all medical care, supplies, and services that 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. (3-17-22)

~~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. (3-17-22)~~

v~~i~~. 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. (3-17-22)

~~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. The Department may authorize additional critical access hospital swing-bed days for participants residing in a community without a nursing facility within thirty-five (35) miles contingent on a review of medical necessity, cost-effectiveness, residency, and quality of care. (3-17-22)~~

~~**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. (3-17-22)~~

06. 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. The Department will send each hospital a DSH survey on or before January 31 of each 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. (3-17-22)

a. Mandatory Eligibility. Mandatory Eligibility for DSH status will be provided for hospitals that: (3-17-22)

i. Meet or exceed the disproportionate share threshold as defined in Subsection 400.13 of these rules. (3-17-22)

ii. Have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services. (3-17-22)

(1) Subsection 405.06.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 (3-17-22)

(2) Does not offer nonemergency inpatient obstetric services as of December 21, 1987. (3-17-22)

iii. The MUR will not be less than one percent (1%). (3-17-22)

iv. If an Idaho hospital exceeds both disproportionate share thresholds, as described in Subsection 400.13 of these rules, and the criteria of Subsections 405.06.b.ii. and 405.06.b.iii. of this rule are met, the payment adjustment will be the greater of the amounts calculated using the methods identified in Subsections 405.06.b.vi. through 405.06.b.x. of this rule. (3-17-22)

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. (3-17-22)

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. (3-17-22)

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. (3-17-22)

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. (3-17-22)

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. (3-17-22)

b. Deemed ~~Disproportionate Share Hospital (~~DSH~~)~~. All hospitals in Idaho that 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 405.06.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:
~~(3-17-22)~~( )

i. Five dollars ($5) per Idaho Medicaid inpatient day included in the hospital's MUR computation; or (3-17-22)

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. (3-17-22)

c. 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. (3-17-22)

d. 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. (3-17-22)

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. (3-17-22)

ii. Claims of uninsured costs that increase the maximum amount that a hospital may receive as a DSH payment must be documented. (3-17-22)

e. 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. (3-17-22)

f. 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. (3-17-22)

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. (3-17-22)

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." (3-17-22)

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: (3-17-22)

(1) Recover the overpayment from the provider; and (3-17-22)

(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. (3-17-22)

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. (3-17-22)

07. Out-of-State Hospitals. ~~(3-17-22)~~

~~a.~~ Cost Settlements for Certain Out-of-State Hospitals. For service periods through June 30, 2021, 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: ~~(3-17-22)~~( )

~~i~~**a.** Total inpatient and outpatient covered charges are more than fifty thousand dollars ($50,000) in the fiscal year; or (3-17-22)

~~ii~~**b.** 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. (3-17-22)

~~**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.~~ ~~(3-17-22)~~

08. 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. (3-17-22)

09. 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. (3-17-22)

10. 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. (3-17-22)

11. **Interim Cost Settlements**. The Department may initiate, or a hospital may request an interim cost settlement based on the Medicare cost report as submitted, for hospitals subject to cost settlement. ~~(3-17-22)~~( )

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. (3-17-22)

b. 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. (3-17-22)

~~**12.** **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 that 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.~~ ~~(3-17-22)~~

~~**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.~~ ~~(3-17-22)~~

~~**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.~~ ~~(3-17-22)~~

1~~3~~2. **Non Appealable Items**. The formula for the determination of the hospital inflation index, the principles of reimbursement that define allowable cost, non-Medicaid program issues, interim rates that 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 are not acceptable as appealable items. (3-17-22)

1~~4~~3. **Interim Reimbursement Rates for Providers Subject to Cost Settlement**. The interim reimbursement rates must be reasonable and adequate to meet the necessary costs that are incurred by economically and efficiently operated providers that provide services in conformity with applicable state and federal laws, rules, and quality and safety standards. (3-17-22)

a. Annual Adjustments. Interim rates will be adjusted at least annually based on the best information available to the Department. (3-17-22)

b. Retrospective Adjustments. Interim rates will not be adjusted retrospectively upon request for rate review by the provider. (3-17-22)

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. (3-17-22)

~~**d.** Unadjusted Rate. The Medicaid interim reimbursement rate on file is synonymous with the term unadjusted rate used by other payors.~~ ~~(3-17-22)~~

~~**15. Audits**. All financial reports are subject to audit by Departmental representatives in accordance with Section 305 of these rules.~~ ~~(3-17-22)~~

406. INPATIENT HOSPITAL SERVICES: QUALITY ASSURANCE.
The designated QIO must prepare, distribute, and maintain a provider manual that is periodically updated. The manual must include the following: (3-17-22)

01. QIO Information. The QIO's policies, criteria, standards, operating procedures, and forms for performing: preadmission monitoring, assessment reviews, continued stay requests, and requests for retroactive medical reviews. (3-17-22)

02. Department Provisions. Department-selected diagnoses and elective procedures in which a hospital will request preauthorization of an admission, transfer, or continuing stay. (3-17-22)

03. Approval Timeframe. A provision that the QIO will inform the hospital of a certification within five (5) days, or other time frame as determined by the Department, of an approved admission, transfer, or continuing stay. (3-17-22)

04. Method of Notice. The method of notice to hospitals of QIO denials for specific admissions, transfers, continuing stays, or services rendered in post-payment reviews. (3-17-22)

05. Procedural Information. The procedures that providers or participants will use to obtain reconsideration of a denial by the QIO prior to appeal to the Department. Such requests for reconsideration by the QIO must be made in writing to the QIO within one hundred eighty (180) days of the issuance of the "Notice of Non-Certification of Hospital Days." (3-17-22)

407. -- 409. (RESERVED)

410. OUTPATIENT HOSPITAL SERVICES: DEFINITIONS.
Outpatient hospital services include preventive, diagnostic, therapeutic, rehabilitative or palliative items, and services furnished by or under the direction of a ~~physician or dentist~~ provider not in need of inpatient hospital care, unless excluded by any other provisions of this chapter. ~~(3-17-22)~~( )

411. (RESERVED)

412. OUTPATIENT HOSPITAL SERVICES: COVERAGE AND LIMITATIONS.

01. Services Are Provided On-Site. ~~Outpatient hospital services must be provided on site.~~ ~~(3-17-22)~~( )

~~**02. Exceptions and Limitations**.~~ ~~(3-17-22)~~

~~**a.** Payment for emergency room service is limited to six (6) visits per calendar year.~~ ~~(3-17-22)~~

~~**b.** Emergency room services that are followed immediately by admission to inpatient status will be excluded from the six (6) visit limit.~~ ~~(3-17-22)~~

0~~3~~2. Co-Payments. (3-17-22)

a. When an emergency room physician ~~conducts a medical screening and~~ determines that an emergency condition does not exist, the hospital can require the participant to pay a co-payment as described in IDAPA 16.03.18, "Medicaid Cost-Sharing." ~~(3-17-22)~~( )

b. ~~A hospital may refuse to provide s~~Services ~~to a participant when a medical screening has~~ may be refused when determined ~~that~~ an emergency condition does not exist and the participant does not make the ~~required~~ co-payment at the time of service. ~~Under these circumstances, t~~The hospital ~~must~~ will provide notification to the participant ~~as specified in~~ per Section 1916A(e) of the Social Security Act. ~~(3-17-22)~~( )

413. OUTPATIENT HOSPITAL SERVICES: PROCEDURAL REQUIREMENTS.

01. Review Prior to Delivery ~~of Outpatient Services~~. Failure to obtain a timely review from the Department ~~or its quality improvement organization (QIO)~~ prior to delivery of ~~outpatient services,~~ listed ~~on the select~~ procedure and diagnosis ~~list~~ codes in the QIO Idaho Medicaid Providers Manual and the Hospital Provider Handbook, as amended, ~~for participants who are eligible at the time of service,~~ will result in a retrospective review. ~~The Department will assess a late review penalty, as outlined in Subsection 405.02 of these rules, when a review is conducted due to an untimely request.~~ ~~(3-17-22)~~( )

02. Follow-Up for Emergency Room Patients. Hospitals must establish procedures to refer Medicaid participants who are not enrolled in Healthy Connections to an Idaho Medicaid Healthy Connections provider, if one is available within a reasonable distance of the participant's residence. Hospitals must coordinate care of patients who already have a Healthy Connections provider with that ~~PCP~~ primary care provider. ~~(3-17-22)~~( )

414. (RESERVED)

415. OUTPATIENT HOSPITAL SERVICES: PROVIDER REIMBURSEMENT.

01. Outpatient Hospital. The Department will not pay more than the combined payments the provider is allowed to receive from the participants and carriers or intermediaries for providing comparable services under comparable circumstances under Medicare. ~~For those p~~Providers subject to cost settlement, outpatient hospital services identified below that are not listed in the Department's fee schedules will be reimbursed reasonable costs based on a year-end cost settlement. ~~(3-17-22)~~( )

a. Maximum payment for hospital outpatient diagnostic laboratory and partial care services will be limited to the Department's ~~established~~ fee schedule. ~~(3-17-22)~~( )

~~**b.** Maximum payment for hospital outpatient partial care services will be limited to the Department's established fee schedule.~~ ~~(3-17-22)~~

~~**e**~~**b.** Hospital-based ambulance services will be reimbursed at the lower of either the provider's actual charge for the service or the maximum allowable charge for the service as established by the Department in its ~~pricing file~~ fee schedule. ~~(3-17-22)~~( )

~~**d.** Hospital Outpatient Surgery. Those items furnished by a hospital to an outpatient in connection with Ambulatory Surgical Center must be surgical procedures covered by Idaho Medicaid. The aggregate amount of payments for related facility services, furnished in a hospital on an outpatient basis, is equal to the lesser of:~~ ~~(3-17-22)~~

~~i. The hospital's reasonable costs as reduced by federal mandates for certain operating costs, capital costs, customary hospital charges; or~~ ~~(3-17-22)~~

~~ii. The blended payment amount that is based on hospital specific cost and charge data and Medicaid rates paid to free-standing Ambulatory Surgical Centers (ASC); or~~ ~~(3-17-22)~~

~~iii. The blended rate of costs and the Department's fee schedule for ambulatory surgical centers at the time of cost settlement; or~~ ~~(3-17-22)~~

~~iv. The blended rate for outpatient surgical procedures is equal to the sum of forty-two percent (42%) of the hospital specific amount and fifty-eight percent (58%) of the ASC amount.~~ ~~(3-17-22)~~

~~**e.** Hospital Outpatient Radiology Services include diagnostic and therapeutic radiology, CAT scan procedures, magnetic resonance imaging, ultrasound and other imaging services. The aggregate payment for hospital outpatient radiology services furnished will be equal to the lesser of:~~ ~~(3-17-22)~~

~~i. The hospital's reasonable costs; or~~ ~~(3-17-22)~~

~~ii. The hospital's customary charges; or (3-17-22)~~

~~iii. The blended payment amount for hospital outpatient radiology equal to the sum of forty-two percent (42%) of the hospital specific amount and fifty-eight percent (58%) of the Department's fee schedule amount. (3-17-22)~~

~~02. Reduction to Outpatient Hospital Costs. For services dates through June 30, 2021, outpatient costs not paid according to the Department's established fee schedule, including the hospital specific component used in the blended rates, will be reduced by five and eight-tenths percent (5.8%) of operating costs and ten percent (10%) of each hospital's capital costs component. This reduction will only apply to the following provider classes: (3-17-22)~~

~~a. In state hospitals specified in Section 56-1408(2), Idaho Code, that are not a Medicare designated sole community hospital or rural primary care hospital. (3-17-22)~~

~~b. Out of state hospitals that are not a Medicare designated sole community hospital or rural primary care hospital. (3-17-22)~~

416. -- 421. (RESERVED)

422. RECONSTRUCTIVE SURGERY: COVERAGE AND LIMITATIONS.
Reconstruction or restorative procedures ~~that may be rendered with prior approval by the Department~~ include procedures that restore function of the affected or related body part(s). Approvable procedures include breast reconstruction after mastectomy, or the repair of other injuries resulting from physical trauma. ~~(3-17-22)~~( )

423. -- 430. (RESERVED)

431. ~~SURGICAL PROCEDURES FOR~~ WEIGHT LOSS: PARTICIPANT ELIGIBILITY.

01. Surgical Procedure. Surgery for the correction of obesity is covered when all of the following conditions are met: ~~(3-17-22)~~( )

~~01~~a. ~~Participant Medical Condition~~. The participant must meet criteria for clinically severe obesity with a Body Mass Index (BMI) equal to or greater than forty (40), or a BMI equal to or greater than thirty-five (35) with comorbid conditions such as type 2 diabetes, hypothyroidism, atherosclerotic cardiovascular disease, or osteoarthritis of the lower extremities. The serious comorbid medical condition must be documented by the primary physician who refers the patient for the procedure, or a physician specializing in the participant's comorbid condition ~~who is~~ not associated by ~~clinic or other~~ affiliation with the performing surgeon~~s who will perform the surgery~~. ~~(3-17-22)~~( )

~~02~~b. ~~Other Medical Condition Exists.~~ The obesity ~~is caused by the serious comorbid condition, or the obesity~~ could aggravate the participant's cardiac, respiratory or other systemic disease. ~~(3-17-22)~~( )

~~03~~c. ~~Psychiatric Evaluation.~~ The participant must have a psychiatric evaluation to determine the stability of personality at least ninety (90) days prior to the ~~date a~~ request for prior authorization is submitted ~~to Medicaid~~. ~~(3-17-22)~~( )

d. Non-Surgical Treatment. Services for non-surgical treatment of obesity, except drugs, are covered when integral and are a necessary part of treatment for another medical condition covered by Medicaid. ( )

432. ~~SURGICAL PROCEDURES FOR~~ WEIGHT LOSS: COVERAGE AND LIMITATIONS.

~~01. Non-Surgical Treatment for Obesity. Services in connection with non-surgical treatment of obesity are covered only when such services are an integral and necessary part of treatment for another medical condition that is covered by Medicaid. (3-17-22)~~

0~~2~~1. Abdominoplasty or Panniculectomy. Abdominoplasty or panniculectomy is covered when ~~medically necessary, as defined in Section 011 of these rules, and when~~ the surgery is prior authorized by the Department. The request for prior authorization must include the following documentation: ~~(3-17-22)~~( )

a. Photographs of the front, side and underside of the ~~participant's~~ abdomen; ~~(3-17-22)~~( )

b. Treatment of any ulceration and skin infections involving the panniculus; (3-17-22)

c. Failure of conservative treatment, including weight loss; (3-17-22)

d. That the panniculus severely inhibits the participant's walking; (3-17-22)

e. That the participant is unable to wear a garment to hold the panniculus up; and (3-17-22)

f. Other detrimental effects of the panniculus on the participant's health such as severe arthritis in the lower body. (3-17-22)

~~**433. SURGICAL PROCEDURES FOR WEIGHT LOSS: PROCEDURAL REQUIREMENTS.**~~

~~**01. Medically Necessary**. The Department must determine the surgery to be medically necessary, as defined in Section 011 of these rules.~~ ~~(3-17-22)~~

~~**02. Prior Authorization**. The surgery must be prior authorized by the Department. The Department will consider the guidelines of private and public payors, evidence-based national standards of medical practice, and the medical necessity of each participant's case when determining whether surgical correction of obesity will be prior authorized.~~ ~~(3-17-22)~~

433. (RESERVED)

434. ~~SURGICAL PROCEDURES FOR~~ WEIGHT LOSS: PROVIDER QUALIFICATIONS AND DUTIES.
Physicians and hospitals performing surgical procedures must meet national medical standards for weight loss surgery. ~~(3-17-22)~~( )

435. -- ~~442.~~ ~~(RESERVED)~~

~~**443. INVESTIGATIONAL PROCEDURES OR TREATMENTS: PROCEDURAL REQUIREMENTS.**~~
~~The Department may consider Medicaid coverage for investigational procedures or treatments on a case-by-case basis for life-threatening medical illnesses when no other treatment options are available. For these cases, a focused case review is completed by a professional medical review organization to determine if an investigational procedure would be beneficial to the participant. The Department will perform a cost-benefit analysis on the procedure or treatment in question. The Department will determine coverage based on this review and analysis.~~ ~~(3-17-22)~~

~~**01. Focused Case Review**. A focused case review consists of assessment of the following:~~ ~~(3-17-22)~~

~~**a.** Health benefit to the participant of the proposed procedure or treatment;~~ ~~(3-17-22)~~

~~**b.** Risk to the participant associated with the proposed procedure or treatment;~~ ~~(3-17-22)~~

~~**c.** Result of standard treatment for the participant's condition, including alternative treatments other than the requested procedure or treatment;~~ ~~(3-17-22)~~

~~**d.** Specific inclusion or exclusion by Medicare national coverage guidelines of the proposed procedure or treatment;~~ ~~(3-17-22)~~

~~**e.** Phase of the clinical trial of the proposed procedure or treatment;~~ ~~(3-17-22)~~

f. Guidance regarding the proposed procedure or treatment by national organizations; (3-17-22)

g. Clinical data and peer-reviewed literature pertaining to the proposed procedure or treatment; and (3-17-22)

h. Ethics Committee review, if appropriate. (3-17-22)

02. Additional Clinical Information. For cases in which the Department determines that there is insufficient information from the focused case review to render a coverage decision, the Department may, at its discretion, seek an independent professional opinion. (3-17-22)

03. Cost-Benefit Analysis. The Department will perform a cost-benefit analysis that will include at least the following: (3-17-22)

a. Estimated costs of the procedure or treatment in question. (3-17-22)

b. Estimated long-term medical costs if this procedure or treatment is allowed. (3-17-22)

c. Estimated long-term medical costs if this procedure is not allowed. (3-17-22)

d. Potential long-term impacts approval of this procedure or treatment may have on the Medical Assistance Program. (3-17-22)

04. Coverage Determination. The Department will make a decision about coverage of the investigational procedure or treatment after consideration of the focused case review, cost-benefit analysis, and any additional information received during the review process. (3-17-22)

444. -- 449. (RESERVED)

SUB AREA: AMBULATORY SURGICAL CENTERS
(Sections 450-499)

450. -- 451. (RESERVED)

452. AMBULATORY SURGICAL CENTER SERVICES: COVERAGE AND LIMITATIONS.
Those sSurgical procedures identified by the Medicare program as appropriately and safely performed in an ASC will be reimbursed by the Department. In addition, tThe Department may add surgical procedures to the list developed by the Medicare program as required by 42 CFR 416.164 if the procedures meet the criteria identified in 42 CFR 416.166. (3-17-22)( )

453. (RESERVED)

454. AMBULATORY SURGICAL CENTER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Approval. The ASC must be surveyed as required by 42 CFR 416.25 through 416.52 and be approved by the U.S. Department of Health and Human Services for participation as a Medicare ASC provider. (3-17-22)( )

02. Cancellation. Grounds for cancellation of the provider agreement include: (3-17-22)

a. The loss of Medicare program approval; or (3-17-22)

b. Identification of any condition that threatens the health or safety of patients by the Department's Bureau of Facility Standards. (3-17-22)

455. AMBULATORY SURGICAL CENTER SERVICES: PROVIDER REIMBURSEMENT.

01. Payment Methodology. ASC services reimbursement is ~~designed to pay~~ packaged for use of facilities and necessary supplies ~~necessary to safely care for the patient. Such services are reimbursed as follows:~~ as recognized by the Medicare program under 42 CFR, Part 416.164. ~~(3-17-22)~~( )

a. ~~ASC service payments represent reimbursement for the costs of goods and services recognized by the Medicare program under 42 CFR, Part 416. Payment will be determined by the Department. Any surgical procedure covered by the Department, but which is not covered by Medicare will have a reimbursement rate established by t~~The Department will establish a reimbursement rate for any covered procedure not covered by Medicare. ~~(7-1-24)~~( )

~~**b.** ASC services include the following: (3-17-22)~~

~~i. Nursing, technician, and related services; (3-17-22)~~

~~ii. Use of ASC facilities; (3-17-22)~~

~~iii. Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of surgical procedures; (3-17-22)~~

~~iv. Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure; (3-17-22)~~

~~v. Administration, recordkeeping, and housekeeping items and services; and (7-1-24)~~

~~vi. Materials for anesthesia. (3-17-22)~~

~~**c.** ASC services do not include the following services: (3-17-22)~~

~~i. Physician services; (3-17-22)~~

~~ii. Laboratory services, x-ray or diagnostic procedures (other than those directly related to the performance of the surgical procedure); (3-17-22)~~

~~iii. Prosthetic and orthotic devices; (3-17-22)~~

~~iv. Ambulance services; (3-17-22)~~

~~v. DME typically used in the participant's place of residence, but may be suitable for use in any setting in which normal life activities take place, other than a hospital, nursing facility, or ICF/IID; and (7-1-24)~~

~~vi. Any other service not specified in Subsection 455.01.b. of this rule. (3-17-22)~~

~~**02. Payment for Ambulatory Surgical Center Services**. Payment is made at a rate established under Section 230 of these rules. (7-1-24)~~

456. -- 4~~9~~79. (RESERVED)

SUB AREA: CASE MANAGEMENT SERVICES
(Sections 480-489)

480. HOME VISITING SERVICES.
Home visiting provides for parents of vulnerable children to receive education and support on parenting topics.
( )

481. HOME VISITING SERVICES: PARTICIPANT ELIGIBILITY.
Participants under five (5) years of age and pregnant women at risk for abuse, neglect, or child welfare involvement.

Additional requirements are in the Idaho Medicaid Provider Handbook. ( )

482. HOME VISITING SERVICES: COVERAGE AND LIMITATIONS.

01. Home Visiting Coverage. ( )

a. Assessment for medical, educational, social, or other service needs; ( )

b. Development and revision of a plan to address goals; ( )

c. Referral and related activities for necessary services; and ( )

d. Monitoring of progress. ( )

02. Home Visiting Limitations. Services do not include case management integral to another covered service or that constitutes direct delivery of referred services. ( )

483. (RESERVED)

484. HOME VISITING SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
This service is provided by the Public Health Districts. Eligible providers are certified in an evidence-based model including: ( )

01. Parents as Teachers. or ( )

02. Nurse-Family Partnership. ( )

485. – 489. (RESERVED)

490. COMMUNITY RE-ENTRY SERVICES: TARGETED CASE MANAGEMENT.
Medicaid will reimburse for targeted case management services for eligible incarcerated participants thirty (30) days prior to, and thirty (30) days after, their release into the community. Eligible participants are those incarcerated with an adjudicated case up to age twenty-one (21) for the general population and up to age twenty-six (26) for those formerly in foster care. Services include transitioning back into the community by providing access to behavioral, educational, mental, social, and other services. ( )

490. – 499. (RESERVED)

SUB AREA: ~~PHYSICIAN~~MEDICAL SERVICES ~~AND ABORTION PROCEDURES~~
(Sections 500-519)

500. ~~PHYSICIAN~~MEDICAL SERVICES.
~~Physician~~Medical services include the treatment of medical and surgical conditions by ~~doctors of medicine or osteopathy~~ licensed professionals subject to the limitations of practice imposed by state law, and to the restrictions and exclusions of coverage ~~contained in Section 390 and Section 502 of~~ under these rules. ~~(3-17-22)~~( )

501. (RESERVED)

502. ~~PHYSICIAN~~MEDICAL SERVICES: COVERAGE AND LIMITATIONS.

~~**01. Sterilization Procedures**. Restrictions pertaining to payment for sterilization procedures are contained in Sections 680 through 686 of these rules. (3-17-22)~~

~~**02. Abortions**. Restrictions governing payment for abortions are contained in Sections 511 through 514 of these rules. (3-17-22)~~

0~~3~~1. **Tonometry**. Payment for tonometry is limited to one (1) examination ~~for individuals over the age~~

~~of forty (40) years during any twelve (12) month period (in addition to tonometry as a component of examination to determine visual acuity). In the event examination to determine visual acuity is not done,~~ or, when the examination to determine visual acuity is not done, two (2) tonometry examinations per twelve (12) month period are allowed for participants over the age of forty (40). This limitation does not apply to participants receiving continuing treatment for glaucoma. ~~(3-17-22)~~( )

~~**04. Physical Therapy Services**. Payment for physical therapy services performed in the physician's office is limited to those services that are described and supported by the diagnosis. (3-17-22)~~

0~~5~~2. **Injectable Vitamins**. Payment for allowable injectable vitamins will be allowed when supported by the diagnosis. Injectable vitamin therapy is limited to Vitamin B12 (and analogues), Vitamin K (and analogues), folic acid, and mixtures consisting of Vitamin B12, folic acid, and iron salts in any combination. (3-17-22)

0~~6~~3. **Corneal Transplants and Kidney Transplants**. Corneal transplants and kidney transplants are covered by ~~the Medical Assistance Program~~ Medicaid. ~~(3-17-22)~~( )

04. Adult Physicals. Adult preventive physical examinations are limited to one (1) per year. ( )

05. Screening Mammograms. Screening mammograms are covered when aligned with the "A" or "B" recommendations of the United States Preventative Services Task Force. ( )

503. (RESERVED)

504. ~~PHYSICIAN~~MEDICAL SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Misrepresentation of Services. Any representation that a service provided by a ~~nurse practitioner, nurse midwife, physical therapist, physician assistant, psychologist, social worker, or other nonphysician professional~~ provider other than a physician as a physician service is prohibited. ~~(3-17-22)~~( )

02. Locum Tenens Claims and Reciprocal Billing. Locum Tenens is allowed as detailed in the Idaho Medicaid Provider Handbook. ~~(3-17-22)~~( )

~~**a.** In reimbursement for Locum Tenens/reciprocal billing, the patient's regular physician may submit the claim and receive payment for covered physician services (including emergency visits and related services) provided by a Locum Tenens physician who is not an employee of the regular physician if: (3-17-22)~~

~~i. The regular physician is unavailable to provide the visit services. (3-17-22)~~

~~ii. The Medicaid patient has arranged for or seeks to receive services from the regular physician. (3-17-22)~~

~~iii. The regular physician pays the Locum Tenens for their services on a per diem or similar fee-for-time basis. (3-17-22)~~

~~iv. The substitute physician does not provide the visit services to Medicaid patients over a continuous period of longer than ninety (90) days for Locum Tenens and over a continuous period of fourteen (14) days for reciprocal billing. (3-17-22)~~

~~v. The regular physician identifies the services as substitute physician services meeting the requirements of this rule by appending modifier Q6 (service furnished by a Locum Tenens physician) to the procedure code or Q5 (services furnished by a substitute physician under reciprocal billing arrangements). (3-17-22)~~

~~vi. The regular physician must keep on file a record of each service provided by the substitute physician associated with the substitute physician's UPIN, and make this record available to the department upon request. (3-17-22)~~

~~vii. The claim identifies, in a manner specified by the Department, the physician who furnished the~~

~~services.~~ ~~(3-17-22)~~

~~**b.** If the only Locum Tenens/reciprocal billing services a physician performs in connection with an operation are post-operative services furnished during the period covered by the global fee, those services may not be reported separately on the claim as substitution services, but must be deemed as included in the global fee payment.~~ ~~(3-17-22)~~

~~**c.** A physician may have Locum Tenens/reciprocal billing arrangements with more than one (1) physician. The arrangements need not be in writing. Locum Tenens/reciprocal billing services need not be provided in the office of the regular physician.~~ ~~(3-17-22)~~

~~**505. PHYSICIAN SERVICES: PROVIDER REIMBURSEMENT.**~~

~~**01. Physician Penalties for Late QIO Review**. Medicaid will assess the physician a penalty for failure to request a preadmission review from the Department, for procedures and diagnosis listed on the select list in the Department's Physician Provider Handbook and the QIO Idaho Medicaid Provider Manual. If a retrospective review determines the procedure was medically necessary, and the physician was late in obtaining a preadmission review the Department will assess a penalty according to Subsection 505.02 of this rule. The penalty will be assessed after payment for physician services has occurred.~~ ~~(3-17-22)~~

~~**02. Physician Penalty Schedule**.~~ ~~(3-17-22)~~

~~**a.** A request for preadmission QIO review that is one (1) day late will result in a penalty of fifty dollars ($50).~~ ~~(3-17-22)~~

~~**b.** A request for preadmission QIO review that is two (2) days late will result in a penalty of one hundred dollars ($100).~~ ~~(3-17-22)~~

~~**c.** A request for preadmission QIO review that is three (3) days late will result in a penalty of one hundred and fifty dollars ($150).~~ ~~(3-17-22)~~

~~**d.** A request for preadmission QIO review that is four (4) days late will result in a penalty of two hundred dollars ($200).~~ ~~(3-17-22)~~

~~**e.** A request for preadmission QIO review that is five (5) days late or later will result in a penalty of two hundred and fifty dollars ($250).~~ ~~(3-17-22)~~

~~**03. Physician Excluded From the Penalty**. Any physician who provides care but has no control over the admission, continued stay, or discharge of the patient will not be penalized. Assistant surgeons and multi-surgeons are not excluded from the penalty.~~ ~~(3-17-22)~~

50~~6~~5. -- 510. (RESERVED)

511. ABORTION PROCEDURES: PARTICIPANT ELIGIBILITY.

The Department will fund abortions under circumstances where the abortion is necessary to save the life of the woman~~, or in cases of rape or incest as determined by the courts, or, where no court determination has been made, if reported to a law enforcement agency or child protective services~~. ~~(7-1-24)~~( )

512. -- 513. (RESERVED)

514. ABORTION PROCEDURES~~: PROVIDER QUALIFICATIONS AND DUTIES~~.

~~**01. Required Documentation in the Case of Rape or Incest**. In the case of rape or incest, the following documentation must be provided to the Department:~~ ~~(3-17-22)~~

~~**a.** A copy of the court determination of rape or incest; or~~ ~~(3-17-22)~~

~~**b.** Where no court determination has been made, documentation that the rape or incest was reported to a law enforcement agency or child protective services; or (7-1-24)~~

~~**c.** Where the rape or incest was not reported to a law enforcement agency or child protective services, a physician must certify in writing their professional opinion that the woman was unable due to her health, to file a report. The certification must contain the name and address of the woman. (7-1-24)~~

~~**02. Required Documentation in the Case to Save a Woman's Life**. In the case w~~Where the abortion is necessary to save the life of the woman, a licensed physician must certify in writing that the woman may die if the fetus is carried to term. ~~The certification must contain the name and address of the woman. (7-1-24)~~( )

515. -- 519. (RESERVED)

SUB AREA: OTHER ~~PRACTITIONER~~ PROVIDER SERVICES
(Sections 520-559)

520. -- ~~521.~~ ~~(RESERVED)~~

~~**522. NON-PHYSICIAN PRACTITIONER SERVICES: COVERAGE AND LIMITATIONS.**~~
~~The Medicaid Program will pay for services provided by non-physician practitioners (NPPs), as defined in these rules and in accordance with the provisions found under Sections 523 through 525 of these rules. (3-17-22)~~

~~**523. (RESERVED)**~~

~~**524. NON-PHYSICIAN PRACTITIONER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.**~~

~~**01. Identification of Services**. The required services must be covered under the legal scope of practice as identified by the appropriate State rules of the NPP. (3-17-22)~~

~~**02. Deliverance of Services**. The services must be delivered under physician supervision, if required by state regulations where the service is provided. (7-1-24)~~

~~**525. NON-PHYSICIAN PRACTITIONER SERVICES: PROVIDER REIMBURSEMENT.**~~

~~**01. Billing of Services**. Billing for the services must be as provided by the NPP and not represented as a physician service. (3-17-22)~~

~~**02. Payments Made Directly to CRNA**. Payments under the fee schedule must be made directly to the CRNA under the individual provider number assigned to the CRNA. Rural hospitals that qualify for a Medicare exception and employ or contract CRNAs may be reimbursed on a reasonable cost basis. (3-17-22)~~

~~**03. Reimbursement Limits**. The Department will reimburse for each service to be delivered by the NP, NM, CNS, PA, or RPh as either the billed charge or reimbursement limit established by the Department, whichever is less. (3-17-22)~~

~~**526. --**~~**529. (RESERVED)**

530. CHIROPRACTIC SERVICES: DEFINITIONS.
Subluxation is partial or incomplete dislocation of the spine. (3-17-22)

531. (RESERVED)

532. CHIROPRACTIC SERVICES: COVERAGE AND LIMITATIONS.
Only treatment involving manipulation of the spine to correct a subluxation condition is covered. ~~The Department will pay for a total of six (6) manipulation visits during any calendar year for remedial care by a chiropractor. (3-17-22)~~( )

533. ~~(RESERVED)~~

~~534. CHIROPRACTIC SERVICES: PROVIDER QUALIFICATIONS.~~
~~A person who is qualified to provide chiropractic services is licensed according to the regulations in the state where the services are provided.~~ ~~(3-17-22)~~

~~535.~~ -- 539. (RESERVED)

540. PODIATRIST SERVICES: DEFINITIONS.

01. Acute Foot Conditions. An acute foot condition~~, for the purpose of this provision,~~ means any condition that hinders normal function, threatens the individual, or complicates any disease. ~~(3-17-22)~~( )

02. Chronic Foot Diseases. Chronic foot diseases~~, for the purpose of this provision,~~ include: ~~(3-17-22)~~( )

a. Diabetes mellitus; (3-17-22)

b. Peripheral neuropathy involving the feet; (3-17-22)

c. Chronic thrombophlebitis;~~ and~~ ~~(3-17-22)~~( )

d. Peripheral vascular disease; (3-17-22)

e. Other chronic conditions that require regular podiatric care for the purpose of preventing recurrent wounds, pressure ulcers, or amputation; or (3-17-22)

f. Other conditions that have the potential to seriously or irreversibly compromise overall health. (3-17-22)

541. PODIATRIST SERVICES: PARTICIPANT ELIGIBILITY.
Participants eligible for podiatrist services are those with a(n): ~~(3-17-22)~~( )

01. ~~Participants Who Have a~~ Chronic Disease.~~ Participants who have a chronic disease where the evidence-based guidelines recommend regular foot care.~~ ~~(3-17-22)~~( )

02. ~~Participants with an~~ Acute Condition. ~~Participants with a~~An acute condition that, if left untreated, may cause an adverse outcome to the participant's health. ~~(3-17-22)~~( )

542. PODIATRIST SERVICES: COVERAGE AND LIMITATIONS.
Coverage for podiatrist services is limited to~~:~~ ~~(3-17-22)~~

~~01. Services Defined in Chronic Care Guidelines~~.~~ Acute and~~ preventive foot care services~~ defined in~~ for chronic~~ care guidelines;~~ foot conditions and ~~(3-17-22)~~

~~02. Treatment of Acute Conditions~~.~~ Treatment of~~ acute conditions that if left untreated will result in chronic damage to the participant's foot. ~~(3-17-22)~~( )

543.~~ – 545.~~ (RESERVED)

~~544. PODIATRIST SERVICES: PROVIDER QUALIFICATIONS.~~
~~A qualified podiatrist is licensed by the Board of Podiatry in the Idaho Board of Occupational Licensing, or licensed according to the regulations in the state where the services are provided.~~ ~~(3-17-22)~~

~~545. (RESERVED)~~

546. LICENSED MIDWIFE (LM) SERVICES.

The Department will reimburse ~~licensed midwives~~ LMs for maternal and newborn services performed within the scope of their practice. This section of rule does not include ~~non-physician practitioner~~ services provided by a nurse midwife ~~(NM) which are described in Sections 522 through 525 of these rules~~. ~~(3-17-22)~~( )

~~**547. LM SERVICES: DEFINITIONS.**~~

~~**01. Licensed Midwife**. An individual who holds a current license issued by the Idaho Board of Midwifery.~~ ~~(3-17-22)~~

~~**02. Board of Midwifery**. The Idaho Board of Midwifery is located within the Idaho Bureau of Occupational Licensing and is the licensing authority for LM providers.~~ ~~(3-17-22)~~

547. (RESERVED)

548. LM SERVICES: PARTICIPANT ELIGIBILITY.
~~A participant is eligible for~~ LM services ~~if the participant is pregnant, in the six (6) week postpartum period, or is a newborn up to six (6) weeks old~~ are available for participants in maternity, or newborn participants. ~~(3-17-22)~~( )

549. LM SERVICES: COVERAGE AND LIMITATIONS.

01. Maternity and Newborn ~~– Coverage~~. Antepartum, intrapartum, and ~~up to six (6) weeks of~~ postpartum maternity and newborn care are covered. ~~(3-17-22)~~

~~**02. Maternity and Newborn – Limitations**.~~ Maternal or newborn services provided after the ~~sixth~~ postpartum ~~week~~ period are not covered when provided by a CPM. ~~(7-1-24)~~( )

0~~3~~2. Medication ~~– Coverage and Limitations~~. ~~LM providers may administer medication and bill Medicaid if the medication is a Medicaid-covered service, and is also~~ Covered medication listed in the LM formulary under IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery." ~~(7-1-24)~~( )

~~**550. LM SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.**~~
~~Each LM provider must:~~ ~~(3-17-22)~~

~~**01. Licensed**. Have a current license as a LM from the Idaho Board of Midwifery or be licensed according to the regulations in the state where the services are provided.~~ ~~(3-17-22)~~

~~**02. Scope of Practice**. Provide only those services that are within the scope of practice under IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery."~~ ~~(3-17-22)~~

~~**551. LM SERVICES: PROVIDER REIMBURSEMENT.**~~
~~Reimbursement for LM services will be the lesser of the billed amount, or eighty five percent (85%) of the Department's physician fee schedule. The physician fee schedule is available from the Central Office for the Division of Medicaid, see online at: http://www.idmedicaid.com.~~ ~~(3-17-22)~~

550. -- 551. (RESERVED)

552. LM SERVICES: PROVIDER QUALITY ASSURANCE ACTIVITIES.
Each ~~Licensed Midwife (~~LM~~)~~ provider must maintain for Department review documentation of: ~~(3-17-22)~~( )

01. Informed Consent ~~– Form Required~~. ~~Keep a signed copy of the participant's informed consent in the participant's record.~~ ~~(3-17-22)~~( )

~~**02. Compliance with Board of Midwifery Requirements**. Adhere to all regulations listed in IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery."~~ ~~(3-17-22)~~

0~~3~~2. ~~Department Access to~~ Practice Data. ~~Make all practice data submitted to the Board of Midwifery according to the provisions in IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery," immediately available to~~

~~the Department upon request.~~ ~~(3-17-22)~~( )

~~553. (RESERVED)~~

~~554. OPTOMETRIST SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.~~
~~Optometrist services are provided to the extent specified in the individual provider agreements entered into under the provisions of Section 205 of these rules.~~ ~~(3-17-22)~~

~~01. Payment Availability. Payment for services included in Sections 780 through 786 of these rules is available to all licensed optometrists.~~ ~~(3-17-22)~~

~~02. Provider Qualifications. Optometrists who have certification or licensure according to the regulations in the state where the services are provided, qualify for provider agreements allowing payment for the diagnosis and treatment of injury or disease of the eye to the extent allowed under Section 54-1501, Idaho Code, and to the extent payment is available to physicians as defined in these rules.~~ ~~(3-17-22)~~

553. OPTOMETRIST SERVICES: COVERAGE AND LIMITATIONS.
The Department will pay for vision services for the diagnosis and treatment of injury or disease of the eye to the extent allowed under Section 54-1501, Idaho Code, and Sections 780 through 786 of these rules. ( )

55~~5~~4. -- 559. (RESERVED)

SUB AREA: PRIMARY CARE CASE MANAGEMENT
(Sections 560-579)

560. HEALTHY CONNECTIONS: DEFINITIONS.
Healthy Connections is a ~~primary care case management~~ PCCM program in which a ~~primary care provider~~ PCP or team provides comprehensive medical care for participants with the goal of improving health outcomes. ~~For purposes of this Sub-Area that includes~~ Under Sections 560 through 566 of these rules, the following ~~terms and~~ definitions apply: ~~(3-17-22)~~( )

~~01. Capitated Payments. Payments to a primary care provider made on a per assigned participant per month basis for patient services. Capitated payments will vary to reflect the level of responsibility for services the provider elects to provide as described in Section 564 of these rules. Capitated payments may include payment for all provider services at a set rate per participant per month when that type of full risk reimbursement is agreed to by the provider and the Department.~~ ~~(3-17-22)~~

0~~2~~1. **Clinic**. Two (2) or more ~~qualified medical professionals~~ providers who provide services jointly through an organization for which an individual is given authority to act on its behalf. ~~It also~~ include~~s~~ing Federally Qualified Health Centers (FQHCs), ~~Certified~~ Rural Health Clinics (RHCs), and Indian Health Clinics.
~~(3-17-22)~~( )

0~~3~~2. **Grievance**. The formal process by which problems and complaints related to Healthy Connections are addressed and resolved. ~~Grievance decisions may be appealed as provided herein.~~ ~~(3-17-22)~~( )

0~~4~~3. **Patient-Centered Medical Home (PCMH)**. A model of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. This results in primary care being delivered at the right place, at the right time, and in the manner that best suits a patient's needs. ~~(3-17-22)~~( )

0~~5~~4. **Preventive Care**. Medical care that focuses on disease prevention and health maintenance.
(3-17-22)

0~~6~~5. **Primary Care Case Management (PCCM)**. A model of care in which ~~primary care providers~~ PCPs and their primary care team are responsible for direct care of a participant, and ~~for~~ coordinating access to services that improve the ~~health of the~~ participant's health. ~~(3-17-22)~~( )

0~~7~~6. **Primary Care Provider (PCP)**. A ~~physician, physician assistant, or advanced practice registered~~

~~nurse as defined in IDAPA 24.34.01,"Rules of the Idaho Board of Nursing,"~~ provider who contracts with Medicaid to coordinate and manage the care of participants enrolled in the Healthy Connections program. ~~(3-17-22)~~( )

0~~8~~7. **Primary Care Team**. A multidisciplinary team of health care providers who work together to meet the physical, emotional, and psychological needs of their patients using a patient-centered and coordinated approach. (3-17-22)

0~~9~~8. **Referral**. A documented communication from a participant's ~~primary care provider (~~PCP~~)~~ to another Medicaid provider authorizing specific covered services subject to ~~primary care case management~~ PCCM that are not provided by the participant's PCP. ~~(3-17-22)~~( )

~~1~~09. **Transitional Care**. A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location. (3-17-22)

561. HEALTHY CONNECTIONS: PARTICIPANT ELIGIBILITY.

01. P~~rimary C~~are C~~ase M~~anagement Enrollment. ~~Each participant in Idaho~~ All Medicaid ~~is~~ participants are enrolled in Healthy Connections, unless ~~the participant is~~ granted an exemption ~~by the Department described in Subsections 561.02.a. through 561.02.h. of this~~ under these rules. ~~Each p~~Participants must choose a PCP within the Healthy Connections program. ~~If a participant fails to choose a PCP~~, or one will be assigned ~~to the participant~~ by the Department. Participants of the same family may choose different Healthy Connections providers. ~~(3-17-22)~~( )

02. Exemption from Participation. An exemption from participation in Healthy Connections may be granted on an individual basis by the Department for a participant who: (3-17-22)

a. Is unable to access a Healthy Connections provider within a distance of thirty (30) miles, or within thirty (30) minutes to obtain primary care services; (3-17-22)

b. Has an eligibility period that is less than three (3) months; (3-17-22)

c. Has an eligibility period that is only retroactive; (3-17-22)

d. Is eligible only as a Qualified Medicare Beneficiary; (3-17-22)

e. Has an existing relationship with a ~~primary care physician~~ PCP or clinic who is not participating in Healthy Connections; ~~(3-17-22)~~( )

f. Is enrolled in the Medicare/Medicaid Coordinated Plan; (3-17-22)

g. Resides in an ~~nursing facility~~ NF or ~~an~~ ICF/IID; or ~~(3-17-22)~~( )

h. Resides in a county where there are not an adequate number of providers to deliver ~~primary care case management~~ PCCM services. ~~(3-17-22)~~( )

562. HEALTHY CONNECTIONS: PRIMARY CARE SERVICES.

01. Eligible Services. Participants enrolled with a ~~primary care provider (~~PCP~~)~~ are eligible to receive: ~~(3-17-22)~~( )

a. Basic care management and care coordination; (3-17-22)

b. Timely access to routine primary care; (3-17-22)

c. A patient-centered health care decision making process; (3-17-22)

d. Twenty-four (24) hour, seven (7) days per week access to an on-call ~~medical professional~~ provider;

and ~~(3-17-22)~~( )

e. Referral to other medically necessary services ~~as specified in Section 210 of~~ under these rules, based on the clinical judgment of their ~~primary care provider~~ PCP. ~~(3-17-22)~~( )

02. Selection or Change in P~~rimary~~ C~~are~~ P~~rovider~~. Participants may select or change their ~~primary care provider~~ PCP as follows: ~~(3-17-22)~~( )

a. When they become eligible for ~~Idaho Medicaid benefits~~, or after a break in their eligibility for, ~~Idaho~~ Medicaid ~~benefits~~; ~~(3-17-22)~~( )

b. For cause ~~at any time ("for cause"~~: reasons ~~are~~ listed in the Idaho Medicaid Provider Handbook~~)~~. ~~(3-17-22)~~( )

c. Without cause: (3-17-22)

i. During the ninety (90) days following the effective date of the participants enrollment with a PCP. (3-17-22)

ii. At least once every twelve (12) months thereafter during the open enrollment period. (3-17-22)

d. All approved PCP change requests will be effective the first of the following month. (3-17-22)

563. HEALTHY CONNECTIONS: PROCEDURAL REQUIREMENTS.

01. Changes to Requirements. The Department will provide sixty (60) day notice of any substantive ~~and significant~~ changes to requirements for referrals, ~~primary care provider~~ PCP reimbursement, ~~as specified in Section 565 of~~ under these rules, or provider duties on its website and provider portal. The Department will provide a method ~~to allow~~ for providers to provide input and comment on proposed changes. ~~(3-17-22)~~( )

02. Problem Resolution. (3-17-22)

a. ~~To help assure the success of Healthy Connections, t~~The Department provides a mechanism for timely and personal attention to problems and complaints related to the program. ~~(3-17-22)~~( )

b. ~~To facilitate problem resolution, t~~The Department will have a designated representative who will receive ~~and attempt to resolve~~ all complaints and problems related to the program and function as a liaison between participants and providers. ~~It is anticipated that most problems and complaints will be resolved informally at this level.~~ ~~(3-17-22)~~( )

c. A participant or a provider may ~~register a complaint or~~ notify the Department of a problem or complaint related to Healthy Connections ~~either~~ in writing, electronically, or by telephone to the designated representative. The ~~designated~~ representative will attempt to resolve conflicts and disputes informally at this level whenever possible and refer the complainant to alternative forums where appropriate. ~~(3-17-22)~~( )

d. If a participant or provider is not satisfied with the resolution of a problem or complaint addressed by the designated representative, they may file a formal grievance in writing to the representative. The manager of the managed care program may~~, where appropriate,~~ refer the matter to a review committee designated by the Department to address issues such as quality of care or medical necessity~~.~~; ~~H~~however, such decisions are not binding on the Department. The Department will respond in writing to grievances within thirty (30) days of receipt. ~~(3-17-22)~~( )

e. Decisions in response to grievances may be appealed. ~~Appeals are governed by the requirements of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings," and must be filed according to the provisions of that chapter.~~ ~~(3-17-22)~~( )

564. HEALTHY CONNECTIONS: PROVIDER QUALIFICATIONS AND DUTIES.

01. P~~rimary C~~are P~~roviders~~s. Primary care services may be provided by enrolled ~~physicians, physician assistants, advanced practice registered nurses,~~ providers and by care teams under those providers' direction. ~~(3-17-22)~~( )

02. Provider Duties. All Healthy Connections providers are responsible for delivering the services ~~listed~~ in Section 562 of these rules. ~~(3-17-22)~~( )

03. Additional Services. Healthy Connections providers may ~~also~~ elect to provide specific additional sets of ~~patient-centered medical home~~ PCMH services in exchange for increased reimbursement ~~as described in~~ under Section 565 of these rules. The definition and provision of additional ~~patient-centered medical home~~ PCMH services are subject to specific requirements ~~as~~ defined by the Department, ~~and described in~~ the Idaho Medicaid Provider Handbook, and individual provider agreements ~~with the Department. Additional services may include:~~ ~~(3-17-22)~~( )

~~**a.** Connection to the Idaho Health Data Exchange; (3-17-22)~~

~~**b.** Maintaining third-party patient-centered medical home recognition or certification; (3-17-22)~~

~~**c.** Expanded patient access to services; (3-17-22)~~

~~**d.** Provision of an evidence-based primary care service model that enables improved patient health outcomes; (3-17-22)~~

~~**e.** Reporting clinical data to the Department to allow for assessment of provider abilities and impact of their services on patient health outcomes; (3-17-22)~~

~~**f.** Coordination of transitions of care between health care settings; (3-17-22)~~

~~**g.** Integration of behavioral health services; and (3-17-22)~~

~~**h.** Other indicators of improved patient health outcomes associated with primary care provider abilities. (3-17-22)~~

04. Provider Participation Conditions and Restrictions. (3-17-22)

a. Provider Agreements. Each independent provider or provider organization participating in ~~primary care case management~~ PCCM must: ~~(3-17-22)~~( )

i. Sign an agreement; (3-17-22)

ii. Enroll with the Department all ~~primary care providers~~ PCPs and ~~all~~ clinic locations participating in ~~the~~ Healthy Connections ~~program~~; and ~~(3-17-22)~~( )

iii. Complete pre-enrollment requirements for participation in ~~the~~ Healthy Connections ~~program as defined by the Department~~ described in the Idaho Medicaid Provider Handbook. ~~(3-17-22)~~( )

b. Patient Limits. A provider may limit the number of participants they manage. Subject to this limit, the provider must accept all participants who either elect or are assigned to the provider, unless disenrolled ~~in accordance with~~ under Subsection 564.02.d. of this rule. A provider may change the participant limit effective the first day of any month. ~~The provider must~~ by make ing the request in writing to the Department thirty (30) days prior to the effective date of the change. ~~(3-17-22)~~( )

c. Disenrollment. When the provider-patient relationship breaks down due to failure of the participant to follow the care plan or for other reasons, a provider may choose to withdraw as the participant's ~~primary care provider~~ PCP effective the first day of any month. The PCP must notify ~~in writing,~~ both the participant and the Department in writing thirty (30) days prior to the date of withdrawal. This advance notice requirement may be waived by the Department. ~~(3-17-22)~~( )

d. Record Retention. Each provider must: (3-17-22)

i. Retain patient and financial records and provide the Department access ~~to those records~~ for a minimum of six (6) years from the date of service; and ~~(3-17-22)~~( )

ii. Upon the reassignment of a participant to another PCP, the provider must transfer (if a request is made) a copy of the patient's medical record to the new PCP~~; and~~. ~~(3-17-22)~~( )

~~iii. Disclose information required by Subsection 205.01 of these rules, when applicable.~~ ~~(3-17-22)~~

~~e. Termination or Amendment of Provider Agreements. The Department may terminate a provider's agreement as provided in Subsection 205.03 of these rules. An agreement may be amended for the same reasons.~~ ~~(3-17-22)~~

565. HEALTHY CONNECTIONS: PROVIDER REIMBURSEMENT.

01. Capitated Payments. Healthy Connections providers are compensated for their patient care services on a per participant per month basis. Capitated payments will vary to reflect the level of responsibility for services the provider elects to provide under Section 564 of these rules. Capitated payments may include payment for all provider services at a set rate per participant per month when that type of full-risk reimbursement is agreed to by the provider and the Department. ~~(3-17-22)~~( )

02. Capitated Payment Amounts. Capitated payment amounts are determined by the Department and reflect the complexity of the patient's health combined with the provider's ability to impact patient health outcomes. This monthly payment to a provider is based on the number of participants assigned to the provider on the first day of each month. (3-17-22)

566. HEALTHY CONNECTIONS: QUALITY ASSURANCE.
The Department will establish performance measurements to evaluate the effectiveness of the ~~primary care case management programs. The performance measurements~~ PCCMs, which will be reviewed at least annually and adjusted as necessary to provide quality assurance. ~~(3-17-22)~~( )

567. -- 569. (RESERVED)

SUB AREA: PREVENTION SERVICES
(Sections 570-649)

570. CHILDREN'S HABILITATION INTERVENTION SERVICES (CHIS).
CHIS are medically necessary, evidence-informed or evidence-based therapeutic techniques based on applied behavior analysis principles used to result in positive outcomes. These intervention services are delivered directly to ~~Medicaid-eligible~~ participants with identified developmental limitations that impact their ~~participant's~~ functional skills and behaviors across an array of developmental domains. Case Management is an available option to assist participants accessing CHIS by the Department as described in the Medicaid Provider Handbook. ~~(3-17-22)~~( )

571. CHIS: DEFINITIONS.

01. Annual. Every three hundred sixty-five (365), days ~~except during a leap year which equals~~ or three hundred sixty-six (366) days during a leap year. ~~(3-17-22)~~( )

02. Aversive Intervention. Uses unpleasant physical or sensory stimuli in an attempt to reduce undesired behavior. The stimuli usually cannot be avoided, or is pain inducing~~, or both~~. ~~(3-17-22)~~( )

03. Community. Natural, integrated environments outside the participant's home, outside of DDA center-based settings, or at school outside of school hours. (3-17-22)

04. Developmental Disabilities Agency (DDA). A ~~DDA is an agency that is:~~ business entity that

meets the definition of a developmental disabilities facility under Section 39-4604(3), Idaho Code, that is certified by the Department to provide services to individuals with developmental disabilities. (3-17-22)( )

~~a. A type of developmental disabilities facility, as defined in Section 39-4604, Idaho Code, that is non-residential and provides services on an outpatient basis; (3-17-22)~~

~~b. Certified by the Department to provide services to participants with developmental disabilities; and (3-17-22)~~

~~c. A business entity, open for business to the general public. (3-17-22)~~

05. Duplicat~~ion of~~ Services. Services are ~~considered~~ duplicate when: (3-17-22)( )

a. Goals are not separate and unique to each service provided; or (3-17-22)

b. When more than one (1) service is provided at the same time, unless otherwise authorized. (3-17-22)

06. Educational Services. Services ~~that are~~ provided in buildings~~, rooms~~ or areas designated or used as a school or as educational facilities; ~~that are~~ provided during ~~specific hours and~~ time periods in which ~~the~~ educational instruction takes place in the normal school day ~~and period of time for these students~~; ~~and that are~~ included in ~~the~~ a participant's individual educational plan ~~for the participant~~ or required by federal and state educational statutes or regulations; ~~are not related service;~~ and such services are provided to school age individuals ~~defined in~~ under Section 33-201, Idaho Code. (3-17-22)( )

07. Evidence-Based Interventions. Interventions that have been scientifically researched and reviewed in peer-reviewed journals, replicated successfully by multiple independent investigators, have been shown to produce measurable and substantiated beneficial outcomes, and are delivered with fidelity by certified or credentialed individuals trained in the evidence-based model (EBM). (3-17-22)( )

08. Evidence-Informed Interventions. Interventions that use elements or components of evidence-based techniques and are delivered by a qualified individual, who are not certified or credentialed in an ~~evidence-based model~~ EBM. (3-17-22)( )

09. Fidelity. The consistent and accurate implementation of children's habilitation services accordance with the modality, manual, protocol, or model. ( )

~~09~~10. Human Services Field. A diverse field that is focused on improving the quality of life for participants. Areas of academic study include, but are not limited to, sociology, special education, counseling, ~~and~~ psychology, or other areas of academic study as referenced in the Medicaid Provider Handbook. (3-17-22)( )

1~~0~~1. Recreational Services. 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, and special day parties ~~(birthday, Christmas, etc.)~~. (3-17-22)( )

1~~1~~2. Restrictive Intervention. Any intervention that is used to restrict the rights or freedom of movement of a person and includes chemical restraint, mechanical restraint, physical restraint, and seclusion. (3-17-22)

~~12. Treatment Fidelity. The consistent and accurate implementation of children's habilitation services accordance with the modality, manual, protocol or model. (3-17-22)~~

13. Vocational Services. Services ~~or programs that 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 workforce within one (1) year. (3-17-22)( )

572. CHIS: ELIGIBILITY REQUIREMENTS.

~~**01. Medicaid Eligibility**. Participants must be eligible for Medicaid and the service for which the CHIS provider is seeking reimbursement. (3-17-22)~~

0~~2~~1. Age of Participants. ~~CHIS are available to participants from b~~Birth through the month of their twenty-first birthday. ~~(3-17-22)~~( )

0~~3~~2. Eligibility Determination. Participants ~~eligible to receive CHIS~~ must have a demonstrated functional need or a combination of functional and behavioral needs that require intervention services; or requires intervention to correct or ameliorate their condition ~~in accordance with~~ under Section 880 of these rules. A functional or behavioral need is determined by the Department approved screening tool when a deficit is identified in three (3) or more of the following areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency, or maladaptive behavior. A deficit is defined as one-point-five (1.5) or more standard deviations below the mean for functional areas or above the mean for maladaptive behavior. ~~(3-17-22)~~( )

573. CHIS: COVERAGE AND LIMITATIONS.

~~**01. Excluded for Medicaid Payment.** (7-1-24)~~

~~i. Vocational services; (3-17-22)~~

~~ii. Educational services; and (3-17-22)~~

~~iii. Recreational services. (3-17-22)~~

0~~2~~1. Service Delivery. ~~The CHIS allowed under the Medicaid State Plan authority include evaluations, diagnostic and therapeutic treatment services provided on an outpatient basis. These services help improve individualized functional skills, develop replacement behaviors, and promote self-sufficiency of the participant.~~ CHIS may be delivered in the community, the participant's home, or in a DDA ~~under the requirements of these rules~~. Duplication of services is not reimbursable. ~~(7-1-24)~~( )

0~~3~~2. Required ~~*Recommendation*~~ *Order*. CHIS must be ~~*recommended*~~ *ordered* by a ~~physician or other licensed practitioner of the healing arts~~ provider within their scope of practice~~, under state law~~. ~~*(3-17-22)*~~( )

a. ~~The~~ CHIS provider~~s may~~ cannot seek reimbursement for services provided more than thirty (30) calendar days prior to the signed and dated ~~*recommendation*~~ *order*. ~~*(3-17-22)*~~( )

b. The ~~*recommendation*~~ *order* is only required to be completed once and must be received prior to submitting the initial prior authorization request. If the participant has not accessed CHIS for more than three hundred sixty-five (365) calendar days~~, then~~ a new ~~*recommendation* must be received~~ *order* is required. ~~*(7-1-24)*~~( )

0~~4~~3. Required Screening. Needs are determined through the current version of the ~~Vineland Adaptive Behavior Scales or other~~ Department-approved screening tools ~~that are conducted by the family's chosen CHIS provider, and the Department, and are administered under the protocol of the tool~~. The ~~screening~~ tool is only required to be completed once and must be completed prior to submitting the initial prior authorization request. The following apply: ~~(7-1-24)~~( )

~~**a.** If a screening tool has been completed by the Department a new screening is not required. (7-1-24)~~

~~**b.** If the participant has been determined eligible by the Department, a new screening tool is not required. (3-17-22)~~

~~e~~**a.** If the participant has not accessed CHIS for more than three hundred sixty-five (365) calendar days, a new screening must be completed. (3-17-22)

~~d. The screening cannot be billed more than once unless an additional screening is required under guidelines as outlined in the Medicaid Provider Handbook.~~ ~~(7-1-24)~~

0~~5~~4. **Services**. All CHIS ~~*recommended*~~ *ordered* on a participant's assessment and clinical treatment plan (ACTP) must be prior authorized by the Department. Group services must be provided by one (1) qualified staff providing direct services for two (2) or three (3) participants. As the number and needs of the participants increase, the participant ratio in the group must be adjusted from three (3) to two (2). Group services will only be reimbursed when the participant's objectives relate to benefiting from group interaction. The following CHIS ~~are available for eligible participants and~~ are reimbursable services when provided under these rules: ~~*(7-1-24)*~~( )

a. Habilitative Skill Building. This direct intervention service includes techniques used to develop, improve, and maintain, to the maximum extent possible, the developmentally appropriate functional abilities and daily living skills needed by a participant. This service may include teaching and coordinating methods of training with family members or others who regularly participate in caring for the eligible participant. Services include individual or group interventions. (3-17-22)

~~i. Group services must be provided by one (1) qualified staff providing direct services for two (2) or three (3) participants.~~ ~~(7-1-24)~~

~~ii. As the number and needs of the participants increase, the participant ratio in the group must be adjusted from three (3) to two (2).~~ ~~(7-1-24)~~

~~iii. Group services will only be reimbursed when the participant's objectives relate to benefiting from group interaction.~~ ~~(3-17-22)~~

b. Behavioral Intervention. This service utilizes direct intervention techniques used to produce positive meaningful changes in behavior that incorporate functional replacement behaviors and reinforcement-based strategies while also addressing any identified habilitative skill building needs. ~~These services are provided to participants who exhibit interfering behaviors that impact the independence or abilities of the participant, such as impaired social skills and communication~~ or destructive behaviors. Intervention services may include teaching and coordinating methods of training with family members or others who regularly participate in caring for the ~~eligible~~ participant. ~~Evidence-based or evidence-informed practices are used to promote positive behaviors and learning while reducing interfering behaviors and developing behavioral self-regulation.~~ Services include individual or group interventions. ~~(3-17-22)~~( )

~~i. Group services must be provided by one (1) qualified staff providing direct services for two (2) or three (3) participants.~~ ~~(7-1-24)~~

~~ii. As the number and severity of the participants with behavioral issues increase, the participant ratio in the group must be adjusted from three (3) to two (2).~~ ~~(7-1-24)~~

~~iii. Group services should only be delivered when the participant's objectives relate to benefiting from group interaction.~~ ~~(3-17-22)~~

c. Interdisciplinary Training. This is a companion service to behavioral intervention and habilitative skill building and is used to assist with implementing a participant's health and medication monitoring, positioning and physical transferring, use of assistive equipment, and intervention techniques in a manner that meets the participant's needs. This service is to be utilized for collaboration, with the participant present, during the provision of services between the intervention specialist or professional and a ~~Speech Language and Hearing Professional (SLP), Physical Therapist (PT), Occupational Therapist (OT), medical professional, behavioral or mental health professional~~ provider. ~~(3-17-22)~~( )

d. Crisis Intervention. This service ~~may~~ includes providing training to staff directly involved with the participant, delivering intervention directly with the eligible participant, and developing a crisis plan that directly addresses the behavior occurring and the necessary intervention strategies to minimize the behavior and future occurrences. Crisis intervention is provided in the home or community on a short-term basis ~~typically~~ not to exceed

thirty (30) days. Positive behavior interventions must be used prior to, and in conjunction with, the implementation of any restrictive intervention. Crisis intervention is available for participants who have an unanticipated event, circumstance, or life situation that places a participant at risk of at least one (1) of the following: ~~(3-17-22)~~( )

i. Hospitalization; (3-17-22)

ii. Out-of-home placement; (7-1-24)

iii. Incarceration; or (3-17-22)

iv. Physical harm to self or others, including a family altercation or psychiatric relapse. (3-17-22)

e. Assessment and Clinical Treatment Plan (ACTP). The ACTP is a comprehensive assessment that guides the formation of the implementation plan(s) that include developmentally appropriate objectives and strategies related to identified needs. ~~The qualified provider conducts an assessment to evaluate the participant's strengths, needs, and functional abilities across environments. This process guides the development of intervention strategies and recommendations for services related to the participant's identified needs. The ACTP must be monitored and adjusted to reflect the current needs of the participant. The CHIS provider must document that a copy of the ACTP was offered to the participant's parent or legal guardian.~~ The ACTP must ~~be completed on a Department-approved form as referenced in the Medicaid Provider Handbook and~~ contain the following ~~minimum standards~~:
~~(7-1-24)~~( )

i. Clinical interview~~(s)~~ must be completed with the parent or legal guardian; ~~(3-17-22)~~( )

ii. ~~Administer or obtain an o~~Objective and validated comprehensive skills or developmental assessment ~~approved by the Department~~. The most current ~~version of the~~ assessment must be used and ~~the assessment must have been completed~~ be from within the last ~~three hundred and sixty-five (365) days~~ year; ~~(3-17-22)~~( )

iii. Review of assessments, reports, and relevant history; (3-17-22)

iv. Observations in at least one (1) environment; (3-17-22)

v. ~~A reinforcement inventory or preference assessment~~Clinical summary and recommendations;
~~(3-17-22)~~( )

vi. A transition plan; and (3-17-22)

vii. Be signed by the individual completing the assessment and the parent or legal guardian. (3-17-22)

574. CHIS: PROCEDURAL REQUIREMENTS.
All CHIS identified on a participant's ACTP must be prior authorized by the Department, or its contractor, and must be maintained in each participant's file. ~~The~~ CHIS providers ~~is~~ are responsible for documenting and submitting the ~~participant's~~ ACTP to obtain prior authorization before delivering any CHIS. ~~(3-17-22)~~( )

01. Prior Authorization Request. The request must be submitted to the Department, or its contractor, who will review and approve or deny prior authorization requests and notify the provider and the parent or legal guardian of the decision. ~~Prior authorization is intended to help ensure the provision of medically necessary services and will be approved according to the timeframes established by the Department and as described in the Medicaid Provider Handbook.~~ ~~(3-17-22)~~( )

a. Once the initial request for prior authorization is submitted, CHIS may be delivered for a maximum of twenty-four (24) total hours for up to thirty (30) calendar days or until the prior authorization is approved. Initial prior authorization requests must include: (3-17-22)

i. A*n ~~recommendation~~ order* from a ~~physician or other practitioner of the healing arts~~ provider; and
~~(3-17-22)~~( )

ii. The ACTP~~; and~~. ~~(3-17-22)~~( )

~~iii. Implementation plan(s).~~ ~~(3-17-22)~~

b. Ongoing prior authorization requests must include: (3-17-22)

i. A list of the participant's goals and objectives; ~~(3-17-22)~~( )

~~ii. Graphs showing change lines;~~ ~~(3-17-22)~~

ii~~i~~. A ~~brief analysis~~ written summary of data regarding progress or lack of progress to meeting each objective including graphs showing change lines; ~~(3-17-22)~~( )

iv~~ii~~. A list of all CHIS hours being requested and the qualification of the individual(s) who will provide them; and ~~(3-17-22)~~( )

~~v. Request for the annual ACTP, if applicable;~~ ~~(3-17-22)~~

~~vi. New implementation plans, if applicable;~~ ~~(3-17-22)~~

v~~ii~~. An updated annual ACTP, if applicable~~; and~~. ~~(3-17-22)~~( )

~~viii. An annual written summary with an analysis of data regarding the participant's progress or lack of progress, justification for any changes made to implementation of programming for new objectives, discontinuation of objectives, if applicable, and a summary of parent(s) or caregiver(s) response to teaching of coordinated methods.~~ ~~(3-17-22)~~

c. The following services may be requested retroactively: (3-17-22)

i. The initial ATCP; (3-17-22)

ii. The screening tool; and (3-17-22)

iii. Crisis intervention within seventy-two (72) hours of the service initiation. (3-17-22)

02. Implementation Plan(s). An implementation plan will provide details on how intervention will be implemented and must be completed and signed by a qualified provider. All implementation plan objectives must be related to a need identified on the ATCP. The provider must document that a copy of the participant's implementation plan(s) was offered to the participant's parent or legal guardian. ~~The implementation plan(s) must include the following requirements:~~ ~~(3-17-22)~~

~~**a.** Participant's name;~~ ~~(3-17-22)~~

~~**b.** Measurable, behaviorally stated objectives including criteria for successful achievement, and a baseline statement;~~ ~~(3-17-22)~~

~~**c.** Location(s) where objectives will be implemented;~~ ~~(3-17-22)~~

~~**d.** Precursor behaviors for participants receiving behavioral intervention;~~ ~~(3-17-22)~~

~~**e.** Description of the treatment modality to be utilized;~~ ~~(3-17-22)~~

~~**f.** Discriminative stimulus or direction;~~ ~~(3-17-22)~~

~~**g.** Targets, steps, task analysis or prompt level;~~ ~~(3-17-22)~~

~~**h.** Correction procedure;~~ ~~(3-17-22)~~

~~i. Data collection; (3-17-22)~~

~~j. Reinforcement, including type and frequency; (3-17-22)~~

~~k. A plan for generalization and a plan for family training; (3-17-22)~~

~~l. A behavior response plan for participants receiving behavioral intervention; (3-17-22)~~

~~m.~~ Any restrictive or aversive interventions being implemented must be reviewed and approved by a licensed or certified individual working within the scope of their practice~~; and~~. ~~(3-17-22)~~( )

~~n. A signature of the qualified provider who completed the document(s), date signed, and credential. (3-17-22)~~

03. Requirements for Program Documentation. Providers must maintain records for each participant served. ~~Failure to maintain such documentation may result in the recoupment of funds paid for undocumented services.~~ Undocumented services are subject to recoupment. For each participant, the following program documentation is required for each visit made or service provided to the participant~~, including at a minimum the following information~~: ~~(3-17-22)~~( )

a. Date, time, and duration; (3-17-22)

b. Summary of session or service provided, and if interdisciplinary training is provided, ~~documentation must include~~ who the service was delivered to and the content covered; ~~(3-17-22)~~( )

c. Data documentation that corresponds to the implementation plans for habilitative skill building or behavioral intervention; (3-17-22)

d. Location of service delivery; and (3-17-22)

e. Signature of the individual providing the service, date signed, and credential. (3-17-22)

04. Supervision. Supervision includes both face-to-face observation and direction to the staff regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for a participant. ~~Supervision is provided to ensure staff demonstrate the necessary skills to correctly provide the services as defined in this rule and informs of any modification needed to the methods implemented to support the accomplishment of outcomes identified in the ACTP.~~ Supervision must be provided ~~in accordance with~~ under the requirements of the ~~evidence-based model~~ EBM or ~~in accordance with~~ each ~~individual~~ provider qualification. Intervention specialists providing services to children birth to three (3) years old must be supervised by a~~n intervention~~ specialist or ~~intervention~~ professional who also meets the birth to three (3) years old requirements. ~~(3-17-22)~~( )

575. CHIS: PROVIDER QUALIFICATIONS AND DUTIES.
CHIS are delivered by individuals who meet or exceed~~s~~ one (1) of the qualifying criteria below in Subsections 575.01 through 575.07 of this rule, and are employed by a certified DDA, or who meet the criteria ~~as defined~~ in Subsection 575.08 of this rule and is enrolled as an independent CHIS provider. ~~All providers of CHIS must meet the continuing training requirements in Subsection 575.09 of this rule.~~ ~~(3-17-22)~~( )

01. Crisis Intervention Technician. ~~A c~~Crisis intervention technician is an employee of a DDA that can deliver crisis intervention directly with the eligible participant and ~~must~~ meets the qualifications of a community-based supports staff ~~as defined in~~ under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 526. The technician must be under the supervision of a specialist or professional who is observing and reviewing the direct crisis intervention services performed. Supervision must occur monthly~~, or more often as necessary, to ensure the technician demonstrates the necessary skills to correctly provide the crisis intervention service~~. ~~(3-17-22)~~( )

02. Intervention Technician. ~~An i~~Intervention technicians can deliver habilitative skill building,

behavioral intervention, and crisis intervention. This is a provisional position ~~intended~~ to allow an individual to gain the necessary degree, competency, or experience needed to qualify as an intervention specialist or higher. ~~An intervention~~ The technician must be an employee of a DDA and be under the supervision of a specialist or professional who is observing and reviewing the ~~direct~~ services performed ~~by the intervention technician~~. Supervision must occur monthly~~, or more often as necessary, to ensure the intervention technician demonstrates the necessary skills to correctly provide the intervention~~. Provisional status is limited to a single eighteen (18) successive month period. ~~The qualifications for this type of p~~Providers ~~can be met by one (1) of the following~~ are qualified that: ~~(3-17-22)~~( )

a. ~~An individual who is currently enrolled and is within twenty-four (24) semester credits, or equivalent, to complete their bachelor's degree or higher from an accredited institution in a human services field and~~Are working towards meeting the experience and competency requirements~~; or~~. ~~(3-17-22)~~( )

~~**b.** An individual who holds a bachelor's degree from an accredited institution in a human services field or has a bachelor's degree and a minimum of twenty-four (24) semester credits, or equivalent, in a human services field and working towards meeting the experience and competency requirements.~~ ~~(3-17-22)~~

03. Intervention Specialist. ~~An i~~Intervention specialists can deliver all CHIS, complete assessments and implementation plans, and must be under the supervision of a specialist or professional who is observing and reviewing the ~~direct CHIS~~ services performed. Supervision must occur monthly~~, or more often as necessary, to ensure the intervention specialist demonstrates the necessary skills to correctly provide the service~~. A~~n intervention~~ specialist who will complete assessments or supervise an individual completing assessments must have a minimum of ten (10) hours of documented training and five (5) hours of supervised experience in completing comprehensive assessments and implementation plans for participants with functional or behavioral needs. ~~The qualifications for this type of p~~Providers ~~can be met by one (1) of~~ must meet the following qualifications: ~~(3-17-22)~~( )

a. ~~An individual who h~~Holds~~s~~ a Habilitative Intervention Certificate of Completion in Idaho with an expiration date of July 1, 2019 or later~~;~~. These providers will be allowed to continue providing services as an intervention specialist as long as there is not a gap of more than three (3) successive years of employment as an intervention specialist; or ~~(3-17-22)~~( )

b. ~~An individual who h~~Holds~~s~~ a bachelor's degree from an accredited institution in a human services field or ~~a has~~ a bachelor's degree and a minimum of twenty-four (24) semester credits, or equivalent, in a human services field; and ~~(3-17-22)~~( )

i. Can demonstrate one thousand forty (1,040) hours of supervised experience working with participants birth to twenty-one (21) years of age who demonstrate functional or behavioral needs; and *(3-17-22)*

ii. Meets the competency requirements by completing one (1) of the following: (3-17-22)

(1) A Department-approved competency checklist ~~referenced in the Medicaid Provider Handbook~~; or ~~(3-17-22)~~( )

(2) A minimum of forty (40) hours of applied behavior analysis training delivered by an individual who is certified or credentialed to provide the training~~; or~~. ~~(3-17-22)~~( )

~~(3) Other Department approved competencies as defined in the Medicaid Provider Handbook.~~ ~~(3-17-22)~~

c. ~~An i~~Individuals who provide~~s~~ services to children birth to three (3) years of age must also demonstrate a minimum of two hundred forty (240) hours of professionally supervised experience providing assessment or evaluation, curriculum development, and service provision in the areas of communication, cognition, motor, adaptive (self-help), and social-emotional development with infants and toddlers birth to five (5) years of age with developmental delays or disabilities. ~~Experience must be through paid employment or university internship or practicum experience and may be documented within the supervised experience listed in Subsection 575.02.b.i. of this rule, and have one (1) of the following:~~ ~~(3-17-22)~~( )

i. An elementary education certificate or special education certificate with an endorsement in early childhood special education; or (3-17-22)

ii. A blended Early Childhood or Early Childhood Special Education (EC or ECSE) certificate; or (3-17-22)

iii. ~~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, counseling, or nursing.~~ This individual must have a minimum of twenty-four (24) semester credits from an accredited college or university, which can be within their bachelor's or master's degree coursework, or can be in addition to the degree coursework. Courses must cover the following ~~as defined in the Medicaid Provider Handbook~~: ~~(3-17-22)~~( )

(1) Promotion of development and learning for children from birth to five (5) years of age. (3-17-22)

(2) Assessment and observation methods that are developmentally appropriate assessment of young children with developmental delays or disabilities; (3-17-22)

(3) Building family and community relationships to support early interventions; (3-17-22)

(4) Development of appropriate curriculum for young children; (3-17-22)

(5) Implementation of instructional and developmentally effective approaches for early learning, including strategies for children and their families; and (3-17-22)

(6) Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development. (3-17-22)

04. Intervention Professional. ~~An i~~Intervention professionals can deliver all CHIS and complete assessments and implementation plans. ~~Intervention professionals~~ Providers must meet the following ~~minimum~~ qualifications: ~~(3-17-22)~~( )

a. Hold a master's degree or higher from an accredited institution in psychology, education, applied behavior analysis, or have a ~~*related discipline with one thousand five hundred (1,500) hours*~~ *minimum of twenty-four (24) upper-division semester credits from an accredited college or university* of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, psychology, education, or behavior analysis which may be documented within the individual's degree program, other coursework, or training; and ~~*(3-17-22)*~~*( )*

b. Have one thousand two hundred (1,200) hours of relevant experience in completing and implementing comprehensive behavioral therapies for participants with functional or behavioral needs, which may be documented within the individual's degree program, other coursework, or training. (3-17-22)

c. ~~An i~~Individuals who provide~~s~~ services to children birth to three (3) years of age must meet the requirements ~~defined in~~ under Subsection 575.03.c. of this rule. ~~(3-17-22)~~( )

05. Evidence-Based Model (EBM) Intervention Paraprofessional. ~~An~~ EBM intervention paraprofessionals can deliver habilitative skill building, crisis intervention, and behavioral intervention, and must be supervised in accordance with the ~~evidence-based model~~ EBM. ~~The qualifications for this type of p~~Providers ~~are:~~ must ~~(3-17-22)~~

~~**a.** An individual who holds a high school diploma or general equivalency diploma; and (3-17-22)~~

~~**b.** H~~holds a para-level certification or credential in an ~~evidence based model~~ EBM approved by the Department. ~~(3-17-22)~~( )

06. Evidence-Based Model (EBM) Intervention Specialist. ~~An~~ EBM intervention specialists can deliver all CHIS and complete assessments and implementation plans. ~~This individual~~ Specialists must be supervised

~~in accordance with~~ according to the ~~evidenced-based model~~ EBM and may ~~also~~ supervise ~~the evidence-based~~ EBM paraprofessionals working within the same ~~evidence-based model~~EBM. ~~The qualifications for this type of p~~Providers ~~are:~~ must ~~(3-17-22)~~

~~**a.** An individual who holds a bachelor's degree from an accredited institution in accordance with their certification or credentialing requirements; and (3-17-22)~~

~~**b.** H~~holds~~** a bachelor-level certification or credential in an ~~evidence-based model~~ EBM approved by the Department. ~~(3-17-22)~~( )

~~**c.** An individual who provides services to children birth to three (3) years of age must also have a minimum of two hundred forty (240) hours of professionally supervised experience providing assessment or evaluation, curriculum development, and service provision in the areas of communication, cognition, motor, adaptive (self help), and social emotional development with infants and toddlers birth to five (5) years of age with developmental delays or disabilities. Experience must be through paid employment or university activities. (3-17-22)~~

07. Evidence-Based Model (EBM) Intervention Professional. ~~An~~ EBM intervention professionals can deliver all CHIS and complete assessments and implementation plans. ~~The qualifications for this type of p~~Providers ~~are:~~ must ~~(3-17-22)~~

~~**a.** An individual who holds a master's degree or higher from an accredited institution in accordance with their certification or credentialing requirements; and (3-17-22)~~

~~**b.** H~~holds~~** a masters-level degree and certification or credential in an ~~evidence-based model~~ EBM approved by the Department. ~~(3-17-22)~~( )

~~**c.** An individual who provides services to children birth to three (3) years of age must meet the requirements defined in Subsection 575.06.c. of this rule. (3-17-22)~~

08. Independent CHIS Provider. ~~This type of~~ Independent CHIS ~~p~~Providers can deliver all types of CHIS, complete assessments and implementation plans ~~in accordance with~~ according to their provider qualification ~~as defined in~~ under Subsections 575.03, 575.04, 575.06, and 575.07 of these rules. Documentation of supervision must be maintained in accordance with the Department's record retention requirements. The following must be met: ~~(3-17-22)~~( )

a. Obtain an independent Medicaid provider agreement through the Department and maintain in good standing; (3-17-22)

b. Be certified in CPR and first aid prior to delivering services and maintain current certification thereafter; (3-17-22)

c. Compete a ~~criminal history and~~ background check, including clearance ~~in accordance with~~ under IDAPA 16.05.06, "Criminal History and Background Checks"; ~~(3-17-22)~~( )

d. Follow all applicable requirements in Sections 570 through 577 of these rules; and (3-17-22)

e. Not receive supervision from an individual that they are directly supervising. (3-17-22)

09. Continuing Training Requirements. ~~Each individual providing~~ CHIS providers must complete a minimum of twelve (12) hours of training each calendar year, including one (1) hour of ethics and six (6) hours of behavior methodology or evidence-based intervention. ~~The following criteria applies: (3-17-22)~~

~~**a.** Training must be relevant to the services being delivered. (3-17-22)~~

~~**b.**~~ Continuing training requirements for new independent providers or employees of a DDA who have not provided CHIS for a full calendar year, may be prorated ~~as defined in the Medicaid Provider Handbook~~. ~~(3-17-22)~~( )

~~c. Individuals who have not completed the required training during the previous calendar year, may not provide services in the current calendar year until the required number of training hours have been completed.~~ (3-17-22)

~~d. Training hours may not be earned in the current calendar year to be applied to a future calendar year.~~ (3-17-22)

~~e. Training topics can be repeated but the content of the continuing training must be different each calendar year; and~~ (3-17-22)

576. CHIS: PROVIDER REIMBURSEMENT.

01. Reimbursement. The CHIS in Sections 570 through 577 of these rules are reimbursed as defined in IDAPA 16.03.10, Medicaid Enhanced Plan Benefits," Section 038. (3-17-22)

~~**02. Claim Forms**. Provider claims for payment must be submitted on claim forms provided or approved by the Department. General billing instructions will be provided by the Department.~~ (3-17-22)

0~~3~~2. **Rates**. The reimbursement rates calculated for CHIS 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. (3-17-22)

577. CHIS: QUALITY ASSURANCE.
The Department will establish performance criteria to meet federal assurances that measure the outcomes and effectiveness of ~~the~~ CHIS. ~~Quality assurance activities will include the observation of service delivery with participants, face-to-face visits to review program protocol, and review of participant records maintained by the provider.~~ All CHIS providers must grant the Department immediate access to all information requested to review compliance with these rules. ~~(3-17-22)~~( )

01. Quality Assurance. Quality assurance consists of reviews to assure compliance with the Department's rules and regulations for CHIS. ~~The Department will visit providers to monitor outcomes, assure treatment fidelity, and assure health and safety. The Department will also gather information to assess family and participant satisfaction with services. These findings may lead to quality improvement activities to enhance provider processes and outcomes for the participant.~~ If problems are identified that impact health and safety or are not resolved through quality improvement activities, implementation of a corrective action process will occur. ~~(3-17-22)~~( )

02. Quality Improvement. Quality improvement ~~consists of the Department working with the provider to resolve identified issues and enhance services provided. Quality improvement~~ activities may include any of the following: ~~(3-17-22)~~( )

a. Consultation; (3-17-22)

b. Technical assistance and recommendations; or (3-17-22)

c. A Corrective Action. ~~(3-17-22)~~

~~**03. Corrective Action.**~~ Corrective action is a formal process used by the Department to address significant, ongoing, or unresolved deficient practices identified during the review process ~~as provided in Section 205.03 of~~ under these rules. Corrective action~~, as outlined in the Department's corrective action plan process,~~ includes: ~~(3-17-22)~~( )

~~a~~i. Issuance of a corrective action plan; (3-17-22)

~~b~~ii. Referral to Medicaid Program Integrity Unit; or (3-17-22)

~~c~~iii. Action against a provider agreement. (3-17-22)

578. -- 579. (RESERVED)

~~**SUB AREA: PREVENTION SERVICES**~~
~~**(Sections 580-649)**~~

580. CHILD WELLNESS SERVICES: DEFINITIONS.

01. Interperiodic Medical Screens. ~~Interperiodic medical screens are s~~Screens that are done at intervals other than those identified in the American Academy of Pediatrics periodicity schedule. ~~(3-17-22)~~( )

02. Periodic Medical Screens. ~~Interperiodic medical screens are s~~Screens done at intervals identified in the American Academy of Pediatrics periodicity schedule. ~~(3-17-22)~~( )

581. CHILD WELLNESS SERVICES: PARTICIPANT ELIGIBILITY.
Child Wellness Services are available to all participants ~~up to, and including,~~ through the month of their twenty-first (21st) birthday. ~~(3-17-22)~~( )

582. CHILD WELLNESS SERVICES: COVERAGE AND LIMITATIONS.

01. Periodic Medical Screens. Periodic medical screens are ~~to be~~ completed according to the American Academy of Pediatrics periodicity schedule including blood lead tests at age twelve (12) months and twenty-four (24) months. The medical screen must include a blood lead test when the participant is age two (2) through age twenty-one (21) and has not been previously tested. ~~(3-17-22)~~( )

02. Interperiodic Screens. Interperiodic screens will be performed when there are indications that it is medically necessary to determine whether a child has a physical or mental illness or condition that may require further assessment, diagnosis, or treatment. Interperiodic screens may occur in children who have already been diagnosed with an illness or condition, and there is indication that the illness or condition may have become more severe or changed sufficiently, so that the further examination is medically necessary (3-17-22)

03. Developmental Screens. Developmental screening is considered part of every routine initial and periodic examination. If the screening identifies a developmental problem, ~~then~~ a developmental assessment will be ordered by the ~~physician, certified nurse midwife, PA, or NP and be conducted by qualified professionals~~ provider. ~~(3-17-22)~~( )

583. (RESERVED)

584. CHILD WELLNESS SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

~~**01. Interperiodic Medical Screens.**~~ Interperiodic and periodic medical screens must be performed by a physician, NP, or PA. ~~(3-17-22)~~( )

~~**02. Periodic Medical Screens**. Periodic medical screens can be performed by a physician, certified nurse midwife, PA, or NP.~~ ~~(3-17-22)~~

585. EARLY INTERVENTION SERVICES.
Early Intervention Services for infants and toddlers enrolled in ~~Idaho~~ Medicaid are provided by the Idaho Infant Toddler Program (ITP). Early Intervention Services must be provided ~~in accordance with~~ under the Individuals with Disabilities Education Act (IDEA), Part C, and all Medicaid regulations. ~~(3-17-22)~~( )

586. EARLY INTERVENTION SERVICES: PROGRAM REQUIREMENTS.
~~Idaho~~ Medicaid and the ITP coordinate the delivery of Early Intervention Services through an intra-agency agreement published on the Department's website. Program requirements include: ~~(3-17-22)~~( )

01. Physician Recommendation. The ITP can bill for health-related services provided to eligible children when the services are documented as medically necessary and provided under the recommendation of a

~~physician, certified nurse midwife, PA, or NP~~ provider. ITP may not seek reimbursement for services provided more than thirty (30) days prior to the signed and dated physician recommendation. The recommendation is valid for up to three hundred sixty-five (365) days. ~~(3-17-22)~~( )

02. Individualized Family Service Plan (IFSP). The ITP may bill for Medicaid services covered by a current IFSP. The plan must be developed by a multi-disciplinary team and be based on the results of assessment(s). (3-17-22)

03. Qualified Staff. ITP staff qualifications must meet IDEA Part C requirements, and all Medicaid regulations as specified in the intra-agency agreement. (3-17-22)

587. EARLY INTERVENTION SERVICES: PROVIDER REIMBURSEMENT.
Medicaid will reimburse the I~~nfant T~~oddler P~~rogram~~ for covered ~~medically necessary~~ services. ~~(3-17-22)~~( )

01. Fee Schedule. Reimbursement for Early Intervention Services will be based on the ~~Idaho~~ Medicaid Fee Schedule for Early Intervention. ~~(3-17-22)~~( )

~~**02. Payment Review**. Reimbursement is subject to pre-payment and post-payment review in accordance with Section 56-209h(3), Idaho Code, and recoupment in accordance with IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct."~~ ~~(3-17-22)~~

588. -- ~~589.~~ ~~(RESERVED)~~

~~**590. ADULT PHYSICALS.**~~
~~Adult preventive physical examinations are limited to one (1) per year.~~ ~~(3-17-22)~~

~~**591. -- 601. (RESERVED)**~~

~~**602. SCREENING MAMMOGRAPHIES: COVERAGE AND LIMITATIONS.**~~

~~**01. Screening Mammographies**. Align with the "A" and "B" recommendations of the United States Preventative Services Taskforce.~~ ~~(7-1-24)~~

~~**02. Diagnostic Mammographies**. Are not subject to the limitations of screening mammographies. Diagnostic mammographies are covered when a physician or licensed practitioner of the healing arts orders the procedure for a participant of any age.~~ ~~(7-1-24)~~

~~**603. (RESERVED)**~~

~~**604. SCREENING MAMMOGRAPHIES: PROVIDER QUALIFICATIONS AND DUTIES.**~~
~~Idaho Medicaid will cover screening or diagnostic mammographies performed with mammography equipment by staff considered certifiable or certified by the Bureau of Laboratories or the equivalent for providers in other states.~~ ~~(3-17-22)~~

~~**605. --**~~**609. (RESERVED)**

610. CLINIC SERVICES: DIAGNOSTIC SCREENING CLINICS.
The Department will reimburse medical social service visits to clinics that coordinate the treatment between ~~physicians and other medical professionals~~ providers for participants which are diagnosed with cerebral palsy, myelomeningitis or other neurological diseases and injuries with comparable outcomes. ~~(3-17-22)~~( )

01. Multidisciplinary Assessments and Consultations. The clinic must perform on site multidisciplinary assessments and consultations with each participant and responsible parent or guardian. Diagnostic and consultive services related to the diagnosis and treatment of the participant will be provided by board certified physician specialists in physical medicine, neurology and orthopedics. (3-17-22)

02. Billings. No more than five (5) hours of medical social services per participant may be billed by the

specialty clinic each state fiscal year for which the medical social worker monitors and arranges participant treatments and provides medical information to providers who have agreed to coordinate the care of their participant. (3-17-22)

03. Services Performed. Services performed or arranged by the clinic will be subject to the amount, scope, and duration for each service as set forth ~~elsewhere~~ in this chapter. ~~(3-17-22)~~( )

04. ~~The Clinic~~Provider Qualifications. The clinic is established as a separate and distinct entity from the hospital~~, physician~~ or other provider practices. ~~(3-17-22)~~( )

611. -- 617. (RESERVED)

618. HEALTH QUESTIONNAIRE.
The Health Questionnaire assesses the general health status and health behaviors of a participant. The information collected is used to provide customized health education to the participant. The Health Questionnaire is administered at initial program entry and at periodic intervals thereafter. Participant responses to the issues addressed in the Health Questionnaire may identify a participant's interest in the Preventive Health Assistance benefits described ~~in Section 620 of~~ under these rules. ~~(3-17-22)~~( )

619. (RESERVED)

620. PREVENTIVE HEALTH ASSISTANCE (PHA): DEFINITIONS.

01. Behavioral PHA. Benefits available to a participant specifically to support weight control. (3-17-22)

02. Benefit Year. A benefit year is twelve (12) continuous months. A participant's PHA benefit year begins the date their initial points are earned. (3-17-22)

03. PHA Benefit. A mechanism to reward healthy behaviors and good health choices of a participant eligible for preventive health assistance. (3-17-22)

04. Wellness PHA. Benefits available to a participant to support wellness. (3-17-22)

621. PREVENTIVE HEALTH ASSISTANCE (PHA): PARTICIPANT ELIGIBILITY.

01. Behavioral PHA. The participant must have a Health Questionnaire on file with the Department. The Health Questionnaire is used to determine eligibility for a Behavioral PHA. The participant must indicate on the Health Questionnaire that they want to change a behavior related to weight management. The participant must meet one (1) of the following criteria: (3-17-22)

a. For an adult, a body mass index (BMI) of thirty (30) or higher or eighteen and one-half (18 1/2) or lower. (3-17-22)

b. For a child, a body mass index (BMI) that falls in either the overweight or the underweight category as calculated using the Centers for Disease Control (CDC) Child and Teen BMI Calculator. (3-17-22)

02. Wellness PHA. A participant who is required to pay premiums to maintain eligibility under IDAPA 16.03.01, "Eligibility for Health Assistance for Families and Children," is eligible for Wellness PHA. (3-17-22)

622. PREVENTIVE HEALTH ASSISTANCE (PHA): COVERAGE AND LIMITATIONS.

01. Point System. The PHA benefit uses a point system to track points earned and used by a participant. Each point equals one (1) dollar. (3-17-22)

a. Maximum Benefit Points. (3-17-22)

i. The maximum number of points that can be earned for a Behavioral PHA is two hundred (200) points each benefit year. (3-17-22)

ii. The maximum number of points that can be earned for a Wellness PHA benefit is one hundred twenty (120) points each benefit year. (3-17-22)

b. Points expire and are removed from a participant's PHA benefit at the end of the participant's benefit year. (3-17-22)

c. Points earned for a specific participant's PHA benefit cannot be transferred to or combined with points in another participant's PHA benefit. (3-17-22)

02. Weight Management Program. Each program must provide weight management services and must include ~~a curriculum that includes~~ at least one (1) of the three (3) following areas: ~~(3-17-22)~~( )

a. Physical fitness; (3-17-22)

b. Balanced diet; or (3-17-22)

c. Personal health education. (3-17-22)

03. Participant Request for Coverage. A participant can request that a previously unidentified service be covered. The Department will approve a request if the product or service meets the requirements described in this rule and the vendor meets the requirements in Section 624 of these rules. (3-17-22)

04. Premiums. ~~(3-17-22)~~

~~**a.**~~ Wellness PHA benefit points must be used to offset a participant's premiums. ~~(3-17-22)~~

~~**b.**~~ ~~Only premiums that must be paid~~ to maintain eligibility under IDAPA 16.03.01, "Eligibility for Health Assistance for Families and Children," ~~can be offset by PHA benefit points~~ if applicable. ~~(3-17-22)~~( )

05. Hearing Rights. A participant does not have hearing rights for issues arising between the participant and a chosen vendor. (3-17-22)

623. PREVENTIVE HEALTH ASSISTANCE (PHA): PROCEDURAL REQUIREMENTS.

01. Behavioral PHA. (3-17-22)

a. A PHA benefit will be established for each participant who meets the eligibility criteria for Behavioral PHA. A participant must complete a PHA Benefit Agreement Form prior to earning any points. (3-17-22)

b. Each participant who chooses to enroll in weight management must participate in a ~~physician~~ provider ~~-~~approved or monitored weight management program. ~~(3-17-22)~~( )

c. An initial one hundred (100) points are earned when the agreement form is received by the Department and the benefit is established. (3-17-22)

d. An additional one hundred (100) points can be earned by a participant who completes their program or reaches a chosen, defined goal. The vendor monitoring the participant's progress must verify that the program was completed or the goal was reached. (3-17-22)

02. Wellness PHA. (3-17-22)

a. A PHA benefit will be established for each participant who meets the eligibility criteria for Wellness PHA. Each participant must demonstrate that they have received recommended wellness visits and immunizations for their age prior to earning any points. (3-17-22)

b. Ten (10) points can be earned each month by a participant who receives all recommended wellness visits and immunizations for their age during the benefit year. (3-17-22)

624. PREVENTIVE HEALTH ASSISTANCE (PHA): PROVIDER QUALIFICATIONS AND DUTIES.

~~**01. Provider Agreement**. A behavioral PHA vendor must have a fully-executed provider agreement on file with the Department prior to providing services or products. (3-17-22)~~

0~~2~~1. **Prior Authorization**. A behavioral PHA vendor must request prior authorization from the Department for each product or service provided as a PHA benefit. (3-17-22)

0~~3~~2. **Medications and Pharmaceutical Supplies Vendor**. Each vendor must be a licensed pharmacy and must meet the criteria in Section 664 of these rules for prescription drug provider qualifications and duties. (3-17-22)

0~~4~~3. **Weight Management Program Vendor**. Each vendor must: (3-17-22)

a. Be established as a business that serves the general public; (3-17-22)

b. Meet all state, county, and local business licensing requirements: and (3-17-22)

c. Be able to provide a weight management program as described in Section 622 of these rules. (3-17-22)

625. PREVENTIVE HEALTH ASSISTANCE (PHA): PROVIDER REIMBURSEMENT.
With the prior agreement of the participant, the vendor may bill the participant for the difference between the Department's reimbursement and the vendor's usual and customary charge for Behavioral PHA products or services provided. (3-17-22)

626. PREVENTIVE HEALTH ASSISTANCE (PHA): QUALITY ASSURANCE.
The Department will establish performance measurements to evaluate the effectiveness of PHA. The performance measurements will be reviewed at least annually and adjusted as necessary to provide quality assurance. (3-17-22)

627. -- 629. (RESERVED)

630. NUTRITIONAL SERVICES: DEFINITIONS.
Nutritional services include intensive nutritional education, counseling, and monitoring. (3-17-22)

631. (RESERVED)

632. NUTRITIONAL SERVICES: COVERAGE AND LIMITATIONS.

~~**01. Order.**~~ The need for nutritional services must be discovered by screening services and ordered by the ~~physician or non-physician practitioner~~ provider. ~~(3-17-22)~~( )

~~**02. Medically Necessary**. The services must be medically necessary. (3-17-22)~~

~~**633. (RESERVED)**~~

~~**634. NUTRITIONAL SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.**
Nutritional services must be performed by a registered dietician or an individual who has a baccalaureate degree from a U.S. regionally accredited college or university and has met the academic and professional requirements in dietetics as approved by the American Dietetic Association. (3-17-22)~~

~~**635. NUTRITIONAL SERVICES: PROVIDER REIMBURSEMENT.**
Payment for nutritional services is made at a rate established in accordance with Section 230 of these rules. (3-17-22)~~

6363. -- 6394340. (RESERVED)

~~**640. DIABETES EDUCATION AND TRAINING SERVICES: DEFINITIONS.**~~
~~A Certified Diabetes Educator is a state licensed health professional who is certified by the Certification Board for Diabetes Care and Education or the Association of Diabetes Care and Education Specialists (ADCES).~~ ~~(7-1-24)~~

641. DIABETES EDUCATION AND TRAINING SERVICES: PARTICIPANT ELIGIBILITY.
The medical necessity for diabetes education and training are evidenced by the following: (3-17-22)

01. Participants with Diabetes. Are eligible for a Diabetes Management Program when: (7-1-24)

a. A recent diagnosis of diabetes within ninety (90) days of enrollment with no history of prior diabetes education; or (7-1-24)

b. Uncontrolled diabetes manifested by two (2) or more fasting blood sugar of greater than one hundred forty milligrams per decaliter (140 mg/dL), hemoglobin A1c greater than eight percent (8%), or random blood sugar greater than one hundred eighty milligrams per decaliter (180 mg/dL), in addition to the manifestations; or (7-1-24)

c. Recent manifestations from poor diabetes control including neuropathy, retinopathy, recurrent hypoglycemia, repeated infections, or nonhealing wounds. (7-1-24)

02. Participants with Pre-Diabetes. Are eligible for the National Diabetes Prevention Program when they meet the program's guidance. (7-1-24)

642. DIABETES EDUCATION AND TRAINING SERVICES: COVERAGE AND LIMITATIONS.

01. Concurrent Diagnosis. Only training and education services that are reasonable and necessary will be covered. Covered professional and educational services will address each participant's medical needs through scheduled outpatient group or individual training or counseling concerning diet and nutrition, exercise, medications, home glucose monitoring, insulin administration, foot care, or the effects of other current illnesses and complications. (7-1-24)

02. No Substitutions. The ~~physician~~ provider may not use the formally structured program, or a Certified Diabetes Educator, as a substitute for basic diabetic care and instruction the ~~physician~~ provider must furnish to the participant, which includes the disease process and pathophysiology of diabetes mellitus, and dosage administration of oral hypoglycemic agents. ~~(3-17-22)~~( )

03. Services Limited. Diabetes education and training services will be limited to twenty-four (24) hours of group sessions and twelve (12) hours of individual counseling every five (5) calendar years. (3-17-22)

643. DIABETES EDUCATION AND TRAINING SERVICES: PROCEDURAL REQUIREMENTS.
To receive diabetes counseling, the participant must have a written order from the primary care provider who referred the participant to the program. (3-17-22)

644. DIABETES EDUCATION AND TRAINING SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Outpatient diabetes education and training services will be covered under one (1) of the following conditions: (7-1-24)

01. Diabetes Management Program. The education and training services are provided through a diabetes management program recognized as meeting the program standards of the American Diabetes Association or Association of Diabetes Care and Education Specialists by a ~~certified diabetic educator~~ CDCES, dietitian, or pharmacist. ~~(7-1-24)~~( )

02. The National Diabetes Prevention Program. The provider meets the requirements for the

program. (7-1-24)

~~**645. DIABETES EDUCATION AND TRAINING SERVICES: PROVIDER REIMBURSEMENT.**~~
~~Diabetes education and training services will be reimbursed according to the Department's established fee schedule in accordance with Section 230 of these rules.~~ ~~(3-17-22)~~

646. -- 649. (RESERVED)

SUB AREA: LABORATORY AND RADIOLOGY SERVICES
(Sections 650-659)

650. LABORATORY AND RADIOLOGY SERVICES: DEFINITIONS.

01. Independent Laboratory. A laboratory ~~that is~~ not located in a ~~physician's~~ provider's office, and receives specimens from a source other than another laboratory. ~~A physician is not an independent laboratory.~~ ~~(3-17-22)~~( )

02. 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~~ to provide information for the diagnosis, prevention, or treatment of any disease, or the impairment or assessment of human health. ~~(3-17-22)~~( )

03. 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. (3-17-22)

04. Quality-Control. ~~A day to day a~~Analysis of reference materials to ensure reproducibility and accuracy of laboratory results, and ~~includes~~ an acceptable system to assure proper functioning of instruments, equipment, and reagents. ~~(3-17-22)~~( )

05. Reference Laboratory. A laboratory that only accepts specimens from other laboratories. (3-17-22)

651. -- 652. (RESERVED)

653. LABORATORY AND RADIOLOGY SERVICES: COVERAGE AND LIMITATIONS.

~~**01. Medical Necessity Criteria**. Services must meet the definition of Medical Necessity in Section 011 of these rules as detailed in the Idaho Medicaid Provider Handbook.~~ ~~(3-17-22)~~

~~**02. Prior Authorization of Services**. The Department may require prior authorization of any laboratory or radiology service as detailed in the Idaho Medicaid Provider Handbook.~~ ~~(3-17-22)~~

The following services are covered when they meet all requirements: ( )

01. Laboratory Services. ( )

02. Radiology Services. ( )

654. LABORATORY AND RADIOLOGY SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Laboratory and Radiology Requirements. Providers of laboratory and radiology services must be eligible for Medicare certification for these services. (3-17-22)

02. Use of Reference Laboratories. Laboratories using reference laboratories must ensure that all requirements of ~~Sections 650 through 659 of~~ these rules are met by the reference laboratory. ~~(3-17-22)~~( )

655. LABORATORY AND RADIOLOGY SERVICES: PROVIDER REIMBURSEMENT.

01. Provider of Service. Payment for laboratory tests can only be made to the actual provider of that service. An exception to the preceding is made, except in the case of: (3-17-22)( )

a. An independent laboratory that can bill for a reference laboratory; (3-17-22)

b. A transplant facility that can bill for histocompatibility testing; and (3-17-22)

c. Healthcare professionals acting within the licensure and scope of their practice to comply with IDAPA 16.02.12, "Newborn Screening." (3-17-22)

02. Tests Performed by or Personally Supervised by a Physician. The payment level for clinical diagnostic laboratory tests performed by or personally supervised by a physician will be at a rate established by the Department that is no higher than Medicare's fee schedule. The payment level for other laboratory tests will be a rate established by the Department. (3-17-22)

03. Tests Performed by an Independent Laboratory. The payment level for clinical diagnostic laboratory tests performed by an independent laboratory will be at a rate established by the Department that is no higher than Medicare's fee schedule. The payment level for other laboratory tests will be at a rate established by the Department. (3-17-22)

04. Tests Performed by a Hospital Laboratory. The payment level for clinical diagnostic laboratory tests performed by a hospital laboratory for anyone who is not an inpatient will be at a rate established by the Department that is no higher than Medicare's fee schedule. The payment level for other laboratory tests will be at a rate established by the Department. (3-17-22)

0**5**2. **Specimen Collection Fee**. Collection fees for specimens drawn by venipuncture or catheterization are payable only to the physician provider or laboratory who draws the specimen. If done during an office visit on the same day the service is ordered, specimen collection may be is reimbursedable even if prior authorization is not approved. (3-17-22)( )

656. LABORATORY AND RADIOLOGY SERVICES: QUALITY ASSURANCE.
Laboratories, as a condition of payment, must maintain a quality-control program, including proficiency testing consistent with federal requirements, as detailed in the Idaho Medicaid Provider Handbook under 42 USC Section 263a. The laboratory must provide the results of proficiency testing to the Department or their Quality Improvement Organization vendor upon request. (3-17-22)( )

657. -- 659. (RESERVED)

SUB AREA: PRESCRIPTION DRUGS
(Sections 660-679)

660. (RESERVED)PRESCRIPTION DRUGS: DEFINITIONS.
Unit Dose: Drugs packaged in individual, sealed doses with tamper-evident packaging such as, but not limited to, single unit-of-use, blister packaging, unused injectable vials, and ampules. ( )

661. PRESCRIPTION DRUGS: PARTICIPANT ELIGIBILITY.

01. Obtaining a Prescription Drug. To obtain a prescription drug, a Medicaid participant or authorized agent must present the participant's Medicaid identification card to a participating pharmacy together with a prescription from a licensed prescriber. (3-17-22)

02. Tamper-Resistant Prescription Requirements. Any written, non-electronic prescription for a Medicaid participant must be written on a tamper-resistant prescription form. The paper on which the prescription is written must have: (3-17-22)

a. One (1) or more industry-recognized features designed to prevent unauthorized copying of a

~~completed or blank prescription form;~~ ~~(3-17-22)~~

~~**b.** One (1) or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber;~~ ~~(3-17-22)~~

~~**c.** One (1) or more industry-recognized features designed to prevent the use of counterfeit prescription forms.~~ ~~(3-17-22)~~

~~**03. Tamper-Resistant Prescription Requirements Not Applicable**. The tamper-resistant prescription requirements do not apply when the prescription is communicated by the prescriber to the pharmacy electronically, verbally, by fax, or when drugs are provided in an inpatient hospital or a nursing facility where the patient and family do not have direct access to the paper prescription.~~ ~~(3-17-22)~~

~~**04. Drug Coverage for Dual Eligibles**. For Medicaid participants who are also eligible for Medicare known as "dual eligibles", the Department~~Medicaid will pay for Medicaid-covered drugs that are not covered by Medicare Part D. for Dual eligibles, ~~will be~~ subject to the same limits and processes used for ~~any~~ other Medicaid participants. ~~(3-17-22)~~( )

662. PRESCRIPTION DRUGS: COVERAGE AND LIMITATIONS.

01. General Drug Coverage. ~~The Department will pay for those~~ Medicaid covers prescription drugs not excluded ~~by Subsections 662.06 and 662.07 of~~ under this rule that are legally obtainable by the order of a ~~licensed~~ prescriber ~~whose licensing allows for the prescribing of prescription drugs or legend drugs, as defined~~ under Section 54-1705, Idaho Code~~, and which are deemed medically necessary as defined in Section 011 of these rules~~. ~~(3-17-22)~~( )

02. Preferred Drug List (PDL). (3-17-22)

a. The PDL identifies ~~the~~ preferred drugs and non-preferred drugs within a therapeutic class designated by the Department, and reviewed by the ~~Idaho Medicaid~~ Pharmacy and Therapeutics Committee (P&T Committee). ~~(3-17-22)~~( )

b. A brand name drug may be designated as a preferred drug by the Department if the net cost of the brand name drug after consideration of all rebates is less than the cost of the generic equivalent. (3-17-22)

c. The Director ~~of the Department~~ makes final decisions regarding the designated preferred or non-preferred status of drugs based on therapeutic recommendations from the P~~harmacy and~~ &T~~herapeutics~~ Committee and cost analysis from the ~~Idaho~~ Medicaid Pharmacy Program. ~~(3-17-22)~~( )

~~**d.** Drugs in a drug class on the Medicaid PDL may require therapeutic prior authorization regardless of preferred or non-preferred designation.~~ ~~(3-17-22)~~

03. Covered Drug Products. ~~Idaho~~ Medicaid provides coverage to ~~Medicaid~~ participants for the following drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under Section 1927(d)(2) of the Social Security Act: ~~(3-17-22)~~( )

a. Agents, when used to promote smoking cessation. (3-17-22)

b. Prescription vitamins and mineral products. Covered agents include the following: (3-17-22)

i. Injectable vitamin B12 (cyanocobalamin and analogues); (3-17-22)

ii. Vitamin K and analogues; (3-17-22)

iii. Prescription vitamin D and analogues; (3-17-22)

iv. Prescription pediatric vitamins, minerals, and fluoride preparations; (3-17-22)

v. Prenatal vitamins for pregnant or lactating individuals; and (3-17-22)

vi. Prescription folic acid and oral prescription drugs containing folic acid in combination with vitamin B12 or iron salts, or both, without additional ingredients. (3-17-22)

c. Certain prescribed non-prescription products, including the following: (3-17-22)

i. Permethrin; (3-17-22)

ii. Oral iron salts; (3-17-22)

iii. Disposable insulin syringes and needles; and (3-17-22)

iv. Insulin. (3-17-22)

d. Barbiturates. (3-17-22)

e. Benzodiazepines. (3-17-22)

04. Additional Criteria for Coverage. ~~(3-17-22)~~

~~**a.** Medical necessity is the primary determinant of whether a therapeutic agent will be covered. The Department will cover generic drugs, and also brand drugs when medically necessary and when that necessity is adequately documented. If case-specific indications of medical necessity are present, the Department may also issue prior authorization for otherwise excluded drugs.~~ ~~(3-17-22)~~

~~**b.**~~ The Director ~~of the Department of Health and Welfare~~, acting upon the recommendation of the P~~harmacy and~~ &T~~herapeutics~~ Committee, may determine ~~that~~ a non-prescription drug product is covered when ~~the non-prescription product~~ it is found to be therapeutically interchangeable with prescription drugs in the same pharmacological class following evidence-based comparisons of efficacy, effectiveness, clinical outcomes, and safety, and the product is deemed by the Department to be a cost-effective alternative. ~~Information regarding the Pharmacy and Therapeutics Committee and covered drug products is posted at http://medicaidpharmacy.idaho.gov.~~ ~~(3-17-22)~~( )

05. Excluded Drug Products. ~~Idaho~~ Medicaid excludes from coverage the following drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under Section 1927(d)(2) of the Social Security Act: ~~(3-17-22)~~( )

a. Agents, when used to promote fertility. (3-17-22)

b. Agents, when used for cosmetic purposes or hair growth. (3-17-22)

c. Agents, when used for the symptomatic relief of cough and colds. (3-17-22)

d. Agents, when used for the treatment of obesity. ( )

~~**d.**~~**e.** Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee. (3-17-22)

~~**e.**~~**f.** Agents, when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration (FDA). ~~(3-17-22)~~( )

06. Additional Excluded Drugs. Drugs are ~~also~~ not covered ~~when~~ under any of the following circumstances ~~apply~~: ~~(3-17-22)~~( )

a. ~~The participant's practitioner has written an order for a p~~Prescription drugs~~ for which~~ ineligible for federal financial participation~~ is not available~~. ~~(3-17-22)~~( )

b. ~~The participant's practitioner has written an order for a p~~Prescription drugs~~ that is~~ deemed to be experimental or investigational,~~ as defined in Subsection 390.03 of~~ under these rules.~~ Investigational drugs are not a covered service under the Idaho Medicaid pharmacy program.~~ The Department may consider Medicaid coverage on a case-by-case basis for life-threatening medical illnesses when no other treatment options are available. When approved for payment, reimbursement will be at actual acquisition cost (AAC), plus~~ the assigned~~ professional dispensing fee. ~~(3-17-22)~~( )

07. Limitation of Quantities. Medication refills provided before at least seventy-five percent (75%) of the estimated days' supply has been utilized are not covered, unless an increase in dosage is ordered. Days' supply is the number of days a medication is expected to last when used at the dosage prescribed for the participant. No more than a thirty-four (34) days' supply of continuously required medication is to be purchased in a calendar month as a result of a single prescription~~ with the following~~ except~~ions~~: ~~(3-17-22)~~( )

a. ~~Maintenance Medications. Pharmacy p~~Providers may be reimbursed for up to a three (3) month supply of select medications or classes of medications for a participant who has received the same dose of the same select medication or class of medications for two months or longer. The Director~~ of the Department of Health and Welfare~~, acting upon the recommendation of the P~~harmacy and ~~&T~~herapeutics~~ Committee, approves the list of covered maintenance medications, which targets medications that are administered continuously rather than intermittently, are used most commonly to treat a chronic disease state, and have a low probability for dosage changes. The list of covered maintenance medications is available on the Medicaid Pharmacy website at http://medicaidpharmacy.idaho.gov. ~~(3-17-22)~~( )

b. ~~Oral Contraceptive Products. Oral c~~Contraceptive products may be dispensed in a quantity sufficient for~~ one (1), two (2), or three (3) cycles~~ up to six (6) months. ~~(3-17-22)~~( )

663. PRESCRIPTION DRUGS: PROCEDURAL REQUIREMENTS.
~~In accordance with Section 1927(d)(1)(A) of the Social Security Act, the Idaho Medicaid Pharmacy Program may subject any covered outpatient drug to prior authorization.~~ ~~(3-17-22)~~

~~**01. Drugs Requiring Prior Authorization**. No payment for drugs requiring prior authorization will be issued until the prior authorization request has been reviewed and approved by the Department.~~ ~~(3-17-22)~~

~~**02. Prior Authorization Criteria**. Criteria for prior authorization for individual drugs and drug classes will be determined by the Department, and will include:~~ ~~(3-17-22)~~

~~**a.** Food and Drug Administration (FDA) indications and labeling, including dosage guidelines.~~ ~~(3-17-22)~~

~~**b.** Compendia of drug information recognized by the Centers for Medicare and Medicaid Services (CMS), including:~~ ~~(3-17-22)~~

~~i. American Hospital Formulary Service-Drug Information;~~ ~~(3-17-22)~~

~~ii. United States Pharmacopeia-Drug Information, or its successor publications; and~~ ~~(3-17-22)~~

~~iii. The DrugDex Information System.~~ ~~(3-17-22)~~

~~**c.** Evidence-based, peer-reviewed, published medical literature, including:~~ ~~(3-17-22)~~

~~i. Systematic reviews;~~ ~~(3-17-22)~~

~~ii. Randomized controlled trials; and~~ ~~(3-17-22)~~

~~iii. Meta-analysis studies.~~ ~~(3-17-22)~~

~~**d.** Guidelines and case-controlled studies may be considered where systematic reviews, randomized controlled trials and meta-analysis studies do not exist.~~ ~~(3-17-22)~~

~~**e.** The requested drug's preferred drug status.~~ ~~(3-17-22)~~

0~~3~~1. **Request for Prior Authorization**. (3-17-22)

a. ~~The p~~Prior authorization ~~procedure~~ is initiated by the prescriber ~~who must~~ by submitting the request to the Department in the format prescribed by the Department. ~~(3-17-22)~~( )

b. Whenever possible, the Department will use automated authorization, in which claims are adjudicated at point of sale using submitted National Council for Prescription Drug Programs (NCPDP) data elements or claims history to verify ~~that~~ the Department's authorization requirements have been satisfied, without the need for the prescriber to submit additional clinical information. ~~(3-17-22)~~( )

0~~4~~2. **Notice of Decision**. The Department will determine coverage based on this request, and will notify the participant of a denial. The participant has twenty-eight (28) days from the date the denial letter is mailed to appeal the decision. ~~Hearings will be conducted in accordance with IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings."~~ ~~(3-17-22)~~( )

0~~5~~3. **Emergency Situation**. The Department will provide for the dispensing of at least a seventy-two (72) hour supply of a covered outpatient prescription drug in an emergency situation as required in 42 U.S.C. 1396r-8(d)(5)(B). (3-17-22)

0~~6~~4. **Response to Request**. The Department will respond within twenty-four (24) hours to a request for prior authorization of a covered outpatient prescription drug ~~as required in~~ under 42 U.S.C. 1396r-8(d)(5)(A). ~~(3-17-22)~~( )

~~**07. Prohibition Against Cash Payment for Controlled Substances**. Pharmacy providers are prohibited from accepting cash as payment for controlled substances from persons known to be Medicaid participants.~~ ~~(3-17-22)~~

0~~8~~5. **Supplemental Rebates**. (3-17-22)

a. ~~Purpose. The purpose of s~~Supplemental rebates ~~is to~~ enable the Department to purchase prescription drugs provided to Medicaid participants in a cost-effective manner. ~~The s~~Supplemental rebates may be one (1) factor considered in determining a drug's preferred drug status, but ~~it is~~ secondary to considerations of the safety, effectiveness, and clinical outcomes of the drug in comparison with other therapeutically interchangeable ~~alternative~~ drugs. ~~(3-17-22)~~( )

b. ~~Rebate Amount.~~ The Department may negotiate with manufacturers supplemental rebates for prescription drugs that are in addition to those required by Title XIX of the Social Security Act. There is no upper limit on the dollar amounts of the supplemental rebates the Department may negotiate. ~~(3-17-22)~~( )

~~**09. Comparative Costs to be Considered**. Whenever possible, physicians and pharmacists are encouraged to utilize less expensive drugs and drug therapies.~~ ~~(3-17-22)~~

06. Dispensing Procedures. The following protocol is required for prescription filling: ( )

a. Refills must be authorized by the prescriber on the original or new prescription order on file and each refill must be recorded on the prescription, logbook, computer print-out, or participant's medication profile. Automatic refills are not allowed. All refills must be initiated by a request from the participant, prescriber, or another person, acting as an agent of the participant. Authorization for each refill must be received prior to the beginning of the filling process by the pharmacy. ( )

b. Dispensing Prescription Drugs. Prescriptions must be dispensed according to: ( )

i. 21 CFR Section 1300, et seq.; ( )

ii. Title 54, Chapter 17, and Title 37, Chapters 1, 27, and 32, Idaho Code; ( )

iii. IDAPA 24.36.01, "Rules of the Idaho State Board of Pharmacy"; and ( )

iv. Sections 660 through 666 of these rules. ( )

c. Prescriptions must be maintained on file in pharmacies and available for immediate review by the Department upon written request. ( )

07. Return of Unused Prescription Drugs. Drugs dispensed in unit does packaging must be returned to the dispensing pharmacy when the participant no longer uses the medication as follows: ( )

a. A pharmacy using unit dose packaging must comply with IDAPA 24.36.01, "Rules of the Idaho State Board of Pharmacy." ( )

b. The pharmacy that receives the returned drugs must credit the Department the amount billed for the cost of the drug less the professional dispensing fee. ( )

664. PRESCRIPTION DRUGS: PROVIDER QUALIFICATIONS AND DUTIES.

01. ~~Payment for Covered Drugs~~Enrollment. ~~Payment will be made, as provided in Section 665 of these rules, only to p~~Pharmacies ~~registered~~ will enroll with the Department ~~as a provider for~~ using the specific location where the service was performed. ~~An out of the state pharmacy shipping or mailing a prescription into Idaho must have a valid mail order license issued by the Idaho Board of Pharmacy and be properly enrolled as a Medicaid provider.~~ ~~(3-17-22)~~( )

02. ~~Dispensing Procedures~~. ~~The following protocol must be followed for proper prescription filling.~~**Out-of-State Providers**. An out of state pharmacy shipping or mailing a prescription into Idaho must have a valid mail order license issued by the Idaho Board of Pharmacy. ~~(3-17-22)~~( )

~~**a.** Prescription Drug Refills. Refills of prescription drugs must be authorized by the prescriber on the original or new prescription order on file and each refill must be recorded on the prescription or logbook, or computer print-out, or on the participant's medication profile.~~ ~~(3-17-22)~~

~~**b.** Automatic Refills.~~ ~~(3-17-22)~~

~~i. Automatic refills are not allowed for Idaho Medicaid participants. A request specific to each medication is required.~~ ~~(3-17-22)~~

~~ii. All prescription refills must be initiated by a request from the participant, the prescriber, or another person, such as a family member, acting as an agent of the participant.~~ ~~(3-17-22)~~

~~iii. Authorization for each prescription refill must be received prior to the beginning of the filling process by the pharmacy.~~ ~~(3-17-22)~~

~~**c.** Dispensing Prescription Drugs. Prescriptions must be dispensed according to:~~ ~~(3-17-22)~~

~~i. 21 CFR Section 1300, et seq.;~~ ~~(3-17-22)~~

~~ii. Title 54, Chapter 17, and Title 37, Chapters 1, 27, and 32, Idaho Code;~~ ~~(3-17-22)~~

~~iii. IDAPA 27.01.03, "Rules Governing Pharmacy Practice"; and~~ ~~(3-17-22)~~

~~iv. Sections 660 through 666 of these rules.~~ ~~(3-17-22)~~

~~d. Prescriptions on File. Prescriptions must be maintained on file in pharmacies in such a manner that they are available for immediate review by the Department upon written request.~~ ~~(3-17-22)~~

~~03. Return of Unused Prescription Drugs.~~ ~~When prescription drugs were dispensed in unit dose packaging, as defined by IDAPA 27.01.03, "Rules Governing Pharmacy Practice," and the participant for whom the drugs were prescribed no longer uses them:~~ ~~(3-17-22)~~

~~a. A licensed skilled nursing care facility may return unused drugs dispensed in unit dose packaging to the pharmacy provider that dispensed the medication.~~ ~~(3-17-22)~~

~~b. A residential or assisted living facility may return unused drugs dispensed in unit dose packaging to the pharmacy provider that dispensed the medication.~~ ~~(3-17-22)~~

~~04. Pharmacy Provider Receiving Unused Prescription Drugs.~~ ~~In order for a pharmacy provider to receive unused prescription drugs that it dispensed in unit dose packaging and that are being returned by a facility identified in Subsection 664.03 of this rule, the pharmacy provider:~~ ~~(3-17-22)~~

~~a. Must comply with IDAPA 27.01.03, "Rules Governing Pharmacy Practice," regarding unit dose packaging;~~ ~~(3-17-22)~~

~~b. Must credit the Department the amount billed for the cost of the drug less the professional dispensing fee; and~~ ~~(3-17-22)~~

~~c. May receive a fee for acceptance of returned unused prescription drugs. The value of the unused prescription drug being returned must be such that return of the drug is cost-effective as determined by the Department.~~ ~~(3-17-22)~~

665. PRESCRIPTION DRUGS: PROVIDER REIMBURSEMENT.
With specific exceptions ~~as set forth in~~ under Subsections 665.01 through 665.04 of this rule, ~~Idaho~~ Medicaid pharmac~~y~~ies ~~providers~~ are reimbursed based on ~~actual acquisition costs~~ AACs. ~~Idaho~~ Medicaid may require providers to supply documentation of their ~~acquisition costs as described in~~ AACs under the Medicaid Pharmacy Claims Submission Manual available at: https://idaho.fhsc.com/downloads/providers/IDRx_Pharmacy_Claims_Submission_Manual.pdf. Reimbursement is restricted to ~~those~~ drugs supplied from labelers ~~that are~~ participating in the CMS Medicaid Drug Rebate Program. ~~(3-17-22)~~( )

01. Pharmacy Reimbursement. Prescriptions not filled ~~in accordance with the provisions of~~ according to Subsection 6643.026 of these rules will be subject to nonpayment or recoupment. The following protocol ~~must be followed~~ is required for ~~proper~~ reimbursement. ~~(3-17-22)~~( )

a. ~~Filing Claims.~~ Pharmacies 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~~ includeing information described in the pharmacy guidelines issued by the Department. ~~(3-17-22)~~( )

~~b. 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.~~ ~~(3-17-22)~~

~~c~~**b.** Reimbursement~~. Reimbursement to pharmacies~~ is limited to the lowest of the following: ~~(3-17-22)~~( )

i. ~~Actual Acquisition Cost (~~AAC~~)~~ based on results of the periodic state cost survey ~~as defined in~~ under this rule, plus ~~the assigned~~ professional dispensing fee. In cases where no AAC is available, reimbursement will be the Wholesale Acquisition Cost (WAC). WAC ~~will mean~~ is the price, for a given calendar quarter, paid by a wholesaler for the drugs purchased from the wholesaler's supplier. The wholesaler's supplier is typically the

manufacturer of the drug as published by a recognized compendium of drug pricing for the same calendar quarter; ~~(3-17-22)~~( )

ii. State Maximum Allowable Cost (SMAC), as established by the Department, plus ~~the assigned~~ professional dispensing fee; ~~(3-17-22)~~( )

iii. 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~~ professional dispensing fee ~~assigned by the Department~~; or ~~(3-17-22)~~( )

iv. The provider's usual and customary charge to the general public. (3-17-22)

d. ~~Periodic State Cost Surveys.~~ The Department will utilize periodic state cost surveys to obtain the most accurate pharmacy drug ~~acquisition costs~~ AACs in establishing a pharmacy reimbursement fee schedule. Pharmacies participating in the ~~Idaho~~ Medicaid Pharmacy Program are required to participate in these periodic state cost surveys by disclosing the costs of all drugs. A pharmacy that is non-responsive to the periodic state cost surveys can be disenrolled as a Medicaid provider by the Department. ~~(3-17-22)~~( )

e. ~~Physician~~Provider Administered Drugs. ~~(3-17-22)~~( )

i. Reimbursement to providers that are not 340B covered entities for medications administered to ~~Medicaid~~ participants by ~~physicians or other qualified and licensed~~ providers will be: ( )

(1) ~~n~~Ninety percent (90%) of the published Medicare Average Sales Price plus six percent (6%) rate (ASP+6% rate). ( )

(2) If the ASP+6% rate is not available, payment will be at the ~~Wholesale Acquisition Cost (~~WAC~~)~~. ~~(3-17-22)~~( )

(3) If the ASP and WAC are not available, an invoice from the manufacturer or wholesaler is required, reimbursement will be at cost plus ten percent (10%). Radiopharmaceuticals will be paid additionally for the cost of shipping. ( )

ii. Reimbursement to 340B covered entities for medications administered to ~~Medicaid~~ participants by ~~physicians or other qualified and licensed~~ providers will be the actual 340B drug ~~acquisition cost~~ AAC, not to exceed the 340B ceiling price. ~~(3-17-22)~~( )

f. Clotting Factors. (3-17-22)

i. Reimbursement to specialty pharmacies will be at a state-based price equivalent to the published Medicare ASP+6% rate, plus ~~the assigned~~ professional dispensing fee. ~~(3-17-22)~~( )

ii. Reimbursement to Hemophilia Treatment Centers will be the 340B ~~actual acquisition cost~~ AAC, not to exceed the 340B ceiling price. ~~(3-17-22)~~( )

g. ~~Professional Dispensing Fee.~~ Professional Dispensing Fee is ~~defined as~~ a tier-based amount paid on a pharmacy claim, over and above the ingredient cost, to compensate the provider for the pharmacist's professional services related to dispensing a prescription to a ~~Medicaid~~ participant, including: ~~(3-17-22)~~( )

i. ~~Looking up information about~~Verifying a participant's coverage ~~on the computer~~; ~~(3-17-22)~~( )

ii. Performing drug use reviews and preferred drug list review activities; (3-17-22)

iii. Measuring or mixing the covered outpatient drug; (3-17-22)

iv. Filling the container; (3-17-22)

v. Participant counseling; (3-17-22)

vi. Physically providing the completed prescription to the ~~Medicaid~~ participant; ~~(3-17-22)~~( )

vii. Special packaging; and (3-17-22)

viii. Overhead associated with maintaining the facility and equipment necessary to operate the dispensing entity. (3-17-22)

h. Limitations on ~~Payment of~~ Professional Dispensing Fees. Only one (1) professional dispensing fee per month ~~will be~~ is allowed for the dispensing of each maintenance drug to any participant as an outpatient or a resident in a care facility except: ~~(3-17-22)~~( )

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; (3-17-22)

ii. Multiple dispensing of oral liquid maintenance medication if a reasonable quantity, as determined by the Department, is dispensed at each filling; (3-17-22)

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 (3-17-22)

iv. When the dose is being titrated for maximum therapeutic response with a minimum of adverse effects. (3-17-22)

~~**i.** Tier-Based Professional Dispensing Fees. A professional dispensing fee for each pharmacy provider will be established in accordance with this rule.~~ ~~(3-17-22)~~

~~**j**~~**i.** ~~Claims Volume Survey for Tier-Based Professional Dispensing Fees.~~ The Department will survey pharmacy providers to establish a professional dispensing fee for each provider. The professional dispensing fees will be paid based on the provider's total annual claims volume. The provider must return the claims volume survey to the Department no later than May 31st each year. ~~Pharmacy p~~Providers who do not complete the annual claims volume survey will be assigned the lowest professional dispensing fee starting on July 1st until the next annual survey is completed. Based upon the annual claims volume of the enrolled pharmacy, the professional dispensing fee is provided online at: https://healthandwelfare.idaho.gov/providers/pharmacy-providers/idaho-medicaid-pharmacy-program. ~~(3-17-22)~~( )

~~**k**~~**j.** ~~Remittance Advice.~~ Claims are processed by computer, and payments are made directly to the pharmacy or its designated bank through electronic funds transfer. A remittance advice with detailed information of each claim transaction will accompany each payment made by the Department. ~~(3-17-22)~~( )

02. 340B Covered Entity Reimbursement. (3-17-22)

a. Participation as a 340B Covered Entity. Medicaid will reimburse 340B covered entities ~~as defined in~~ under Section 340B of the Public Health Service Act, codified under 42 U.S.C. 256b(a)(4), when the provider meets the following requirements: ~~(3-17-22)~~( )

i. A 340B covered entity ~~may receive reimbursement for drugs provided to Idaho Medicaid participants through the 340B drug pricing program if the 340B covered entity~~ submits its unique 340B identification number issued by the Health Resources and Services Administration (HRSA) and a copy of its completed HRSA 340B registration to ~~Idaho~~ Medicaid. ~~(3-17-22)~~( )

ii. A 340B covered entity that elects to provide drugs to ~~Idaho~~ Medicaid participants through the 340B drug pricing program must use 340B covered outpatient drugs for all dispensed or administered drugs, including those dispensed through the 340B covered entity's retail pharmacy or administered in an outpatient clinic. A 340B covered entity must ensure that a contract pharmacy does not dispense drugs, or receive Medicaid reimbursement for

drugs, acquired by the 340B covered entity through the 340B drug pricing program. An entity that does not use 340B covered outpatient drugs for all dispensed or administered drugs, including those dispensed through the 340B covered entity's retail pharmacy or administered in an outpatient clinic, will be ~~deemed to be~~ carved out of the 340B drug pricing program and will be reimbursed for brand name and generic drugs ~~as provided in~~ under Subsection 665.01 of this rule. ~~(3-17-22)~~( )

iii. A 340B covered entity must provide ~~Idaho~~ Medicaid with thirty (30) days ~~advance~~ written notice of its intent to discontinue the provision of drugs acquired through the 340B drug pricing program to ~~Idaho Medicaid~~ participants. ~~(3-17-22)~~( )

~~**b.** Filing Claims. A 340B covered entity must file claims electronically with Department approved software or by submitting the appropriate claim form to the fiscal contractor. The form must include information described in the pharmacy guidelines issued by the Department.~~ ~~(3-17-22)~~

~~**e**~~**b.** ~~Reimbursement Exclusions.~~ Drugs acquired through the ~~federal~~ 340B drug pricing program and dispensed by 340B contract pharmacies are not covered. ~~(3-17-22)~~( )

~~**d**~~**c.** Reimbursement~~. Reimbursement~~ to 340B covered entities is limited to their actual 340B drug ~~acquisition cost~~ AAC submitted, not to exceed the 340B ceiling price, plus ~~the assigned~~ professional dispensing fee. ~~(3-17-22)~~( )

~~**e.** Professional Dispensing Fee. Only one (1) professional 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:~~ ~~(3-17-22)~~

~~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;~~ ~~(3-17-22)~~

~~ii. Multiple dispensing of oral liquid maintenance medication if a reasonable quantity, as determined by the Department, is dispensed at each filling;~~ ~~(3-17-22)~~

~~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~~ ~~(3-17-22)~~

~~iv. When the dose is being titrated for maximum therapeutic response with a minimum of adverse effects.~~ ~~(3-17-22)~~

~~**f.** Tier-Based Professional Dispensing Fees. A professional dispensing fee for each 340B covered entity will be established in accordance with this rule.~~ ~~(3-17-22)~~

~~**g.** Remittance Advice. Claims are processed by computer, and payments are made directly to the 340B covered entity or its designated bank through electronic funds transfer. A remittance advice with detailed information of each claim transaction will accompany each payment made by the Department.~~ ~~(3-17-22)~~

03. Reimbursement for Drugs Dispensed by Other Provider Types. (3-17-22)

a. Drugs acquired through non-340B Indian Health Service, Tribal, or Urban Indian pharmacies will be reimbursed at the ~~actual acquisition cost~~ AAC to the entity, plus ~~the assigned~~ professional dispensing fee. ~~(3-17-22)~~( )

b. Drugs acquired via the Federal Supply Schedule (FSS) will be reimbursed at the FSS ~~actual acquisition cost~~ AAC, plus ~~the assigned~~ professional dispensing fee. ~~(3-17-22)~~( )

c. Drugs acquired at nominal price, ~~which is~~ defined as pricing that is outside of 340B regulations or FSS, will be reimbursed at the ~~actual acquisition cost~~ AAC, plus ~~the assigned~~ professional dispensing fee. ~~(3-17-22)~~( )

d. Specialty drugs not dispensed by retail community pharmacies and dispensed primarily through the mail will be reimbursed at the Idaho ~~actual acquisition cost~~ AAC, if such cost is available, plus ~~the~~ professional dispensing fee. If the ~~actual acquisition cost~~ AAC is not available, drugs will be reimbursed at the lower of the ~~Wholesale Acquisition Cost (~~WAC~~)~~ or ~~State Maximum Allowable Cost (~~SMAC~~)~~ as established by the Department, plus the assigned professional dispensing fee. ~~(3-17-22)~~( )

e. Drugs not distributed by a retail community pharmacy, such as drugs dispensed in a long-term care facility or dispensed to participants receiving swing-bed services, ~~as described in Subsection 405.05 of~~ under these rules, will be reimbursed at the actual ingredient cost, plus ~~the assigned~~ professional dispensing fee. ~~(3-17-22)~~( )

04. Limitations on Payment. Medicaid payment for prescription drugs will be limited as follows: (3-17-22)

a. ~~Medication for Multiple Persons.~~ When the medication dispensed is for more than one (1) person, Medicaid will only pay for the amount prescribed for ~~the person or persons~~ those covered by Medicaid. ~~(3-17-22)~~( )

~~**b.** No Prior Authorization. Medicaid will not pay for a covered drug or pharmacy item that requires, but has not received, prior authorization for Medicaid payment as required in Section 663 of these rules. (3-17-22)~~

~~**c**~~**b.** Limitations to Discourage Waste. Medicaid may conduct drug utilization reviews and impose limitations for participants whose drug utilization exceeds the standard participant profile or disease management guidelines determined by the Department. (3-17-22)

~~**05. Return of Drugs**. Drugs dispensed in unit dose packaging as defined by IDAPA 27.01.01, "General Provisions," must be returned to the dispensing pharmacy when the participant no longer uses the medication as follows: (3-17-22)~~

~~**a.** A pharmacy provider using unit dose packaging must comply with IDAPA 27.01.03, "Rules Governing Pharmacy Practice." (3-17-22)~~

~~**b.** The pharmacy provider that receives the returned drugs must credit the Department the amount billed for the cost of the drug less the professional dispensing fee. (3-17-22)~~

~~**c.** 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. (3-17-22)~~

0~~6~~5. Cost Appeal Process. Cost appeals will be determined by the Department's process provided online ~~at: https://healthandwelfare.idaho.gov/providers/pharmacy-providers/idaho-medicaid-pharmacy-program~~. ~~(3-17-22)~~( )

~~666. PRESCRIPTION DRUGS: QUALITY ASSURANCE.~~

~~**01. Pharmacy And Therapeutics Committee (P&T Committee).** (3-17-22)~~

~~**a.** Membership. The P&T Committee is appointed by the Director and is composed of practicing pharmacists, physicians and other licensed health care professionals with authority to prescribe medications. (3-17-22)~~

~~**b.** Function. The P&T Committee has the following responsibilities for the prior authorization of drugs under Section 663 of these rules: (3-17-22)~~

~~i. To serve in evaluational, educational and advisory capacities to the Idaho Medicaid Pharmacy Program specific to the prior authorization of drugs. (3-17-22)~~

~~ii. To review evidence-based clinical and pharmacy economic data and recommend to the Department~~

~~preferred and non-preferred drugs in classes designated for the Idaho Medicaid Preferred Drug List.~~ ~~(3-17-22)~~

~~iii. To recommend to the Department the classes of medications to be reviewed through evidence-based evaluation.~~ ~~(3-17-22)~~

~~iv. To review drug utilization outcome studies and intervention reports from the Drug Utilization Review Board as part of the process of reviewing and developing recommendations to the Department.~~ ~~(3-17-22)~~

~~c. Meetings. The P&T Committee meetings will be open to the public and a portion of each meeting will be set aside to hear and review public comment. The P&T Committee may adjourn to executive session to consider the following:~~ ~~(3-17-22)~~

~~i. Relative cost information for prescription drugs that could be used by representatives of pharmaceutical manufacturers or other people to derive the proprietary information of other pharmaceutical manufacturers; or~~ ~~(3-17-22)~~

~~ii. Participant specific or provider specific information.~~ ~~(3-17-22)~~

66~~7~~6. -- 679. (RESERVED)

SUB AREA: FAMILY PLANNING
(Sections 680-699)

680. (RESERVED)

681. FAMILY PLANNING SERVICES: PARTICIPANT ELIGIBILITY.

01. Sterilization Procedures~~ -- General Restrictions~~. ~~The following restrictions govern payment for s~~Sterilization procedures~~ for eligible persons~~ are only a covered service when they meet the requirements in 42 CFR 441.253, 42 CFR 441.257, and 42 CFR 441.258. ~~(3-17-22)~~( )

~~a. No sterilization procedures will be paid on behalf of a participant who is not at least twenty one (21) years of age at the time they sign the informed consent.~~ ~~(3-17-22)~~

~~b. No sterilization procedures will be paid on behalf of any participant who is twenty one (21) years of age or over and who is incapable of giving informed consent.~~ ~~(3-17-22)~~

~~c. Each participant must voluntarily sign the properly completed "Consent Form" HW 0034, or its equivalent, in the presence of the person obtaining consent in accordance with Section 683 of these rules.~~ ~~(3-17-22)~~

~~d. Each participant must sign the "Consent Form" at least thirty (30) days but not more than one hundred eighty (180) days, prior to the sterilization procedures. Exceptions to these time requirements are described under Subsection 682.03 of these rules.~~ ~~(3-17-22)~~

02. ~~Circumstances Under Which Payment Can be Made for a~~ Hysterectom~~y~~ies. Payment can be made for a hysterectomy only if: ~~(3-17-22)~~( )

~~a. It is medically necessary. A document must be attached to the claim to substantiate this requirement; and~~ ~~(3-17-22)~~

~~b. There was more than one (1) purpose in performing the hysterectomy, and the hysterectomy would not have been performed for the sole purpose of rendering an individual permanently incapable of reproducing; and~~ ~~(3-17-22)~~

~~c~~a. The participant was advised orally and in writing that sterility would result~~ and that she would no longer be able~~ in the inability to bear children; and ~~(3-17-22)~~( )

~~d~~b. The participant signs and dates a~~n "Authorization for Hysterectomy"~~ form~~. The form must state "I have been informed orally and in writing that a hysterectomy will render me permanently incapable of reproducing. I was informed of these consequences prior to the surgery being performed~~ that meets the requirements of the Idaho Medicaid Provider Handbook~~."~~ ~~(3-17-22)~~( )

c. Claims require supporting documentation attached to the claim. ( )

682. FAMILY PLANNING SERVICES: COVERAGE AND LIMITATIONS.
Family planning includes counseling and medical services prescribed or performed by a~~n independent licensed physician, or a qualified certified nurse practitioner or physician's assistant~~ provider. Specific items covered are diagnosis, treatment, contraceptive supplies, related counseling, and restricted sterilization. ~~(3-17-22)~~( )

01. Contraceptive Supplies. (3-17-22)

a. Contraceptive supplies include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives. (3-17-22)

b. Contraceptives requiring a prescription are payable subject to Section 662 of these rules. (3-17-22)

c. Payment for oral contraceptives is limited to purchase of a ~~three~~ six (~~3~~6) month supply. ~~(3-17-22)~~( )

02. Sterilization. (3-17-22)

a. No sterilizations for individuals institutionalized in correctional facilities, mental hospitals, or other rehabilitative facilities are ~~eligible for payment~~ payable unless such sterilizations are ordered by a court of law. ~~(3-17-22)~~( )

b. Hysterectomies ~~performed solely for sterilization purposes are not eligible for payment (see Subsection 681.02 of~~ are subject to these rules ~~for those conditions under which a hysterectomy can be eligible for payment)~~. ~~(3-17-22)~~( )

c. All requirements of state or local law for obtaining consent, except for spousal consent, must be followed. (3-17-22)

~~**d.** Suitable arrangements must be made to insure that information as specified in Subsection 681.01 of these rules is effectively communicated to any individual to be sterilized who is blind, deaf, or otherwise disabled. (3-17-22)~~

03. Exceptions to Sterilization Time Requirements. If premature delivery occurs or emergency abdominal surgery is required, the physician must certify that the sterilization was performed because of the premature delivery or emergency abdominal surgery less than thirty (30) days, but no less than seventy-two (72) hours after the date of the participant's signature on the consent form; and (3-17-22)

a. In the case of premature delivery, the physician must also state the expected date of delivery and describe the emergency in detail; and (3-17-22)

b. Describe, in writing to the Department, the nature of any emergency necessitating emergency abdominal surgery; and (3-17-22)

c. Under no circumstance can the period between consent and sterilization exceed one hundred eighty (180) days. (3-17-22)

04. Requirements for Sterilization Performed Due to a Court Order. When a sterilization is performed after a court order is issued, the physician performing the sterilization must have been provided with a copy of the court order prior to the performance of the sterilization~~. In addition they must:~~, and: ~~(3-17-22)~~( )

a. Certify~~, by signing a properly completed "Consent Form" HW 0034, or its equivalent, and submitting the consent form with their claim,~~ that all requirements have been met concerning sterilizations; and ~~(3-17-22)~~( )

b. Submit~~ to the Department~~ a copy of the court order together with the "Consent Form" and claim. ~~(3-17-22)~~( )

683. FAMILY PLANNING SERVICES: PROCEDURAL REQUIREMENTS.

01. Sterilization Consent Form Requirements. Informed consent exists when a properly completed "Consent Form"~~ HW 0034~~, or its equivalent, is submitted to the Department together with the physician's claim for the sterilization. Completed informed consent forms must meet all the requirements in 42 CFR 441.258, in order to be eligible for reimbursement. The person obtaining informed consent must ensure and certify all the requirements in 42 CFR 441.257 have been met. If the individual obtaining the consent and the physician who will perform the sterilization procedure are the same person, that person must sign both statements on the consent form. ~~(3-17-22)~~( )

~~**a.** The consent form must be signed and dated by: (3-17-22)~~

~~i. The participant to be sterilized; and (3-17-22)~~

~~ii. The interpreter, if one (1) is provided; and (3-17-22)~~

~~iii. The individual who obtains the consent; and (3-17-22)~~

~~iv. The physician who will perform the sterilization procedure. (3-17-22)~~

~~v. If the individual obtaining the consent and the physician who will perform the sterilization procedure are the same person, that person must sign both statements on the consent form. (3-17-22)~~

~~**b.** Informed consent must not be obtained while the participant in question is: (3-17-22)~~

~~i. In labor or childbirth; or (3-17-22)~~

~~ii. Seeking to obtain or obtaining an abortion; or (3-17-22)~~

~~iii. Under the influence of alcohol or other substances that affect the individual's state of awareness. (3-17-22)~~

~~**c.** An interpreter must be provided if the participant does not understand the language used on the consent form or the language used by the person obtaining the consent. (3-17-22)~~

~~**d.** The person obtaining consent must: (3-17-22)~~

~~i. Offer to answer any questions the participant may have concerning the procedure; and (3-17-22)~~

~~ii. Orally advise the participant that they are free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting their right to future care or treatment, and without loss or withdrawal of any federally funded program benefits to which the individual might otherwise be entitled; and (3-17-22)~~

~~iii. Provide a description of available alternative methods of family planning and birth control; and (3-17-22)~~

~~iv. Orally advise the participant that the sterilization procedure is considered to be irreversible; and (3-17-22)~~

~~v. Provide a thorough explanation of the specific sterilization procedure to be performed; and~~ ~~(3-17-22)~~

~~vi. Provide a full description of the discomfort and risks that may accompany and follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used; and~~ ~~(3-17-22)~~

~~vii. Provide a full description of the benefits or advantages that can be expected as a result of the sterilization; and~~ ~~(3-17-22)~~

~~viii. Advise that the sterilization procedure will not be performed for at least thirty (30) days except under extreme circumstances as specified in Subsection 682.03 of these rules.~~ ~~(3-17-22)~~

~~**e.** The person securing the consent from the participant must certify by signing the "Consent Form" that:~~ ~~(3-17-22)~~

~~i. Before the participant signed the consent form, they were advised that no federal benefits would be withheld because of the decision to be or not to be sterilized; and~~ ~~(3-17-22)~~

~~ii. The requirements for informed consent as set forth on the consent form were orally explained; and~~ ~~(3-17-22)~~

~~iii. To the best of their knowledge and belief, the participant appeared mentally competent and knowingly and voluntarily consented to the sterilization.~~ ~~(3-17-22)~~

~~**f.** The physician performing the sterilization must certify by signing the "Consent Form" that:~~ ~~(3-17-22)~~

~~i. At least thirty (30) days have passed between the participant's signature on that form and the date the sterilization was performed; and~~ ~~(3-17-22)~~

~~ii. To the best of the physician's knowledge the participant is at least twenty-one (21) years of age; and~~ ~~(3-17-22)~~

~~iii. Before the performance of the sterilization the physician advised the participant that no federal benefits will be withdrawn because of the decision to be or not to be sterilized; and~~ ~~(3-17-22)~~

~~iv. The physician explained orally the requirement for informed consent as set forth in the "Consent Form"; and~~ ~~(3-17-22)~~

~~v. To the best of their knowledge and belief the participant to be sterilized appeared mentally competent and knowingly and voluntarily consented to the sterilization.~~ ~~(3-17-22)~~

~~**g.** If an interpreter is provided, they must certify by signing the "Consent Form" that:~~ ~~(3-17-22)~~

~~i. They accurately translated the information and advice presented orally to the participant; and~~ ~~(3-17-22)~~

~~ii. They read the "Consent Form" and accurately explained its contents; and~~ ~~(3-17-22)~~

~~iii. To the best of their knowledge and belief, the participant understood the interpreter.~~ ~~(3-17-22)~~

~~**h.** The person obtaining consent must sign the "Consent Form" and certify that they have fulfilled specific requirements in obtaining the participant's consent.~~ ~~(3-17-22)~~

~~**i.** The physician who performs the sterilization must sign the "Consent Form" HW-0034, certifying that the requirements of this rule have been fulfilled.~~ ~~(3-17-22)~~

684. (RESERVED)

685. FAMILY PLANNING SERVICES: PROVIDER REIMBURSEMENT.
Payment to providers of family planning services for contraceptive supplies is limited to estimated acquisition cost. (3-17-22)

686. -- 699. (RESERVED)

SUB AREA: BEHAVIORAL HEALTH SERVICES
(Sections 700-719)

700. ~~INPATIENT BEHAVIORAL HEALTH SERVICES: DEFINITIONS.~~(RESERVED)

~~01. Freestanding Psychiatric Hospital~~. ~~A hospital, nursing facility, or other institution of sixteen (16) beds or less that is primarily engaged in the diagnosis and treatment of mental diseases. The hospital is not considered freestanding if it shares a building or campus with another hospital, or is owned by another hospital.~~ ~~(3-17-22)~~

~~02. Hospital Psychiatric Unit~~. ~~The psychiatric unit of a general hospital that furnishes inpatient care and treatment services for mental illness under a psychiatrist or other physician qualified to treat mental diseases.~~ ~~(3-17-22)~~

~~03. Institutions for Mental Disease (IMD)~~. ~~A hospital, nursing facility or other institution of seventeen (17) beds or more that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. A specific licensure is not necessary to meet this definition. This definition does not apply to ICF/IIDs.~~ ~~(3-17-22)~~

~~04. Substance Use Disorder~~. ~~A substance use disorder is evidenced by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using a substance despite significant substance-related problems. A diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to use of the substance and the current DSM.~~ ~~(3-17-22)~~

701. ~~INPATIENT~~ BEHAVIORAL HEALTH SERVICES: PARTICIPANT ELIGIBILITY.
All participants eligible for Medicaid, except for participants in the Idaho Medicare-Medicaid coordinated plan (MMCP), are automatically enrolled in the Idaho behavioral health plan (IBHP) and may access behavioral health services that are medically necessary. A court-ordered admission or physician's emergency certificate alone does not justify Medicaid reimbursement for inpatient services. ( )

~~01. Inpatient Psychiatric Hospital Services~~. ~~Participants are eligible who have a diagnosis from the current DSM with substantial impairment in thought, mood, perception, or behavior. A court-ordered admission or physician's emergency certificate alone does not justify Medicaid reimbursement for these services. Medical necessity must be demonstrated for admission or extended stay by meeting the severity of illness and intensity of service criteria as found in Subsections 701.03 and 701.04 of this rule. Services may be provided in:~~ ~~(3-17-22)~~

~~a.~~ ~~A freestanding psychiatric hospital;~~ ~~(3-17-22)~~

~~b.~~ ~~A hospital psychiatric unit; and~~ ~~(3-17-22)~~

~~c.~~ ~~Subject to federal approval, an institution for mental diseases.~~ ~~(3-17-22)~~

~~02. Inpatient Substance Use Disorder Services~~. ~~Participants are eligible when medical necessity is demonstrated by meeting the severity of illness and intensity of service criteria as found in Subsections 701.03 and 701.04 of this rule. A court-ordered admission or physician's emergency certificate alone does not justify Medicaid reimbursement for these services.~~ ~~(3-17-22)~~

~~03. Severity of Illness Criteria~~. ~~Both severity of illness and intensity of services criteria must be met for admission to an IMD or psychiatric unit of a general hospital.~~ ~~(3-17-22)~~

~~a. Severity of illness criteria. The participant must meet one (1) of the following criteria related to the severity of their psychiatric illness: (3-17-22)~~

~~i. Is currently dangerous to self as indicated by at least one (1) of the following: (3-17-22)~~

~~(1) Has actually made an attempt to take their own life in the last seventy-two (72) hours (details of the attempt must be documented); or (3-17-22)~~

~~(2) Has demonstrated self-mutilative behavior within the past seventy-two (72) hours (details of the behavior must be documented); or (3-17-22)~~

~~(3) Has a clear plan to seriously harm himself, overt suicidal intent, and lethal means available to follow the plan (this information can be from the participant or a reliable source and details of the participant's plan must be documented); or (3-17-22)~~

~~(4) The participant has a current plan, specific intent, or recurrent thoughts to seriously harm himself or others, and is at significant risk of making an attempt without immediate intervention; or (3-17-22)~~

~~ii. Participant is actively violent or aggressive and exhibits homicidal ideation or other symptoms that indicate they are a probable danger to others as indicated by one (1) of the following: (3-17-22)~~

~~(1) The participant has engaged in, or threatened, behavior harmful or potentially harmful to others or caused serious damage to property that would pose a serious threat of injury or harm to others within the last twenty-four (24) hours (description of the behavior and extent of injury or damage must be documented, as well as the time the behavior occurred relative to the present); or (3-17-22)~~

~~(2) The participant has made threats to kill or seriously injure others or to cause serious damage to property that would pose a threat of injury or harm to others and has effective means to carry out the threats (details of threats must be documented); or (3-17-22)~~

~~(3) A mental health professional has information from the participant or a reliable source that the participant has a current plan, specific intent, or recurrent thoughts to seriously harm others or property and is at significant risk of making the attempt without immediate intervention (details must be documented); or (3-17-22)~~

~~iii. Participant is gravely impaired as indicated by at least one (1) of the following criteria: (3-17-22)~~

~~(1) The participant has such limited functioning that their physical safety and well-being are in jeopardy due to their inability for basic self-care, judgment, and decision making (details of the functional limitations must be documented); or (3-17-22)~~

~~(2) The acute onset of psychosis or severe thought disorganization or clinical deterioration has rendered the participant unmanageable and unable to cooperate in non-hospital treatment (details of the participant's behaviors must be documented); or (3-17-22)~~

~~(3) There is a need for treatment, evaluation, or complex diagnostic testing where the participant's level of functioning or communication precludes assessment or treatment, or both, in a non-hospital based setting, and may require close supervision of medication or behavior or both. (3-17-22)~~

~~(4) The participant is undergoing severe or medically complicated withdrawal from alcohol, opioids, stimulants, or sedatives. (3-17-22)~~

~~**04. Intensity of Service Criteria**. The participant must meet all of the following criteria related to the intensity of services needed for treatment. (3-17-22)~~

~~a. Documentation that ambulatory care resources available in the community do not meet the treatment needs of the participant; and (3-17-22)~~

~~**b.** The services provided can reasonably be expected to improve the participant's condition or prevent further regression so that inpatient services will no longer be needed; and (3-17-22)~~

~~**c.** Treatment of the participant's condition requires services on an inpatient basis, including twenty-four (24) hour nursing observation. (3-17-22)~~

~~**d.** Exceptions. The requirement to meet intensity of service criteria may be waived for first-time admissions if severity of illness is met and the physician is unable to make a diagnosis or treatment decision while the participant is in their current living situation. The waiver of the intensity of services requirement can be for no longer than forty-eight (48) hours and is not waivable for repeat hospitalizations. (3-17-22)~~

~~**05. Exclusions**. If a participant meets one (1) or more of the following criteria, Medicaid reimbursement will be denied: (3-17-22)~~

~~**a.** The participant is unable to actively participate in an outpatient treatment program solely because of a major medical condition, surgical illness or injury; or (3-17-22)~~

~~**b.** The participant has a primary diagnosis of being intellectually disabled and the primary treatment need is related to the intellectual disability. (3-17-22)~~

702. ~~INPATIENT~~ BEHAVIORAL HEALTH SERVICES: COVERAGE AND LIMITATIONS.
Services included in the IBHP or State Plan are covered services that evaluate the need for and provide therapeutic and rehabilitative treatment to minimize symptoms of mental illness and substance use disorders and restore independent functioning. ( )

~~**01. Initial Length of Stay**. An initial length of stay, or a prior authorization requirement, will be established by the Department, or its designee, in the Idaho Medicaid Provider Handbook. Requirements for establishing length of stay will never be more restrictive than requirements for non-behavioral health services in a general hospital. (3-17-22)~~

~~**02. Extended Stay**. The Department, or its designee, will establish authorization requirements in the Idaho Medicaid Provider Handbook. An authorization is necessary when the appropriate care of the participant indicates the need for inpatient days in excess of the initial length of stay or previously approved extended stay. (3-17-22)~~

703. ~~INPATIENT~~ BEHAVIORAL HEALTH SERVICES: PROCEDURAL REQUIREMENTS.

~~**01. Prior Authorization**. Some services may require a prior authorization from the Department, or its designee. The Department will set documentation requirements in the Idaho Medicaid Provider Handbook to ensure quality of care and integrity of services. Requests for prior authorization must include: (3-17-22)~~

~~**a.** Diagnosis; and (3-17-22)~~

~~**b.** Summary of present medical findings including symptoms, complaints and complications indicating the need for admission; and (3-17-22)~~

~~**c.** Medical history; and (3-17-22)~~

~~**d.** Mental and physical functional capacity; and (3-17-22)~~

~~**e.** Prognosis. (3-17-22)~~

~~**02. Individual Plan of Care -- Content**. The individual plan of care is a written plan developed for the participant upon admission. The objective of the plan is to improve their condition to the extent that acute psychiatric care is no longer necessary. It must be developed by an interdisciplinary team as defined in Subsection 703.03 of this rule. The plan of care must be implemented within seventy-two (72) hours of admission, and reviewed at least every~~

~~three (3) days. The individual plan of care must contain:~~ ~~(3-17-22)~~

~~**a.** A diagnostic evaluation that includes examination of the medical, behavioral, and developmental aspects of the participant's situation and reflects the medical necessity for in-patient care; and~~ ~~(3-17-22)~~

~~**b.** Treatment objectives related to conditions that necessitated the admission; and~~ ~~(3-17-22)~~

~~**c.** An integrated program of therapies, treatments (including medications), activities (including special procedures to assure the health and safety of the participant), and experiences designed to meet the objectives; and~~ ~~(3-17-22)~~

~~**d.** A discharge plan designed to achieve the participant's discharge at the earliest possible time that includes plans for coordination of community services to ensure continuity of care with the participant's family, school, and community upon discharge.~~ ~~(3-17-22)~~

~~**03. Individual Plan of Care -- Interdisciplinary Team**. The individual plan of care must be developed by an interdisciplinary team capable of assessing the participant's immediate and long range therapeutic needs, developmental priorities and personal strengths and liabilities, assessing the potential resources of the participant's family, setting the treatment objectives, and prescribing therapeutic modalities to achieve the plan's objectives. The team must include at a minimum:~~ ~~(3-17-22)~~

~~**a.** One (1) of the following:~~ ~~(3-17-22)~~

~~i. A board-certified psychiatrist; or~~ ~~(3-17-22)~~

~~ii. A licensed psychologist and a physician licensed to practice medicine or osteopathy; or~~ ~~(3-17-22)~~

~~iii. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental disease and a licensed clinical professional counselor; and~~ ~~(3-17-22)~~

~~**b.** One (1) of the following:~~ ~~(3-17-22)~~

~~i. A licensed, clinical or master's social worker; or~~ ~~(3-17-22)~~

~~ii. A registered nurse with specialized training or one (1) year's experience in treating individuals with behavioral health needs; or~~ ~~(3-17-22)~~

~~iii. A licensed occupational therapist who has had specialized training or one (1) year of experience in treating individuals with behavioral health needs,~~ ~~(3-17-22)~~

~~**c.** The participant and their parents, legal guardians, or others into whose care they will be released after discharge.~~ ~~(3-17-22)~~

01. Enrollment. Providers will enroll in the IBHP with the contractor and meet both the credentialing and quality assurance guidelines of the contractor. ( )

02. Administer IBHP. The contractor is responsible for administering the IBHP, including: eligibility verification, management of behavioral health service provision, behavioral health claims processing, payments to providers, data reporting, utilization management, and customer service. ( )

03. Authorization. The contractor is responsible for authorization of covered behavioral health services that require prior authorization. ( )

04. Complaints, Grievances, and Appeals. Complaints, grievances, and appeals are handled between the contractor and the Department in compliance with state and federal requirements. Participants will utilize the complaint, grievance, and appeal process required by the contractor prior to initiating an administrative appeal with the Department. ( )

704. ~~INPATIENT~~ BEHAVIORAL HEALTH SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. All Services. IBHP services are delivered by network providers who are enrolled with the contractor and meet reimbursement, quality, and utilization standards. All behavioral health service providers are subject to the limitations of practice imposed by state law, federal regulations, and by the various state boards that regulate professional competency requirements, and in accordance with applicable Department rules. The contractor will enter into agreements with enrolled providers to provide the services under the IBHP. ( )

0~~1~~2. ~~Provider Qualifications~~Inpatient Services. Inpatient hospital psychiatric services must be provided under the direction of a physician in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and licensed by the state ~~of Idaho or the state~~ in which they provide services. To provide services beyond emergency medical screening and stabilization treatment, the hospital must have a separate psychiatric unit with staff qualified to provide psychiatric services. General hospitals licensed to provide services in their state, but are not JCAHO certified, may not bill for psychiatric services beyond emergency screening and stabilization. All inpatient services must comply with 42 CFR 456 when applicable. ~~(3-17-22)~~( )

~~**02. Record Keeping**. A written report of each evaluation and the plan of care must be entered into the participant's record at the time of admission or if the participant is already in the facility, immediately upon completion of the evaluation or plan. (3-17-22)~~

~~**03. Utilization Review (UR)**. The facility must have in effect a written utilization review plan that provides for review of each participant's need for the services that the hospital furnishes them. The UR plan must meet the requirements under 42 CFR 456.201 through 456.245. (3-17-22)~~

705. ~~INPATIENT~~ BEHAVIORAL HEALTH SERVICES: PROVIDER REIMBURSEMENT.

~~Failure to request a prior authorization, concurrent review, or continued stay review in a timely manner will result in a retrospective review being conducted by the Department. If the retrospective review determines the stay is medically necessary, the Department will assess a penalty to the hospital as specified in Subsection 705.02 of this rule. The admitting physician will be assessed a penalty for failure to request a prior authorization, concurrent review, or continued stay review in a timely manner as specified in Subsection 705.03 of this rule. A physician who provides hospital care but has no control over the admission, continued stay, or discharge of the participant is not subject to this penalty. (3-17-22)~~

~~**01. Payment**. Reimbursement for the participant's admission and length of stay is subject to prior authorization, concurrent review, continued stay review, or retrospective review by the Department. The hospital and the participant's physician are responsible for obtaining the required review. If such review identifies that an admission or continued stay is not medically necessary, then no Medicaid payment will be made. (3-17-22)~~

~~**a.** In reimbursing for inpatient hospital psychiatric services the Department will pay the lesser of customary charges or the established Medicaid semi-private rates for inpatient hospital care in accordance with the rules set forth in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (3-17-22)~~

~~**b.** The cost of services that would be the responsibility of the Department of Education for school age children cannot be considered in the cost of inpatient psychiatric hospital services. (3-17-22)~~

~~**02. Hospital Penalty Schedule**. Failure to request a prior authorization, concurrent review, or continued stay review from the Department in a timely manner will result in the hospital being assessed a penalty as follows. The penalty will be assessed after payment for hospital services for a medically necessary hospital admission. (3-17-22)~~

~~**a.** A request for a preadmission or continued stay review that is one (1) day late will result in a penalty of two hundred sixty dollars ($260). (3-17-22)~~

~~**b.** A request for a preadmission or continued stay review that is two (2) days late will result in a penalty of five hundred twenty dollars ($520). (3-17-22)~~

~~**c.** A request for a preadmission or continued stay review that is three (3) days late will result in a penalty of seven hundred eighty dollars ($780).~~ ~~(3-17-22)~~

~~**d.** A request for a preadmission or continued stay review that is four days (4) late will result in a penalty of one thousand forty dollars ($1,040).~~ ~~(3-17-22)~~

~~**e.** A request for a preadmission or continued stay review that is five (5) or more days late will result in a penalty of one thousand three hundred dollars ($1,300).~~ ~~(3-17-22)~~

~~**03. Physician Penalty Schedule**. Failure to request a preadmission review from the Department in a timely manner will result in the admitting physician being assessed a penalty as follows. The penalty will not be assessed against a physician who provides hospital care but has no control over the admission, continued stay, or discharge of the participant. The penalty will be assessed after payment for physician services for a medically necessary hospital admission:~~ ~~(3-17-22)~~

~~**a.** A request for a preadmission review that is one (1) day late will result in a penalty of fifty dollars ($50).~~ ~~(3-17-22)~~

~~**b.** A request for a preadmission review that is two (2) days late will result in a penalty of one hundred dollars ($100).~~ ~~(3-17-22)~~

~~**c.** A request for a preadmission review that is three (3) days late will result in a penalty of one hundred fifty dollars ($150).~~ ~~(3-17-22)~~

~~**d.** A request for a preadmission review that is four (4) days late will result in a penalty of two hundred dollars ($200).~~ ~~(3-17-22)~~

~~**e.** A request for a preadmission review that is five (5) or more days late will result in a penalty of two hundred fifty dollars ($250).~~ ~~(3-17-22)~~

Provider agreements will include the reimbursement methodology agreed upon by the contractor and Department. The cost of services that would be the responsibility of the Department of Education for school age children cannot be considered in the cost of inpatient psychiatric services. ( )

~~706. INPATIENT BEHAVIORAL HEALTH SERVICES: QUALITY ASSURANCE.~~
~~The policy, rules, and regulations to be followed must be those cited in 42 CFR 456.480 through 42 CFR 456.482.~~ ~~(3-17-22)~~

~~707. (RESERVED)~~

~~708. OUTPATIENT BEHAVIORAL HEALTH SERVICES: PARTICIPANT ELIGIBILITY.~~
~~All participants who are eligible for Medicaid Basic or Enhanced Benchmark State Plan services, except for participants enrolled in the Idaho Medicare Medicaid Coordinated Plan (MMCP), are automatically enrolled in the Idaho Behavioral Health Plan and may access behavioral health services that are determined to be medically necessary.~~ ~~(3-17-22)~~

~~709. OUTPATIENT BEHAVIORAL HEALTH SERVICES: COVERAGE AND LIMITATIONS.~~

~~**01. Community-Based Outpatient Behavioral Health Services**. The Community Based Outpatient Behavioral Health Services included in the Idaho Behavioral Health Plan (IBHP) or the Idaho State Plan are covered services that evaluate the need for and provide therapeutic and rehabilitative treatment to minimize symptoms of mental illness and substance use disorders and restore independent functioning.~~ ~~(7-1-24)~~

~~**02. Prior Authorization**. Some behavioral health services may require prior authorization from the IBHP contractor.~~ ~~(3-17-22)~~

~~**710. OUTPATIENT BEHAVIORAL HEALTH SERVICES: PROVIDER QUALIFICATIONS.**~~
~~The IBHP services are delivered by network providers who are enrolled with the contractor and meet reimbursement, quality, and utilization standards. All community-based outpatient behavioral health service providers are subject to the limitations of practice imposed by state law, federal regulations, and by the various state boards that regulate professional competency requirements, and in accordance with applicable Department rules. The contractor will enter into agreements with enrolled providers to provide the services under the IBHP. These agreements will include the reimbursement methodology agreed upon by the contractor and Department.~~ ~~(3-17-22)~~

~~**711. OUTPATIENT BEHAVIORAL HEALTH SERVICES: PROCEDURAL REQUIREMENTS.**~~
~~Providers must enroll in the IBHP with the contractor and meet both the credentialing and quality assurance guidelines of the contractor.~~ ~~(3-17-22)~~

~~**01. Administer IBHP**. The contractor is responsible for administering the IBHP, including: eligibility verification, management of behavioral health service provision, behavioral health claims processing, payments to providers, data reporting, utilization management, and customer service.~~ ~~(3-17-22)~~

~~**02. Authorization**. The contractor is responsible for authorization of covered behavioral health services that require authorization prior to claim payment.~~ ~~(3-17-22)~~

~~**03. Complaints, Grievances, and Appeals**. Complaints, grievances, and appeals are handled through a process between the contractor and Department that is in compliance with state and federal requirements. Participants must utilize the complaint, grievance, and appeal process required by the contractor prior to initiating an administrative appeal with the Department.~~ ~~(3-17-22)~~

7~~12~~06 -- 719. (RESERVED)

SUB AREA: HOME HEALTH SERVICES
(Sections 720-729)

720. HOME HEALTH SERVICES: DEFINITIONS.

01. Aggregator. System that collects provider EVV information from multiple software platforms and standardizes the information in MMIS for EVV data validation. (3-17-22)

~~**02. Claims Adjudication**. The process of determining Medicaid financial responsibility for claims submitted to MMIS.~~ ~~(3-17-22)~~

0~~3~~2. Electronic Visit Verification (EVV). EVV is a software or device(s) that electronically captures information verifying service delivery. (3-17-22)

0~~4~~3. Home Health Plan of Care. A written description of home health services to be provided to a participant as defined in IDAPA 16.03.07, "Home Health Agencies." (3-17-22)

0~~5~~4. Home Health Services. Home health services and items include nursing services, home health aide services, physical therapy, occupational therapy, speech-language pathology services, audiology services, and medical supplies, equipment, and appliances provided by a qualified professional under a home health plan of care.
~~(3-17-22)~~( )

721. (RESERVED)

722. HOME HEALTH SERVICES: COVERAGE AND LIMITATIONS.

01. Settings. Home health services are covered in a participant's ~~place of~~ residence and any setting in which normal life activities take place. Services are not covered ~~when provided~~ in a: ~~(3-17-22)~~( )

a. ~~Hospital~~Any setting in which Medicaid covers inpatient services, including room and board; or
~~(3-17-22)~~( )

~~**b.** Nursing facility;~~ ~~(3-17-22)~~

~~**c**~~**b.** ICF/IID, unless such services are not otherwise required to be provided by the ICF/IID~~; or~~. ~~(3-17-22)~~( )

~~**d.** Any setting in which Medicaid covers inpatient services, including room and board.~~ ~~(3-17-22)~~

02. Limitations. Home health services are limited to one hundred (100) visits per calendar year per person. Provision of durable medical equipment or supplies is not a visit. ~~(3-17-22)~~( )

03. Requirements. Services and items ~~must be medically necessary and~~, when appropriate, will meet the requirements for: ~~(3-17-22)~~( )

a. Audiology services under Sections 740 through 749 of these rules; (3-17-22)

b. Medical supplies, items, and appliances under Sections 750 through 779 of these rules; (3-17-22)

c. Physical therapy, occupational therapy, and speech-language pathology services under Sections 730 through 739 of these rules; and (3-17-22)

d. Early Periodic, Screening, Diagnosis, and Treatment Services under Sections 880 through 889 of these rules. (3-17-22)

723. HOME HEALTH SERVICES: PROCEDURAL REQUIREMENTS.

01. Orders. (3-17-22)

a. Home health services must be ordered by a ~~physician, or a licensed practitioner of the healing arts~~ provider. Orders ~~must~~ include the provider's National Provider Identifier (NPI), the services or items to be provided, the frequency, and, where applicable, the expected duration of time for which the home health services will be needed. Orders for medical supplies, equipment, and appliances are detailed in Section 753 of these rules. ~~(7-1-24)~~( )

b. Home health services required for extended periods must be reordered at least every sixty (60) days for services and annually for medical supplies, equipment, and appliances. (3-17-22)

02. Face-to-Face Encounter for Home Health Services, Medical Supplies, Equipment, and Appliances. (3-17-22)

a. To initiate home health services, medical supplies, equipment, and appliances, the participant's ~~physician, or a licensed practitioner of the healing arts~~ provider must document a face-to-face encounter related to the primary reason the patient requires home health services. Documentation must indicate the ~~practitioner~~ provider who conducted the encounter, and the date of the encounter as described in the CMS/Medicare DME coverage manual. ~~(7-1-24)~~( )

i. For home health services, the face-to-face encounter must have occurred no more than ninety (90) days before, or thirty (30) days after, the start of the home health services. (3-17-22)

ii. For home health medical supplies, equipment, and appliances, the face-to-face encounter must have occurred no more than six (6) months before the start of services. (3-17-22)

b. The face-to-face encounter may occur virtually under Subsection 210.09 of these rules. (7-1-24)

c. The face-to-face encounter may be performed by participant's ~~physician, including an attending acute or post-acute physician, or licensed practitioner of the healing arts~~ provider. ~~(3-17-22)~~( )

03. Home Health Plan of Care. (3-17-22)

a. All home health services must be provided under a home health plan of care that is established prior to beginning treatment and must be signed by the ~~licensed, qualified professional~~ provider who established the plan. ~~(3-17-22)~~( )

b. All home health plans of care must be reviewed by the ordering provider at least every sixty (60) days for services, and annually for medical supplies, equipment, and appliances. (3-17-22)

724. ELECTRONIC VISIT VERIFICATION (EVV).
~~Effective July 1, 2021,~~ Home Health Agencies (HHAs) are required to submit claims using a compliant EVV system as mandated by Section 12006 of the 21st Century Cures Act for all services provided except for the provision of medical supplies and equipment. Providers must: ~~(3-17-22)~~( )

01. Maintain System. Maintain an EVV system chosen by their agency that is certified as compliant with the MMIS aggregator, as determined by the Department and/or the MMIS Contractor; (3-17-22)

02. Document Consent. Document and retain participant consent for use of electronic verification methods; (3-17-22)

03. Develop Policies and Procedures. Develop and maintain policies and procedures outlining agency implementation and use of EVV technology, including strategies for safeguarding of participant information and privacy; and (3-17-22)

04. Submit EVV Data. Submit EVV data that captures these six (6) system-validated data elements for services rendered: (3-17-22)

a. Date of service; (3-17-22)

b, Time the service begins and ends; (3-17-22)

c. Individual providing the service; (3-17-22)

d. Participant receiving the service; (3-17-22)

e. Billable service performed; and (3-17-22)

f. Location of service delivery. (3-17-22)

725. ~~HOME HEALTH SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.~~(RESERVED)
~~In order to participate as a Home Health Agency (HHA) provider for Medicaid eligible persons, the provider must be licensed as required by the state, and be certified to participate in the Medicare Program. Loss of either state license or Medicare Program certification is cause for termination of Medicaid provider status.~~ ~~(3-17-22)~~

726. HOME HEALTH SERVICES: PROVIDER REIMBURSEMENT.

01. Home Health Services. Payment for home health services is limited to the services authorized in Sections 720 through 722 of these rules and must not exceed the lesser of reasonable cost as determined by a finalized Medicare cost report or the Medicaid percentile cap. ~~(3-17-22)~~( )

a. The Medicaid percentile cap is revised annually, effective at the beginning of each state fiscal year. Revisions are made using the data from the most recent finalized Medicare cost reports ~~on hand~~ thirty (30) days prior to the effective date. ~~(3-17-22)~~( )

b. Payment by the Department for home health will include mileage as part of the cost of the visit. (3-17-22)

c. Provider claims for services requiring EVV will include the corresponding EVV data elements listed in Subsection 724.04 of these rules. Provider EVV data will be submitted to the state's aggregator prior to billing claims. Claims corresponding to EVV data submissions are subject to a quality review in accordance with Subsection 210.10 of these rules. (3-17-22)

d. If a person is eligible for Medicare, all services ordered by the ~~physician or licensed practitioner of the healing arts~~ provider will be purchased by Medicare, except for the deductible and co-insurance amounts that the Department will pay. ~~(3-17-22)~~( )

02. Medical Supplies, Equipment, and Appliances. Payment for medical supplies, equipment, and appliances is detailed in Section ~~755~~ 230 of these rules. ~~(3-17-22)~~( )

727. -- 729. (RESERVED)

SUB AREA: THERAPY SERVICES
(Sections 730-739)

730. THERAPY SERVICES: DEFINITIONS.
For the purposes of these rules, the following terms are used as defined below: (3-17-22)

01. Duplicate Services. Services are considered duplicate: (3-17-22)

a. When participants receive any combination of physical therapy, occupational therapy, or speech-language pathology services with treatments, evaluations, treatment plans, or goals that are not separate and unique to each service provided; or (3-17-22)

b. When more than one (1) type of therapy is provided at the same time. (3-17-22)

02. Feeding Therapy. ~~Feeding Therapy means t~~Those therapy services necessary for the treatment of feeding disorders. Feeding disorders include problems gathering food and getting ready to suck, chew, or swallow it. ~~(3-17-22)~~( )

03. Maintenance Program. A program established by a therapist that requires the skills of a therapist or therapy professional and consists of activities and mechanisms to assist a participant in maximizing or maintaining the progress they have made during therapy or to prevent or slow further deterioration due to a disease or illness. (3-17-22)

04. Occupational Therapy Services. Therapy services that: (3-17-22)

a. Are ~~provided~~ within the scope of practice of licensed occupational therapy professionals; ~~(3-17-22)~~( )

b. Are necessary for the evaluation and treatment of impairments, functional disabilities, or changes in physical function and health status; and (3-17-22)

c. Improve the individual's ability to perform those tasks required for independent functioning. (3-17-22)

05. Physical Therapy Services. Therapy services that: (3-17-22)

a. Are ~~provided~~ within the scope of practice of licensed physical therapy professionals; ~~(3-17-22)~~( )

b. Are necessary for the evaluation and treatment of physical impairment or injury by the use of therapeutic exercise and the application of modalities that are intended to restore optimal function or normal development; and (3-17-22)

c. Focus on the rehabilitation and prevention of neuromuscular, musculoskeletal, integumentary, and cardiopulmonary disabilities. (3-17-22)

06. Speech-Language Pathology Services. Therapy services that are: (3-17-22)

a. ~~Provided w~~Within the scope of practice of licensed speech-language pathologists; and ~~(3-17-22)~~( )

b. Necessary for the evaluation and treatment of speech and language disorders that result in communication disabilities; or (3-17-22)

c. Necessary for the evaluation and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. (3-17-22)

07. Therapeutic Procedures. Therapeutic procedures are the application of clinical skills, services, or both, that attempt to improve function. (3-17-22)

08. Therapist. An individual licensed by the appropriate state licensing board as an occupational therapist, physical therapist, or speech-language pathologist. (3-17-22)

09. Therapy Professional. An individual licensed by the appropriate state licensing board as an occupational therapist or occupational therapist assistant, physical therapist or physical therapist assistant, or speech-language pathologist. (3-17-22)

10. Therapy Services. Occupational therapy, physical therapy, and speech-language pathology services are all considered to be therapy services. These services are ordered by the participant's ~~attending physician, nurse practitioner, or physician assistant~~ provider as part of a plan of care. ~~(3-17-22)~~( )

11. Treatment Modalities. A treatment modality is any physical agent applied to produce therapeutic changes to biological tissue, including the application of thermal, acoustic, light, mechanical or electrical energy. (3-17-22)

731. THERAPY SERVICES: PARTICIPANT ELIGIBILITY.
To be eligible for therapy services, a participant must be eligible for Medicaid benefits and must have: (3-17-22)

01. Order. A ~~physician or licensed practitioner of the healing arts~~ provider order for therapy services; and ~~(3-17-22)~~( )

02. A Therapy Evaluation Showing Need. A therapy evaluation of the participant showing a need for therapy due to a functional limitation, a loss or delay of skill, or both; and (3-17-22)

03. A Therapy Evaluation Establishing Participant Benefit. A therapy evaluation establishing that the participant will benefit and demonstrate progress as a result of the therapy services. (3-17-22)

732. THERAPY SERVICES: COVERAGE AND LIMITATIONS.
Therapy services are covered under these rules when delivered by a therapy professional and provided by one (1) of the following providers: outpatient hospitals, outpatient rehabilitation facilities, comprehensive outpatient rehabilitative facilities, nursing facilities, school-based services, independent practitioners, and home health agencies. ~~Therapy services provided by a home health agency under a home health plan of care must meet the requirements under Sections 730 through 739 of these rules, and the requirements under Sections 720 through 729 of these rules.~~ ~~(7-1-24)~~( )

01. Service Description: **Occupational Therapy and Physical Therapy**. Modalities, therapeutic procedures, tests, and measurements as described in the Idaho Medicaid Provider Handbook are covered with the following limitations: (3-17-22)

a. Any evaluation or re-evaluation may only be performed by the therapist. Any changes in the

participant's condition not consistent with planned progress or treatment goals necessitate a documented re-evaluation by the therapist before further treatment is carried out. (3-17-22)

b. Any CPT procedure code that falls under the heading of either, "Active Wound Care Management," or "Tests and Measurements," requires the therapist to have direct, one-to-one (1:1) patient contact. (3-17-22)

c. The therapist may be reimbursed for the technical component of muscle testing, joint range of motion, electromyography, or nerve velocity determinations as described in the CPT Manual when ordered by a ~~physician, nurse practitioner, or PA~~ provider. ~~(7-1-24)~~( )

d. Any assessment provided under the heading "Orthotic Management and Prosthetic Management" must be completed by the therapist. (3-17-22)

e. The services of occupational or physical therapy assistants used when providing covered therapy benefits are included as part of the covered service. These services are billed by the supervising therapist. Therapy assistants may not provide evaluation services, or take responsibility for the service. The therapist has full responsibility for the service provided. (3-17-22)

02. Service Description: Speech-Language Pathology. Speech-language pathology services must be provided as defined in Section 730 of these rules. Services provided by speech-language pathology aides and assistants are considered unskilled services, and will be denied as not medically necessary ~~if they are billed as speech-language pathology services~~. ~~(3-17-22)~~( )

03. Non-Covered Services: Occupational Therapy, Physical Therapy, and Speech-Language Pathology. (3-17-22)

a. Continuing services for participants who do not exhibit the capability to achieve measurable improvement and who do not meet the criteria for a maintenance program. (3-17-22)

b. Services that address developmentally acceptable error patterns. (3-17-22)

c. Services that do not require the skills of a therapy professional. (3-17-22)

d. Massage, work hardening, and conditioning. (3-17-22)

~~**e.** Services not medically necessary, under Section 011 of these rules.~~ ~~(7-1-24)~~

~~**f.** Duplicate services, under Section 730 of these rules.~~ ~~(7-1-24)~~

~~**g**~~**e.** Acupuncture (with or without electrical stimulation). (3-17-22)

~~**h**~~**f.** Biofeedback, unless provided to treat urinary incontinence. (3-17-22)

~~**i.** Services that are experimental or investigational.~~ ~~(7-1-24)~~

~~**j.** Vocational Program.~~ ~~(3-17-22)~~

04. Service Limitations. (3-17-22)

a. Physical therapy (PT) and speech-language pathology (SLP) services are limited to a combined annual dollar amount for all PT and SLP services. The Department will set the total amount based on the annual Medicare caps. The Department may allow additional therapy services, when the services are determined to be medically necessary and supporting documentation is provided upon request of the Department. (3-17-22)

b. Occupational therapy services are limited to an annual dollar amount set by the Department based on the annual Medicare caps. The Department may allow additional therapy services, when the services are determined to be medically necessary and supporting documentation is provided upon request of the Department.

(3-17-22)

c. Exceptions to service limitations. (3-17-22)

~~i. Therapy provided by home health agencies is subject to the limitations on home health services under Section 722 of these rules.~~ ~~(7-1-24)~~

~~i~~ii. Therapy provided through school-based services or the Idaho Infant Toddler Program is not included in the service limitations under Subsection 732.04 of this rule. (3-17-22)

~~iii. Therapy provided to EPSDT participants under the age of twenty one (21) under the EPSDT requirements in Sections 881 through 883 of these rules, and Section 1905(r) of the Social Security Act, will be authorized by the Department when additional therapy services are medically necessary.~~ ~~(7-1-24)~~

d. Feeding therapy services are covered for children with a diagnosed feeding disorder that results in a clinically significant deviation from normal childhood development. The provider of feeding therapy is an occupational therapist or speech therapist with training specific to feeding therapy. (3-17-22)

e. Maintenance therapy is covered when an individualized assessment of the participant's condition demonstrates that skilled care is required to carry out a safe and effective maintenance program. (3-17-22)

f. Virtual care modalities are covered to the extent they are allowed under the rules of the applicable board of licensing. The Department will define limitations on virtual care in the Idaho Medicaid ~~p~~Provider ~~h~~Handbook ~~to promote quality services and program integrity~~. ~~(7-1-24)~~( )

733. THERAPY SERVICES: PROCEDURAL REQUIREMENTS.
The Department will pay for therapy services rendered by a therapy professional if such services are ordered by a ~~physician, nurse practitioner, or PA~~ provider as part of a plan of care. ~~(7-1-24)~~( )

01. Orders. (3-17-22)

~~**a.** All therapy must be ordered by a physician, nurse practitioner, or PA.~~ ~~(7-1-24)~~

~~**b**~~**a.** If services are required for extended periods, they must be reordered as necessary, but at least every ninety (90) days for all participants with the following exceptions: (7-1-24)

i. Therapy provided by home health agencies must be included in the home health plan of care and be reordered at least every sixty (60) days. (3-17-22)

ii. Therapy for individuals with long-term medical conditions, as documented by ~~physician, nurse practitioner, or PA~~ a provider, must be reordered at least every three hundred sixty-five (365) days. ~~(7-1-24)~~( )

~~**c**~~**b.** Therapy services provided under a home health plan of care must comply with the order requirements in Section 723 of these rules. (3-17-22)

02. Level of Supervision. Supervision of physical therapist assistants and occupational therapist assistants by the physical therapist or occupational therapist must be done under rules of the applicable licensure board. (7-1-24)

~~**03. Face-to-Face Encounter for Home Health Therapy Services**. Therapy services provided under a home health plan of care must comply with requirements in Subsection 723.02 of these rules.~~ ~~(7-1-24)~~

0~~4~~3. Therapy Plan of Care. All therapy services must be provided under a therapy plan of care that is based on an evaluation and is established prior to beginning treatment. (3-17-22)

a. The plan of care must be signed by the person who established the plan, and sent to the ordering provider within thirty (30) days of the evaluation to continue therapy services. (7-1-24)

b. The plan of care must be consistent with the therapy evaluation and contain: (7-1-24)

i. Diagnoses; (3-17-22)

ii. Treatment goals that are measurable and pertain to the identified functional impairment(s); and (3-17-22)

iii. Type, frequency, and duration of therapy services. (3-17-22)

c. Therapy services provided under a home health plan of care must comply with the home health plan of care requirements in Section 723 of these rules. (3-17-22)

~~**734. THERAPY SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.**~~
~~The following providers are qualified to provide therapy services as Medicaid providers.~~ ~~(3-17-22)~~

~~**01. Occupational Therapist, Licensed**. A person licensed to conduct occupational therapy assessment and therapy according to the regulations in the state where the services are provided.~~ ~~(3-17-22)~~

~~**02. Physical Therapist, Licensed**. A person licensed to conduct physical therapy assessments and therapy according to the regulations in the state where the services are provided.~~ ~~(3-17-22)~~

~~**03. Speech-Language Pathologist, Licensed**. A person licensed to conduct speech language assessments and therapy according to the regulations in the state where the services are provided 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.~~ ~~(3-17-22)~~

734. (RESERVED)

735. THERAPY SERVICES: PROVIDER REIMBURSEMENT.

01. Payment for Therapy Services. The payment for therapy includes the use of therapeutic equipment to provide the modality or therapy. No additional charge may be made to either the Medicaid program or the participant for the use of such equipment. (3-17-22)

02. Payment Procedures. Payment procedures are as follows: (3-17-22)

a. Therapy provided by home health agencies will be paid at a per visit rate as described in Section 725 of these rules and in accordance with IDAPA 16.03.07, "Home Health Agencies." (3-17-22)

b. Therapists enrolled with Medicaid as independent ~~practitioners~~ providers and licensed by the appropriate state licensing board will be reimbursed on a fee-for-service basis. ~~Only those independent practitioners who have been enrolled as Medicaid providers can bill the Department directly for their services.~~ A therapy assistant cannot bill Medicaid directly. ~~The maximum fee will be based upon the Department's fee schedule, available from the central office for the Division of Medicaid.~~ ~~(3-17-22)~~( )

c. Therapy rendered on-site to hospital inpatients or outpatients will be paid at a rate not to exceed the payment determined as reasonable cost using Title XVIII (Medicare) standards and principles. (3-17-22)

d. Payment for therapy services rendered to participants in long-term care facilities is included in the facility reimbursement as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (3-17-22)

e. Payment for therapy services rendered to participants in school-based services is described in Section 855 of these rules. (3-17-22)

736. THERAPY SERVICES: QUALITY ASSURANCE ACTIVITIES.

01. Unreimbursable Services and Penalties. Therapy services ~~that are not medically necessary or that are not specifically covered by these rules are not reimbursable, and if paid~~ are subject to recoupment and penalties under IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct." ~~(3-17-22)~~( )

02. Therapist Conditions and Requirements. The therapist is required to formulate all therapy interventions in accordance with the applicable licensure rules in IDAPA 24.06.01, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants," or IDAPA 24.13.01, "Rules Governing the Physical Therapy Licensure Board," or IDAPA 24.23.01, "Rules of the Speech and Hearing Services Licensure Board," as well as the applicable association's professional Code of Ethics and Standards supporting best practice. (3-17-22)

03. Documentation. (3-17-22)

a. The provider must maintain financial and other records in sufficient detail to allow the Department to audit them as described in Section 305 of these rules. (3-17-22)

b. The following documentation must be maintained in the files of the provider: (3-17-22)

i. ~~Physician, nurse practitioner, or physician assistant~~Provider orders for therapy services; ~~(3-17-22)~~( )

ii. Therapy plans of care; and (3-17-22)

iii. Progress or other notes documenting each assessment, each therapy session, and results of tests and measurements related to therapy services. (3-17-22)

~~**c.** The provider must grant the Department immediate access to all information required to review compliance with these rules, as required in Section 330 of these rules. The absence of such documentation is cause for recoupment of Medicaid payment.~~ ~~(3-17-22)~~

737. -- 739. (RESERVED)

SUB AREA: AUDIOLOGY SERVICES
(Sections 740-749)

740. AUDIOLOGY SERVICES.
Audiology services are diagnostic, screening, preventive, or corrective services provided by an audiologist~~. These services must be provided~~, and in accordance with Title 54, Chapter 29, Idaho Code, ~~and~~ require the order of a ~~physician, nurse practitioner, or physician assistant~~ provider. Audiology services do not include equipment needed by the patient such as communication devices or environmental controls. ~~(3-17-22)~~( )

741. AUDIOLOGY SERVICES: PARTICIPANT ELIGIBILITY.

~~**01. All Participants.**~~ All participants are eligible to receive diagnostic screening services necessary to obtain a differential diagnosis. ~~(3-17-22)~~

~~**02. Participants Under the Age of 21.**~~ Participants under the age of twenty-one (21) are eligible for all services listed in Section 742 of these rules. ~~(3-17-22)~~( )

742. AUDIOLOGY SERVICES: COVERAGE AND LIMITATIONS.
~~All audiology services must be ordered by a physician or non-physician practitioner. The Department~~Medicaid will ~~pay for~~ cover routine audiometric examination and testing once ~~in each~~ per calendar year, and audiometric services and supplies ~~in accordance with the following guidelines and limitations~~ as follows: ~~(3-17-22)~~( )

01. Non-Implantable Hearing Aids. When there is a documented hearing loss that meets the criteria of the Idaho Medicaid Provider Handbook, ~~the Department~~ Medicaid will cover the purchase of non-implantable hearing aids for participants under the age of twenty-one (21) ~~with the following requirements and limitations:~~. ~~(3-17-22)~~( )

~~a. Covered services included with the purchase of the hearing aid include proper fitting and refitting of the ear mold or aid, or both, during the first year, instructions related to the aid's use, and extended insurance coverage for two (2) years.~~ ~~(3-17-22)~~

~~b~~a. The following services may be covered in addition to the purchase of the hearing aid for participants under the age of twenty-one (21): batteries purchased on a monthly basis, follow-up testing, necessary repairs ~~resulting from normal use after the second year~~ not covered by warranty, ~~and~~ the refitting of the hearing aid after the first two (2) years, or additional ear molds every six (6) months. ~~(3-17-22)~~( )

~~c. Lost, misplaced, stolen or destroyed hearing aids are the responsibility of the participant. The Department has no responsibility for the replacement of any hearing aid. In addition, the Department has no responsibility for the repair of hearing aids that have been damaged as a result of neglect, abuse or use of the aid in a manner for which it was not intended.~~ ~~(3-17-22)~~

02. Implantable Hearing Aids. The Department ~~may~~ covers ~~a~~ surgically implantable hearing aids for participants under the age of twenty-one (21) only when: ~~(3-17-22)~~( )

a. There is a documented hearing loss ~~as described in Subsection 742.01 of~~ under this rule; ~~(3-17-22)~~( )

b. Non-implantable options have been tried, but ~~have not been~~ are unsuccessful; and ~~(3-17-22)~~( )

c. ~~The Department has determined that a~~A surgically implanted hearing aid is determined medically necessary through the prior authorization ~~process. The Department will consider the guidelines of private and public payers, evidence-based national standards or medical practice, and the medical necessity of each participant's case~~. ~~(3-17-22)~~( )

03. Provider Documentation Requirements. ~~The~~ Documentation of the following ~~information~~ must ~~be documented and~~ be kept on file by the provider: ~~(3-17-22)~~( )

a. The participant's diagnosis; (3-17-22)

b. The results of the basic comprehensive audiometric exam that include pure tone, air and bone conduction, speech reception threshold, most comfortable loudness, discrimination and impedance testing; and (3-17-22)

c. The brand name and model type of the hearing aid needed. (3-17-22)

04. Allowance to Waive Impedance Test. The Department will allow a medical doctor to waive the impedance test based on their documented judgment. (3-17-22)

743. AUDIOLOGY SERVICES: PROCEDURAL REQUIREMENTS.

01. Audiology Examinations. Basic audiometric testing by licensed audiologists or ~~licensed physicians~~ providers will be covered ~~without prior approval~~. ~~(3-17-22)~~( )

02. Additional Testing. Any hearing testing beyond the basic comprehensive audiometry and impedance testing must be ordered in writing before the testing is done and kept on file by the provider. (3-17-22)

~~**744. AUDIOLOGY SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.**~~
~~The following are qualified to provide audiology services as Medicaid providers:~~ ~~(3-17-22)~~

~~**01. Audiologist, Licensed**. A person licensed to conduct hearing assessment and therapy, according to the regulations in the state where the services are provided, who meets the requirements of 42 CFR 440.110(c)(3).~~ ~~(3-17-22)~~

~~02. Speech-Language Pathologist, Licensed. A person licensed to conduct speech-language assessment and therapy according to the regulations in the state where the services are provided, 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.~~ ~~(3-17-22)~~

744. (RESERVED)

745. AUDIOLOGY SERVICES: PROVIDER REIMBURSEMENT.

01. Payment Procedures. ~~The following procedures must be followed when billing the Department:~~ ~~(3-17-22)~~( )

~~a. The Department will only pay the hearing aid provider for an eligible Medicaid participant if a properly completed claim is submitted to the Department within the one (1) year billing limitation.~~ ~~(3-17-22)~~

~~b. Payment will be based upon the Department's fee schedule in accordance with Section 230 of these rules).~~ ~~(3-17-22)~~

02. Limitations. The following limitations apply to audiometric services and supplies: (3-17-22)

~~a. Hearing aid selection is restricted to the most cost-effective type and model that meets the participant's medical needs.~~ ~~(3-17-22)~~

~~b~~a. Follow-up services are included in the purchase of the non-implantable hearing aid for the first two (2) years and one (1) year for implantable hearing aid including ~~repair, servicing and refitting of ear molds~~ proper fitting and refitting of the ear mold or aid, instructions on the aid's use, and extended insurance coverage. ~~(3-17-22)~~( )

~~c~~b. Providers are required to maintain warranty and insurance information on file on each hearing aid purchased ~~from them by the Department~~ through Medicaid and are responsible for exercising the use of the warranty or insurance during the first year following the purchase of the hearing aid. ~~(3-17-22)~~( )

~~d~~c. ~~Providers must not bill participants for charges in excess of the fees allowed by the Department for materials and services.~~ Lost, misplaced, stolen, or destroyed hearing aids are the responsibility of the participant. The Department has no responsibility for the repair of hearing aids that have been damaged as a result of neglect, abuse, or use of the aid in a manner for which it was not intended ~~(3-17-22)~~( )

746. -- 749. (RESERVED)

SUB AREA: DURABLE MEDICAL EQUIPMENT AND SUPPLIES
(Sections 750-779)

750. – 751. (RESERVED)

~~751. DURABLE MEDICAL EQUIPMENT AND SUPPLIES: PARTICIPANT RESPONSIBILITY.~~
~~The participant has a responsibility to reasonably protect and preserve equipment issued to them. Replacement of medical equipment or supplies that are lost, damaged or broken due to participant misuse or abuse are the responsibility of the participant.~~ ~~(3-17-22)~~

752. DURABLE MEDICAL EQUIPMENT AND SUPPLIES: COVERAGE AND LIMITATIONS.
The Department will purchase, repair, or rent~~, when medically necessary, reasonable and cost-effective,~~ durable medical equipment (DME) and medical supplies that are suitable for use in any setting in which normal life activities take place. ~~Medical supplies, equipment, and appliances provided by a home health agency under a home health plan of care must meet the requirements found in Sections 750 through 779 of these rules and the requirements found in Sections 720 through 729 of these rules.~~ ~~(3-17-22)~~( )

01. Medical Necessity Criteria~~ -- Equipment and Supplies~~. Department standards for medical

necessity and coverage limitations are those national standards set by Centers for Medicare and Medicaid Services (CMS) in the CMS/Medicare DME coverage manual. Exceptions to Medicare coverage are described in the Idaho Medicaid Provider Handbook available at: www.idmedicaid.com. Items for convenience, comfort, or cosmetic reasons are not covered. (3-17-22)( )

02. Prior Authorization — Equipment and Supplies. (3-17-22)( )

a. The Department will specify in the Idaho Medicaid Provider Handbook, which durable medical equipment DME and medical supplies require prior authorization by the Department. (3-17-22)( )

b. Each request for prior authorization must include all medical necessity documentation required under Section 753 of these rules. (3-17-22)

03. Coverage Conditions — Equipment and Supplies. (3-17-22)( )

a. Medical equipment and supplies are subject to coverage limitations in the CMS/Medicare DME coverage manual. Exceptions to these coverage conditions and coverage conditions for medically necessary items not included in that manual are described in the Idaho Medicaid Provider Handbook available at: www.idmedicaid.com. Exceptions must be established using evidence-based or best clinical practice standards as determined by the Department. (3-17-22)

ba. The Department will purchase no more than three (3) months of necessary medical supplies in a three (3) month period for the treatment or amelioration of a medical condition identified by the attending physician or non-physician practitioner. Supplies in excess of coverage limitations must be prior authorized by the Department. (3-17-22)( )

753. DURABLE MEDICAL EQUIPMENT AND SUPPLIES: PROCEDURAL REQUIREMENTS.

01. Orders. (3-17-22)

a. All medical supplies, equipment, and appliances medical supplies must be ordered by a physician or non-physician practitioner acting provider within the scope of their licensure. Such oOrders must meet the requirements in the CMS/Medicare DME coverage manual., be kept on file with the DME provider, and include: (7-1-24)( )

i. The participant's medical diagnosis that requires the use of the medical equipment or supplies; and ( )

ii. How long the item will be necessary and frequent of use, and for (PRN) orders the conditions for use. ( )

b. If medical equipment and supplies are required for extended periods, these must be reordered as necessary, but at least annually, for all participants. (7-1-24)( )

c. The following information to support the medical necessity of the item(s) must be included in the order and accompany all requests for prior authorization, or be kept on file with the DME provider for items that do not require prior authorization: (3-17-22)

i. The participant's medical diagnosis, including current information on the medical condition that requires the use of the supplies or medical equipment, or both; (3-17-22)

ii. An estimate of the time period that the medical equipment or supply item will be necessary and frequency of use. As needed (PRN) orders must include the conditions for use and the expected frequency; (3-17-22)

iii. For medical equipment, a full description of the equipment needed. All modifications or attachments to the basic equipment must be supported; (3-17-22)

~~iv. For medical supplies, the type and quantity of supplies necessary must be identified; and (3-17-22)~~

02. Documentation. ( )

~~v~~**a.** Documentation of the participant's medical necessity for the item~~, that meets coverage criteria~~ will be kept on file by the DME vendor. ~~(3-17-22)~~( )

~~vi~~**b.** Additional information may be requested by the Department ~~for specific equipment or supplies~~. ~~(3-17-22)~~( )

~~**02. Face-to-Face Encounter for Home Health Medical Supplies, Equipment, and Appliances**. Medical supplies, equipment, and appliances provided under a home health plan of care must comply with requirements in Subsection 723.02 of these rules. (7-1-24)~~

~~**03. Plan of Care Requirements for Home Health Medical Supplies, Equipment, and Appliances**. Medical supplies, equipment, and appliances provided under a home health plan of care must comply with requirements in Subsection 723.03 of these rules. (7-1-24)~~

~~**04. Prior Authorizations**. (3-17-22)~~

~~**a.** Prior authorization means a written, faxed, or electronic approval from the Department that permits payment or coverage of a medical item or service that is covered only by such authorization. (3-17-22)~~

~~i. Medicaid payment will be denied for the medical item or service or portions thereof that were provided prior to the submission of a valid prior authorization request. An exception may be allowed on a case-by-case basis, when events beyond the provider's control prevented the request's submission. (7-1-24)~~

~~ii. The provider may not bill the Medicaid participant for services not reimbursed by Medicaid solely because the authorization was not requested or obtained in a timely manner. (7-1-24)~~

~~**b.** An item or service will be deemed prior approved where the individual to whom the service was provided was not eligible for Medicaid when the service was provided, but was subsequently found eligible under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled," or IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and the medical item or service provided is approved by the Department by the same guidance that applies to other prior authorization requests. (7-1-24)~~

~~**c.** A valid prior authorization request is a written, faxed, or electronic request from a provider for services that contains all information and documentation as required by these rules to justify the medical necessity, amount of and duration for the item or service. (7-1-24)~~

~~**05. Notification of Changes to Prior Authorization Requirements**. The Department will provide sixty (60) days notice of any substantive changes to requirements for prior authorization in its provider handbook. The Department will provide a method to allow providers to provide input and comment on proposed changes. (7-1-24)~~

0~~6~~3. Equipment ~~Rental -- Purchase~~ Procedures. ~~Unless~~ When specified by the Department, ~~all~~ equipment must be rented ~~except when it would be more cost effective to purchase it. Rentals are~~ and subject to the following guidelines: ~~(3-17-22)~~( )

a. Rental payments, including intermittent payments, are ~~to be automatically~~ applied to the purchase of the equipment. ~~(3-17-22)~~( )

b. The Department may choose to continue to rent certain equipment without purchasing it. ~~Such items include apnea monitors, ventilators, and other respiratory equipment.~~ ~~(3-17-22)~~( )

c. The ~~total~~ monthly rental cost of a DME item ~~must~~ is not to exceed one-tenth (1/10) of the ~~total~~ purchase price ~~of the item~~. ~~(3-17-22)~~( )

~~**07. Notice of Decision**. A Notice of Decision approving or denying a requested item will be issued to the participant by the Department. The participant has twenty-eight (28) days from the date of the denial to request a fair hearing on the decision. Hearings will be conducted under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings."~~ ~~(7-1-24)~~

754. (RESERVED)

755. DURABLE MEDICAL EQUIPMENT AND SUPPLIES: PROVIDER REIMBURSEMENT.

01. Items Included in Per Diem Excluded. No payment will be made for any ~~participant's DME or medical supplies that are~~ items included in the per diem payment while such an individual is an inpatient in a hospital nursing facility or ICF/IID. ~~(3-17-22)~~( )

02. Least Costly Limitation. ~~When multiple features, models or brands of equipment or supplies are available, c~~Coverage will be limited to the least costly version that will reasonably and effectively meet the minimum requirements of the individual's medical needs. ~~(3-17-22)~~( )

03. Billing Procedures. The Department will provide billing instructions to providers of DME/medical supplies. ~~When prior authorization by the Department is required, the authorization number must be included on the claim form.~~ ~~(3-17-22)~~( )

~~**04. Fees and Upper Limits**. The Department will reimburse according to Section 230 of these rules.~~ ~~(3-17-22)~~

0~~5~~4. **Date of Service**. Unless specifically authorized by the Department, the date of services for ~~durable medical equipment~~ DME and supplies is the date of delivery ~~of the equipment or supply(s)~~ for items provided in-person or the date of shipment for supplies mailed through a third-party courier. ~~(3-17-22)~~( )

~~**06. Manually Priced Codes**. For codes that are manually priced, including miscellaneous codes, a copy of the manufacturer's suggested retail pricing (MSRP) or an invoice or quote from the manufacturer is required. Reimbursement will be seventy five percent (75%) of MSRP. If the pricing documentation is the invoice, reimbursement will be at cost plus ten percent (10%), plus shipping, if that documentation is provided.~~ ~~(3-17-22)~~

0~~7~~5. **Warranties and Cost of Repairs**. No reimbursement will be made for the cost of repairs (materials or labor, or both) covered under the manufacturer's warranty. The date of purchase and the warranty period must be kept on file by the DME vendor. The following warranty periods are required to be provided on equipment purchased by the Department: (3-17-22)

a. A power drive wheelchair must have a minimum one (1) year warranty period; (3-17-22)

b. An ultra-light or high-strength lightweight wheelchair must have a lifetime warranty period on the frame and crossbraces; (3-17-22)

~~**c. All other wheelchairs must have a minimum one (1) year warranty period;** (3-17-22)~~

~~**d**~~**c.** All electrical components and new or replacement parts must have a minimum six (6) month warranty period; (3-17-22)

~~**e**~~**d.** All other DME not specified ~~in Subsections 755.07.a. through 755.07.d. of~~ under this rule must have a minimum one (1) year warranty period; ~~(3-17-22)~~( )

~~**f**~~**e.** If the manufacturer denies the warranty due to user misuse or abuse, ~~or both,~~ that information must be forwarded to the Department at the time of the request for repair or replacement; ~~(3-17-22)~~( )

~~**g**~~**f.** The monthly rental payment must include a full service warranty. All routine maintenance, repairs, and replacement of rental equipment are the responsibility of the provider. (3-17-22)

756. DURABLE MEDICAL EQUIPMENT AND SUPPLIES: QUALITY ASSURANCE.
The use or provision of DME/medical supply items to an individual other than the participant for which such items were ordered is prohibited. ~~The provision of DME/medical supply items that is not supported by required medical necessity documentation is prohibited and subject to recoupment. Violators are subject to penalties for program fraud or abuse, or both, that will be enforced by the Department.~~ The Department has no obligation to repair or replace any piece of ~~durable medical equipment~~ DME that has been damaged, defaced, lost, or destroyed as a result of neglect, abuse, or misuse ~~of the equipment. Participants suspected of the same will be reported to the Surveillance and Utilization Review (SUR/S) committee~~. ~~(3-17-22)~~( )

757. -- 770. (RESERVED)

771. PROSTHETIC AND ORTHOTIC SERVICES: PARTICIPANT ELIGIBILITY.
The ~~Medical Assistance Program~~ Department will purchase or repair~~, or both,~~ medically necessary prosthetic and orthotic devices and related services ~~that artificially replace a missing portion of the body or support a weak or deformed portion of the body~~ within the established limitations ~~established by the Department~~. ~~(3-17-22)~~( )

772. PROSTHETIC AND ORTHOTIC SERVICES: COVERAGE AND LIMITATIONS.

01. Program Requirements. The following program requirements ~~will be~~ are applicable for all prosthetic and orthotic devices or services ~~purchased by the Department~~: ~~(3-17-22)~~( )

a. A temporary lower limb prosthesis will be purchased when documented by the ~~attending physician or non-physician practitioner~~ ordering provider that it is in the best interest of the participant's rehabilitation to have a temporary lower limb prosthesis prior to a permanent limb prosthesis. A new permanent limb prosthesis will only be requested after the residual limb size is considered stable; ~~(3-17-22)~~( )

b. A ~~request for a~~ replacement prosthesis or orthotic device must be justified to be the least costly alternative ~~as opposed~~ to repairing or modifying the current ~~prosthesis or orthotic~~ device; ~~(3-17-22)~~( )

c. All prosthetic and orthotic devices that require fitting must be provided by a Podiatrist, or an individual ~~who is~~ certified or registered by the American Board for Certification in Orthotics, Prosthetics & Pedorthics (ABC) or the Board of Certification/Accreditation (BOC); ~~(4-6-23)~~( )

d. All equipment ~~that is purchased~~ must be new at the time of purchase. Modification to existing prosthetic or orthotic equipment~~, or both,~~ will be covered by the Department; ~~(3-17-22)~~( )

e. Prosthetic limbs ~~purchased by the Department~~ must be guaranteed to fit properly for three (3) months from the date of service; ~~therefore,~~ any modifications, adjustments, or replacements within the three (3) months are ~~the responsibility of the provider that supplied the item at no additional cost to the Department or the participant~~ included in the cost of purchase; and ~~(3-17-22)~~( )

f. Not more than ninety (90) days may elapse between the ~~time of the~~ order date and date of the prior ~~pre~~authorization request ~~is presented to the Department for consideration~~. ~~(3-17-22)~~( )

02. Program Limitations. The following limitations apply to all prosthetic and orthotic services and equipment: (3-17-22)

a. No replacement will be allowed for prosthetic or orthotic devices within sixty (60) months of the date of purchase except in cases where there is clear documentation that there has been major physical change to the residual limb~~, and ordered by the attending physician or non-physician practitioner~~; ~~(3-17-22)~~( )

b. Refitting, repairs, or additional parts ~~must be~~ are limited to once per calendar year for all prosthetics or orthotics~~, or both,~~ unless ~~it has been~~ documented that a major medical change has occurred to the limb~~, and ordered by the attending physician~~; ~~(3-17-22)~~( )

~~**c.** All refitting, repairs or alterations require preauthorization based on medical justification by the~~

~~participant's attending physician;~~ ~~(3-17-22)~~

~~**d.** Prosthetic and orthotic devices provided for cosmetic or convenience purposes are not covered by the Department.~~ ~~(3-17-22)~~

~~e~~**c.** Electronically powered or enhanced ~~prosthetic~~ devices are not covered; ~~(3-17-22)~~( )

~~f~~**d.** The Department will only authorize corrective shoes or modification to an existing shoe ~~owned by the participant~~ when ~~they are~~ attached to an orthosis or prosthesis or when ~~specially constructed~~ to provide for a totally or partially missing foot; ~~(3-17-22)~~( )

~~g~~**e.** Shoes and accessories ~~such as mismatch shoes, comfort shoes following surgery, shoes to support an overweight individual, or shoes used as bandage following foot surgery, arch supports, foot pads, metatarsal head appliances or foot supports~~ are not covered except when provided for the treatment of diabetes; and ~~(3-17-22)~~( )

~~h~~**f.** Corsets ~~are not a benefit nor are~~ and canvas braces with plastic or metal bones are not a benefit. ~~However, s~~Special braces enabling a participant to ambulate will be covered when ~~the attending physician~~ a provider documents ~~that~~ the only other method of treatment for this condition would be ~~application of~~ a cast. ~~(3-17-22)~~( )

773. PROSTHETIC AND ORTHOTIC SERVICES: PROCEDURAL REQUIREMENTS.
Prosthetic and orthotic devices and services ~~will be paid for~~ are covered only if prescribed by a ~~physician or non-physician practitioner~~ provider. The following information must be included in the order and kept on file by the provider: ~~(3-17-22)~~( )

01. Full Description of the Services Requested. (3-17-22)

02. Number of Months the Equipment Will Be Needed and the Participant's Prognosis. (3-17-22)

03. Participant's Medical Diagnosis and Condition. The participant's medical diagnosis and the condition that requires the use of the prosthetic or orthotic services ~~, or both, supplies, equipment~~ or modifications ~~, or both; and~~. ~~(3-17-22)~~( )

~~**04. Modifications to the Prosthetic or Orthotic Device**. All modifications must be supported by the attending physician's description on the prescription.~~ ~~(3-17-22)~~

~~**774. (RESERVED)**~~

~~**775. PROSTHETIC AND ORTHOTIC SERVICES: PROVIDER REIMBURSEMENT.**
The Department will reimburse according to Section 230 of these rules.~~ ~~(3-17-22)~~

77~~6~~4. -- 779. (RESERVED)

**SUB AREA: VISION SERVICES
(Sections 780-789)**

780. -- 781. (RESERVED)

782. VISION SERVICES: COVERAGE AND LIMITATIONS.
The Department will pay for vision services and supplies ~~in accordance with the guidelines and limitations~~ as listed below. ~~(3-17-22)~~( )

01. Eye Examinations. ~~(3-17-22)~~

~~**a.**~~ The Department will pay ~~participating physicians and optometrists~~ providers for one (1) eye examination during any twelve (12) month period to determine the need for glasses to correct a refractive error. ~~(3-17-22)~~( )

~~b~~02. **Eyeglasses and Contacts**. The Department will pay for eyeglasses ~~within Department guidelines~~ following a diagnosis of visual defects and a recommendation that eyeglasses are needed for correction of a refractive error. ~~(3-17-22)~~( )

~~02~~a. ~~**Lenses.**~~ Lenses~~, single vision or bifocal,~~ will be ~~purchased by the Department not more often than~~ covered once every four (4) years except when there is documentation of a major visual change ~~as defined by the Department~~. ~~(3-17-22)~~( )

~~a~~i. Scratch resistant coating is required for all plastic and polycarbonate lenses (3-17-22)

~~b~~ii. Payment for tinted lenses will only be made when there is a diagnosis of albinism or in the case of other extreme medical conditions ~~as defined by the Department as~~ defined in the Provider Handbook. Documentation must be kept on file by both the examining and supplying providers. ~~(3-17-22)~~( )

~~c~~b. ~~All contact lenses require prior authorization by the Department.~~ Contact lenses will be covered for participants only with documentation of: ~~(3-17-22)~~( )

i. A need for correction equal to or greater than plus or minus ten (±10) diopters; or (3-17-22)

ii. An extreme medical condition that does not allow correction through the use of conventional lenses, such as cataract surgery, keratoconus, anisometropia, or other ~~extreme~~ conditions ~~as~~ defined by the Department. ~~(3-17-22)~~( )

~~03. Replacement Lenses. Replacement lenses will be purchased for participants under the age of twenty-one (21) prior to the four (4) year limitation only with documentation of a major visual change as defined by the Department in the Idaho Medicaid Provider Handbook. Replacement lenses for participants age twenty-one (21) and older will be purchased when necessary to prevent permanent damage to the eye.~~ ~~(3-17-22)~~

~~04~~c. ~~**Frames.**~~ Frames~~. will be purchased according to the following guidelines:~~ ~~(3-17-22)~~

~~a.~~ One (1) set of frames will be purchased by the Department for eligible participants ~~not more often than~~ once every four (4) years~~;~~ except ~~(3-17-22)~~

~~b.~~ ~~W~~when ~~it is documented by the vision provider that there has been a major change in visual acuity~~ receiving new lenses that cannot be accommodated in ~~lenses that will fit in the~~ existing frames~~, new frames also may be authorized~~. ~~(3-17-22)~~( )

~~05~~d. ~~**Fitting Fees.**~~ Fitting fees ~~for either contact lenses or conventional frames and lenses~~ are covered only when the participant is eligible ~~under the Medicaid program guidelines to receive~~ for the associated supplies ~~associated with the fitting fee~~. ~~(3-17-22)~~( )

04. Vision Therapy. Vision therapy is covered for participants between the ages of nine (9) and twenty-one (21) with a diagnosis of convergence insufficiency. ( )

0~~6~~5. **Non-Covered Items**. ~~A Medicaid Provider may receive payment from a Medicaid participant for vision services that are either not covered by the State Plan, or include special features or characteristics that are desired by the participant but are not medically necessary.~~ ~~(3-17-22)~~( )

a. ~~Non-covered items include~~ Trifocal lenses, Progressive lenses, photo gray, and tint. ~~(3-17-22)~~( )

b. Replacement of broken, lost, or missing glasses is the responsibility of the participant. (3-17-22)

783. -- 784. (RESERVED)

785. VISION SERVICES: PROVIDER REIMBURSEMENT.
The Department will designate a supplier to provide ~~A~~all eyeglass frames and lenses ~~provided to Medicaid~~

~~participants and paid for by the Medicaid Program will be purchased from the supplier designated by the Department~~. ~~(3-17-22)~~( )

786. -- 799. (RESERVED)

SUB AREA: DENTAL SERVICES
(Sections 800-819)

800. DENTAL SERVICES: SELECTIVE CONTRACT FOR DENTAL COVERAGE.
All participants eligible for Medicaid dental benefits are covered under a selective contract for a dental insurance program called Idaho Smiles at: http://www.healthandwelfare.idaho.gov/Medical/Medicaid/MedicalCare/DentalServices/tabid/696/Default.aspx. (3-17-22)

801. DENTAL SERVICES: DEFINITIONS.
For the purposes of dental services covered in Sections 800 through 807 of these rules, the following definitions apply: (3-17-22)

01. Adults~~.~~. ~~A person who is~~ Participants past the month of their twenty-first birthday. ~~(3-17-22)~~( )

02. Children~~.~~. ~~A person~~ Participants from birth through the month of their twenty-first birthday. ~~(3-17-22)~~( )

03. Idaho Smiles. A dental insurance program provided to eligible Medicaid participants through a selective contract between the Department and a dental insurance carrier. (3-17-22)

802. DENTAL SERVICES: PARTICIPANT ELIGIBILITY.
~~Children and adults eligible for Medicaid~~Participants are eligible for Idaho Smiles dental benefits~~ described in Section 803 of these rules~~. ~~(3-17-22)~~( )

803. DENTAL SERVICES: COVERAGE AND LIMITATIONS.
~~Some c~~Covered dental services may be subject to limitations, authorization from the Idaho Smiles contractor or benefit restrictions according to the terms of its contract with the Department, in addition to those specified in these rules. ~~(3-17-22)~~( )

01. Dental Coverage for Children. Children are covered for dental services that include preventative screenings, problem-focused and comprehensive exams, diagnostic, restorative, endodontic services (including root canals and crowns), periodontics, prosthodontic, orthodontic treatments, dentures, and oral surgery; (3-17-22)

02. Dental Limitation for Children. Orthodontics are limited to children who meet Medicaid eligibility requirements~~ and the Idaho Medicaid Handicapping Malocclusion Index~~ as determined by the State's contractor. ~~(3-17-22)~~( )

03. Dental Coverage for Adults. Adults are covered for dental services that include preventative screenings, problem-focused and comprehensive exams, diagnostic, restorative, periodontics, prosthodontic, dentures, oral surgery, and endodontic services with limitations. (3-17-22)

04. Dental Limitation for Adults. Root canals and crowns are not covered. (3-17-22)

804. DENTAL SERVICES: PROCEDURAL REQUIREMENTS.
Providers must enroll in the Idaho Smiles network with the dental insurance contractor and meet both credentialing and quality assurance guidelines of the contractor. (3-17-22)

01. Administer Idaho Smiles. The contractor is responsible for administering the Idaho Smiles program, including dental claims processing, payments to providers, customer service, eligibility verification, and data reporting. (3-17-22)

02. Authorization. The contractor is responsible for authorization of covered dental services that

require authorization prior to claim payment. (3-17-22)

03. Grievances. The contractor is responsible for tracking and reporting all grievances to the State's contract monitor. (3-17-22)

04. Appeals. Appeals are handled by a process between the contractor and the Department as specified in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings," and in compliance with state and federal requirements. (3-17-22)

805. DENTAL SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Providers are credentialed by the contractor to ensure they meet licensing requirements of the Idaho Board of Dentistry standards or the applicable state in which services are provided. Providers' duties are based on the contract requirements and are monitored and enforced by the contractor. (3-17-22)

806. DENTAL SERVICES: PROVIDER REIMBURSEMENT.
The Idaho Smiles administrator reimburses dental providers on a fee-for-service basis under a Department-approved fee schedule. The State will collaborate with the contractor to establish rates that promote and ensure adequate access to dental services. (3-17-22)

807. DENTAL SERVICES: QUALITY ASSURANCE.
Providers are subject to the contractor's Quality Assurance guidelines including monitoring for potential fraud, overutilization, or abuse of Medicaid. The contractor is required to share such potential cases with the Medicaid Fraud Unit as discovered. (3-17-22)

808. -- 819. (RESERVED)

SUB AREA: ESSENTIAL PROVIDERS
(Sections 820-859)

820. ~~RURAL HEALTH CLINIC~~FQHC AND ~~(~~RHC~~)~~ SERVICES: DEFINITIONS.

01. Change in Intensity of Services. A change in the intensity of services means a change in the quantity and complexity of services delivered that could change the total allowable cost per encounter. This does not include an expansion or remodeling of an existing provider. This may include the addition of new services or the deletion of existing services. ( )

02. Encounter. An encounter, for payment purposes, is a face-to-face contact for the provision of medical, mental or dental services between a FQHC or RHC patient and a provider as specified in Subsections 823.01 through 823.15 of these rules. ( )

03. Federally Qualified Health Centers (FQHCs). FQHCs are defined in federal law at 42 USC Section 1369d(1)(2), and 42 USC Section 1395x(aa)(1), and includes community health centers, migrant health centers, providers of care for the homeless, and outpatient health programs or clinics operated by a tribe or tribal organizations under the Indian Self-Determination Act (P.L. 93-638). It also includes clinics that qualify for, but are not actually receiving, grant funds according to Sections 329, 330, or 340 of the Public Health Service Act (42 USC Sections 201, et seq.) that may provide ambulatory services to Medicaid participants. ( )

04. Medicare Cost Report Period. The period of time covered by the Medicare-required annual report of cost. ( )

05. Medicare Economic Index (MEI). An annual measure of inflation designed to estimate the increase in the total cost for the average physician to operate a medical practice, and takes into account cost categories such as a physician's own time, non-physician employee's compensation, rents, and medical equipment. The MEI is used in establishing the annual changes to the payment conversion factors used in the methodology for determining reimbursement rates. ( )

06. ~~A~~ Rural Health Clinic (RHC). An RHC is located in a rural area designated as a physician

shortage area, and is neither a rehabilitation agency nor does it primarily provide for the care and treatment of mental diseases. ~~(3-17-22)~~( )

821. -- 822. (RESERVED)

823. ~~RURAL HEALTH CLINIC~~FQHC AND ~~(~~RHC~~)~~ SERVICES: COVERAGE AND LIMITATIONS. RHC and FQHC services are defined as follows: ~~(3-17-22)~~( )

01. Physician Services. ~~Physician services;~~ ~~(3-17-22)~~( )

~~**02. Services and Supplies Incident to a Physician Service.** Services and supplies incident to a physician service, which cannot be self administered; (3-17-22)~~

0~~3~~2. Physician Assistant Services. ~~Physician assistant services;~~ ~~(3-17-22)~~( )

0~~4~~3. Nurse Practitioner or Clinical Nurse Specialist Services. ~~Nurse practitioner or clinical nurse specialist services;~~ ~~(3-17-22)~~( )

04. Visiting Nurse Services. Part-time or intermittent nursing care, and related medical services to a home bound individual, when an RHC located in an area with a shortage of home health agencies. ( )

05. Chiropractor Services. ( )

06. Podiatrist Services. ( )

0~~5~~7. Clinical Psychologist Services. ~~Clinical psychologist services;~~ ~~(3-17-22)~~( )

08. Licensed Social Worker Services. ( )

0~~6~~9. Licensed Clinical Social Worker Services. ~~Clinical social worker services;~~ ~~(3-17-22)~~( )

10. Licensed Masters Social Worker Services. ( )

11. Licensed Professional Counselor Services. ( )

12. Licensed Clinical Professional Counselor Services. ( )

13. Licensed Marriage and Family Therapist Services. ( )

14. Other DOPL Licenses. Any other behavioral health or substance use disorder license type recognized by the Idaho Division of Occupational and Professional Licensing (DOPL). ( )

15. Licensed Dentist and Dental Hygienist Services. ( )

16. Pharmacist Services. ( )

0~~1~~17. ~~Other~~Incidental Services and Supplies. Services and supplies incident to a ~~nurse practitioner, physician's assistant, clinical psychologist, or clinical social worker~~ provider listed in Subsections 823.01 through 823.15 of these rules as would otherwise be covered by a physician service are part of an encounter; or ~~(3-17-22)~~( )

~~**08. Home Health Agency Shortage Area Services.** Part-time or intermittent nursing care, and related medical services to a home bound individual, when an RHC located in an area with a shortage of home health agencies. (3-17-22)~~

18. Other Payable Services. Other ambulatory services covered by Medicaid that the FQHC or RHC undertakes to provide, including immunizations. These services are billed separately from an encounter. ( )

824. -- 825. (RESERVED)

826. ~~RURAL HEALTH CLINIC~~FQHC AND ~~(~~RHC~~)~~ SERVICES: REIMBURSEMENT METHODOLOGY.

01. Payment. Payment for F~~ederally~~ Q~~ualified~~ H~~ealth~~ C~~enter~~ and R~~ural~~ H~~ealth~~ C~~linic~~ services must be made in accordance with Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, P.L. 106-554, 42USC Section 1396a(bb), Subsections (1) through (4). ~~(3-17-22)~~( )

02. FQHC or RHC Encounter. ~~An encounter, for RHC payment purposes, is a face-to-face contact for the provision of a medical or mental service between a clinic patient and a provider as specified in 823.01 through 823.06 of these rules.~~ Each contact with a separate discipline of health professional (medical, mental or dental), on the same day at the same location, is reimbursed as a separate encounter. All contact with all practitioners within a disciplinary category (medical, mental or dental) on the same day is a single encounter. ~~(3-17-22)~~( )

a. ~~Each contact with a separate discipline of health professional (medical or mental) on the same day at the same location is considered a separate encounter.~~Reimbursement for services is limited to one (1) encounter per discipline per participant per day. ~~(3-17-22)~~( )

b. ~~Reimbursement for services is limited to two (2) encounters per participant per day.~~An additional encounter may be reimbursed, if the encounter is caused by an illness or injury that occurs later than the first encounter and requires additional diagnosis or treatment. ~~(3-17-22)~~( )

c. ~~As an exception to Subsection 826.02.a. of this rule, a second encounter with the same professional on the same day may be reimbursed; or~~The encounter rate does not include drugs for biologicals which cannot be self-administered, long-acting reversible contraception (LARC) or Non-surgical transcervical permanent female contraceptive devices. ~~(3-17-22)~~( )

~~**d.** As an exception to Subsection 826.02.b. of this rule, an additional encounter may be reimbursed, if the encounter is caused by an illness or injury that occurs later in time than the first encounter and requires additional diagnosis or treatment. (3-17-22)~~

~~**e.** A core service ordered by a health professional who did not perform the service but was performed by support staff is considered a single encounter. (3-17-22)~~

~~**f.** Multiple contacts with clinic staff of the same discipline (medical, mental) on the same day related to the same illness or injury are considered a single encounter. (3-17-22)~~

827. FQHC AND RHC: RATE SETTING METHODOLOGY.

01. Prospective Payment System. ( )

a. For rate periods beginning in January, 2001, the Department will establish separate, finalized rates for medical/mental and dental encounters. The Department will prospectively set these finalized encounter rates using the FQHC's medical/mental and dental encounter costs. ( )

b. The Department will pay each provider an encounter rate equal to the amount paid in the previous federal fiscal year. The Department will adjust the encounter rate for inflation using the Medicaid Economic Index (MEI), as published by CMS. ( )

c. If an out-of-state FQHC becomes an Idaho Medicaid provider and provides less than one hundred (100) Idaho Medicaid encounters or receives less than ten thousand dollars ($10,000) in Idaho Medicaid payments in the first year after entering the program, the Department will deem the FQHC a low utilization provider. The finalized encounter rate for low utilization providers will be the same as the interim encounter rate as defined under these rules. If there is an increase in the number of encounters or the amount of payments over any twelve (12) month Medicare cost report period, the Department reserves the right to audit a low utilization provider's Medicare cost report in order

to set a new interim encounter rate as defined under these rules. ( )

02. New Providers to Idaho Medicaid. ( )

a. If the provider is new, the Department will set the interim encounter rate by referring to the encounter rates paid to other providers in the same or adjacent regional areas with similar caseloads. Regional areas are defined by the Department. If encounter rate information for others in the same or adjacent regional areas with similar caseloads is not available, the Department will set the interim encounter rate using historical cost information. If historical cost information is not available, the Department will use budgeted cost and encounter information submitted by the provider. ( )

b. If the provider has been designated as an FQHC or RHC for at least twenty-four (24) consecutive months and provides the historical cost and encounter information for this period to the Department, the Department will use the second full twelve (12) month audited Medicare cost report to calculate a finalized encounter rate. The Department will provide the provider a supplemental information worksheet to complete. This worksheet will be used by the Department to identify dental encounters and other incidental costs related to either medical/mental or dental encounters. ( )

c. For both new and existing providers that become Idaho Medicaid providers, the Department will audit the Medicare cost report for the twenty-four (24) consecutive months that represent two (2) complete fiscal years after the FQHC has become a Medicaid provider. The Department will also audit the Medicare cost report for any partial year prior to the twenty-four (24) consecutive months. ( )

d. For both new and existing FQHCs that become Idaho Medicaid providers, the Department will adjust the finalized encounter rate annually for inflation in accordance with these rules. ( )

e. The Department will adjust the claim payments for all provider claims paid at the interim encounter rate(s). These adjustments will reflect the payment at the finalized encounter rate(s). The Department will pay the provider for any total adjustment amount over what was reimbursed. The provider must pay the Department for any total adjustment amount that is under what was reimbursed. ( )

03. Change in an Encounter Rate Due to a Change in Scope of Services. ( )

a. After an approval is obtained for a change in scope of service from the federal Human Resources and Services Administration (HRSA), Bureau of Primary Healthcare, the provider must request the Department to review the encounter rate(s). This will include reviewing the addition of a new service(s), deletion of an existing service(s), or other changes in the intensity of services offered by the provider that could change the total cost per encounter. The provider must request the Department to review the encounter rate(s) within sixty (60) days after the approval from the HRSA Bureau of Primary Health Care for a change in scope of service. The Department requires the same supporting documentation required by the HRSA Bureau of Primary Health Care. ( )

b. When the provider does not have to file a change in scope of service with the HRSA Bureau of Primary Health Care, but plans an increase or decrease in the intensity of services to be offered that will result in a change to the scope of services, the provider must request the Department to review the request for a change in intensity and determine if there will be an increase or decrease in the encounter rate(s). The Department will review the request for a change in intensity within sixty (60) days of the planned change. ( )

c. The Department reserves the right to audit the Medicare cost report and recalculate the encounter rates when a change in the scope of service is reported. ( )

d. The Department will determine the encounter rate in accordance with this rule when the provider had reported a change in scope of service. The Department will audit the most recent twenty-four (24) consecutive months of Medicare cost reports following any change(s) in the scope of service. The Department will also audit the Medicare cost report for any partial year prior to the twenty-four (24) consecutive months. The finalized encounter rate(s) for both medical/mental and dental encounters will be recalculated and audited using the Medicare cost report for the second full twelve (12) month period. ( )

04. Annual Filing Requirements. Each provider is required to file a copy of its Medicare cost report on an annual basis. Department deadlines are the same as those imposed by Medicare. ( )

~~**827. -- 829. (RESERVED)**~~

~~**830. FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES: DEFINITIONS.**~~

~~**01. Change in Intensity of Services of an FQHC**. A change in the intensity of services of an FQHC means a change in the quantity and complexity of services delivered that could change an FQHC's total allowable cost per encounter. This does not include an expansion or remodeling of an existing FQHC. This may include such things as the addition of new services or the deletion of existing services. (3-17-22)~~

~~**02. Encounter**. An encounter, for FQHC payment purposes, is a face-to-face contact for the provision of medical/mental or dental services between a FQHC patient and a provider as specified in Subsections 832.01 through 832.07 of these rules. For the purposes of establishing encounter rates, the term "medical/mental" refers to a single category of service. (3-17-22)~~

~~**03. Encounter Rate**. An encounter rate can be of two (2) types, either medical/mental or dental; either of these two (2) types can be either an interim rate or a finalized rate. An encounter rate is the total amount of annual costs for the type of encounter divided by the total number of encounters for that type of encounter for the FQHC's fiscal year. (3-17-22)~~

~~**a.** Interim Encounter Rate. If the FQHC is new and historical cost information is not available, the Department sets the interim encounter rate using budgeted cost and encounter information submitted by the provider. If the FQHC is not able to obtain its financial budget information, the Department sets the interim encounter rate by referring to encounter rates paid to other FQHCs in the same or adjacent regional areas with similar caseloads. (3-17-22)~~

~~**b.** Finalized Encounter Rate. If the FQHC is an existing facility and has at least twenty four (24) consecutive months of historical cost and encounter information, the Department uses the second full twelve (12) month audited Medicare cost report to calculate a finalized encounter rate. (3-17-22)~~

~~**04. Federally Qualified Health Centers (FQHCs)**. Federally qualified health centers are defined in federal law at 42 USC Section 1396d(1)(2), which incorporates the definition at 42 USC Section 1395x(aa)(1), and includes community health centers, migrant health centers, providers of care for the homeless, and outpatient health programs or clinics operated by a tribe or tribal organization under the Indian Self-Determination Act (P.L. 93-638). It also includes clinics that qualify for, but are not actually receiving, grant funds according to Sections 329, 330, or 340 of the Public Health Service Act (42 USC Sections 201, et seq.) that may provide ambulatory services to medical assistance participants. (3-17-22)~~

~~**05. Medicare Cost Report Period**. The period of time covered by the Medicare required annual report of an FQHC's costs. (3-17-22)~~

~~**06. Medicare Economic Index (MEI)**. MEI is an annual measure of inflation designed to estimate the increase in the total cost for the average physician to operate a medical practice. The MEI takes into account cost categories such as a physician's own time, non-physician employees' compensation, rents, and medical equipment. The MEI is used in establishing the annual changes to the payment conversion factors used as part of the methodology for determining FQHC reimbursement rates. (3-17-22)~~

~~**831. (RESERVED)**~~

~~**832. FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES: COVERAGE AND LIMITATIONS.**~~
~~FQHC services are defined as follows: (3-17-22)~~

~~**01. Physician Services**. Physician services; or (3-17-22)~~

02. Incidental Services and Supplies to Physician Services. Services and supplies incidental to physician services, including drugs and pharmaceuticals that cannot be self-administered; or (3-17-22)

03. Physician Assistant Services. Physician assistant services; or (3-17-22)

04. Nurse Practitioner or Clinical Nurse Specialist Services. Nurse practitioner or clinical nurse specialist services; or (3-17-22)

05. Clinical Psychologist Services. Clinical psychologist services; or (3-17-22)

06. Clinical Social Worker Services. Clinical social worker services; or (3-17-22)

07. Licensed Dentist and Dental Hygienist Services. Licensed dentist and dental hygienist services; or (3-17-22)

08. Incidental Services and Supplies to Non-Physicians. Services and supplies incident to a nurse practitioner, physician's assistant, clinical psychologist, clinical social worker, or dentist or dental hygienist services that would otherwise be covered if furnished by or incident to physician services; or (3-17-22)

09. FQHC Services. In the case of an FQHC that is located in an area that has a shortage of home health agencies, FQHC services are part-time or intermittent nursing care and related medical services to a home-bound individual; and (3-17-22)

10. Other Payable Medical Assistance Ambulatory Services. Other payable medical assistance ambulatory services offered by the Idaho Medicaid program that the FQHC undertakes to provide, including pneumococcal or immunization vaccine and its administration. (3-17-22)

833. -- 834. (RESERVED)

835. FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES: REIMBURSEMENT METHODOLOGY.

01. Payment. Payment for Federally Qualified Health Center and Rural Health Clinic services must be made in accordance with Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, P.L. 106-554, 42 USC Section 1396a(bb), Subsections (1) through (4). (3-17-22)

02. FQHC Encounter Limitations and Exceptions. FQHC encounters have the following limitations and exceptions to these limitations as described in Subsections 835.02.a. through 835.02.d. of this rule: (3-17-22)

a. Each contact with a separate discipline of health professional (medical/mental or dental), on the same day at the same location, is considered a separate encounter. All contacts with all practitioners within a disciplinary category (medical/mental or dental) on the same day is one (1) encounter. (3-17-22)

b. Reimbursement for services is limited to three (3) encounters per participant per day. (3-17-22)

c. As an exception to Subsection 835.02.a. of this rule, a second encounter with the same professional on the same day may be reimbursed; or (3-17-22)

d. As an exception to Subsection 835.02.b. of this rule, an additional encounter may be reimbursed, if the encounter is caused by an illness or injury that occurs later in time than the first encounter and requires additional diagnosis or treatment. (3-17-22)

836. FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES: RATE SETTING METHODOLOGY.

01. Prospective Payment System. (3-17-22)

~~a. For rate periods beginning on January 1, 2001, the Department will establish separate, finalized rates for medical/mental encounters and for dental encounters. The Department will prospectively set these finalized encounter rates using the FQHC's medical/mental and dental encounter costs.~~ (3-17-22)

~~b. Beginning in federal fiscal year 2002, and for each federal fiscal year thereafter, the Department will pay each FQHC an encounter rate equal to the amount paid in the previous federal fiscal year. For the period starting with federal fiscal year 2002 and thereafter, the Department will adjust the encounter rate for inflation using the Medicaid Economic Index (MEI), as published by CMS. For both medical/mental encounters and dental encounters, FQHCs are paid on a per encounter basis, with the limitations and exceptions described under Subsection 835.02 of these rules.~~ (3-17-22)

~~c. If an out-of-state FQHC becomes an Idaho Medicaid provider and provides less than one hundred (100) Idaho Medicaid encounters or receives less than ten thousand dollars ($10,000) in Idaho Medicaid payments in the first year after entering the program, the Department will deem the FQHC a low utilization provider. The finalized encounter rate for low utilization providers will be the same as the interim encounter rate as defined in Subsection 836.02.a. of this rule. If there is an increase in either the number of encounters or in the amount of payments over any twelve (12) month Medicare cost report period, the Department reserves the right to audit a low utilization provider's Medicare cost report in order to set a new interim encounter rate as defined in Subsection 836.02.a. of this rule.~~ (3-17-22)

~~02. FQHCs That Become Idaho Medicaid Providers~~. (3-17-22)

~~a. If the FQHC is new and encounter rate information for other FQHCs in the same or adjacent regional areas with similar caseloads is not available, the Department will set the interim encounter rate using historical cost information. If historical cost information is not available, the Department will use budgeted cost and encounter information submitted by the provider. If the FQHC is not able to provide its financial budget information, the Department will set the interim encounter rate by referring to encounter rates paid to other FQHCs in the same or adjacent regional areas with similar caseloads. Regional areas are defined by the Department.~~ (3-17-22)

~~b. If the FQHC has been designated as an FQHC for at least twenty-four (24) consecutive months and provides the historical cost and encounter information for this period to the Department, the Department will use the second full twelve (12) month audited Medicare cost report to calculate a finalized encounter rate. The Department will provide the FQHCs a supplemental information worksheet to complete. This worksheet will be used by the Department to identify dental encounters and other incidental costs related to either medical/mental or dental FQHC encounters.~~ (3-17-22)

~~c. For both new and existing FQHCs that become Idaho Medicaid providers, the Department will audit the Medicare cost report for the twenty-four (24) consecutive months that represent two (2) complete fiscal years after the FQHC has become a Medicaid provider. The Department will also audit the Medicare cost report for any partial year prior to the twenty-four (24) consecutive months.~~ (3-17-22)

~~d. For both new and existing FQHCs that become Idaho Medicaid providers, the Department will adjust the finalized encounter rate annually for inflation in accordance with Subsection 836.01.b. of this rule.~~ (3-17-22)

~~e. The Department will adjust the claim payments for all FQHC claims paid at the interim encounter rate(s). These adjustments will reflect the payment at the finalized encounter rate(s). The Department will pay the FQHC for any total adjustment amount over what was reimbursed. The FQHC must pay the Department for any total adjustment amount that is under what was reimbursed.~~ (3-17-22)

~~03. Change in an FQHC Encounter Rate Due to a Change in the FQHC's Scope of Services~~. (3-17-22)

~~a. After an FQHC obtains approval for a change in scope of service from the federal Human Resources and Services Administration (HRSA), Bureau of Primary Healthcare, the FQHC must request the Department to review the encounter rate(s) for the FQHC. The review will include reviewing the addition of a new service(s), deletion of an existing service(s), or other changes in the intensity of services offered by an FQHC that~~

~~could change an FQHC's total cost per encounter. The FQHC must request the Department to review the encounter rate(s) within sixty (60) days after the FQHC has gained approval from the HRSA Bureau of Primary Health Care for a change in scope of service. The Department requires the same supporting documentation required by the HRSA Bureau of Primary Health Care.~~ ~~(3-17-22)~~

~~**b.** When an FQHC does not have to file a change in scope of service with the HRSA Bureau of Primary Health Care, but plans an increase or decrease in the intensity of services to be offered that will result in a change the FQHC's scope of services, the FQHC must request the Department to review the request for a change in intensity and determine if there will be an increase or decrease in the encounter rate(s) for the FQHC. The Department will review the request for a change in intensity within 60 (sixty) days of the planned change in intensity of services.~~ ~~(3-17-22)~~

~~**c.** The Department reserves the right to audit the Medicare cost report and recalculate the encounter rates when the FQHC has reported a change in scope of service.~~ ~~(3-17-22)~~

~~**d.** The Department will determine the encounter rate in accordance with Subsection 836.02 of this rule when the FQHC has reported a change in scope of service. The Department will audit and cost settle the most recent twenty-four (24) consecutive months of Medicare cost reports following any change(s) in an FQHC's scope of service. The Department will also audit the Medicare cost report for any partial year prior to the twenty-four (24) consecutive months. The finalized encounter rate(s) for both medical/mental and dental encounters will be recalculated and audited using the Medicare cost report for the second full twelve (12) month period.~~ ~~(3-17-22)~~

~~**04. Annual Filing Requirements**. Each provider is required to file a copy of its Medicare cost report on an annual basis. Department deadlines are the same as those imposed by Medicare.~~ ~~(3-17-22)~~

~~**05. Quarterly Supplemental Payments**. In the case of any FQHC that contracts with a managed care organization, the Department will make quarterly supplemental payments to the FQHC for the difference between the payment amounts paid by the managed care organization and the amount to which the FQHC is entitled under the prospective payment system for Medicaid participants.~~ ~~(3-17-22)~~

8~~37~~28. -- 841. (RESERVED)

842. INDIAN HEALTH SERVICE (IHS) CLINIC SERVICES: COVERAGE AND LIMITATIONS.
Payment will be available to Indian Health Service (IHS) clinics for any service provided within the conditions of the scope of care and services described in S~~ubs~~ection ~~835.02~~ 823 of these rules. ~~(3-17-22)~~( )

843. -- 844. (RESERVED)

845. INDIAN HEALTH SERVICE (IHS) CLINIC SERVICES: PROVIDER REIMBURSEMENT.

01. Payment Procedure. Payment for services other than prescribed drugs will be made on a per visit basis at a rate not exceeding the outpatient visit rate established by the Federal Office of Management and Budget as published annually in the Federal Register. (3-17-22)

02. Payment for Prescribed Drugs. Payment for prescribed drugs will be available as described in Subsection 662.01 of these rules. (3-17-22)

03. Dispensing Fee for Prescriptions. The allowed dispensing fee used to compute maximum payment for each prescription will be the midpoint dispensing fee of the range of fees in effect at the date of service unless a higher fee is justified by a pharmacy cost of operations report on file with the Department. (3-17-22)

04. Third Party Liability Not Applicable. The provisions of Section 215 of these rules are not applicable to Indian health service clinics. (3-17-22)

846. -- 849. (RESERVED)

850. SCHOOL-BASED SERVICE: DEFINITIONS.

01. Activities of Daily Living (ADL). The performance of basic self-care activities in meeting a participant's needs for sustaining them in a daily living environment, including, but not limited to, bathing, washing, dressing, toileting, grooming, eating, communication, continence, mobility, and associated tasks. (7-1-24)

02. Children's Habilitation Intervention Services (CHIS). ~~CHIS are medically necessary, evidence-informed or evidence-based therapeutic techniques based on applied behavior analysis principles used to result in positive outcomes. These intervention services are delivered directly to Medicaid eligible students with identified developmental limitations that impact the student's functional skills and behaviors across an array of developmental domains. CHIS include habilitative skill building, behavioral intervention, behavioral consultation, crisis intervention, and interdisciplinary training services~~ As defined in Section 570 of these rules. ~~(7-1-24)~~( )

03. Educational Services. Services that are provided in buildings, rooms, or areas designated or used as a school or an educational setting, which are provided during the specific hours and time periods in which the educational instruction takes place in the school day and period of time for these students, which are included in the individual educational plan (IEP) for the student. (3-17-22)

04. Evidence-Based Interventions. Interventions that have been scientifically researched and reviewed in peer reviewed journals, replicated successfully by multiple independent investigators, ~~have been~~ shown to produce measurable and substantiated beneficial outcomes, and are delivered with fidelity by certified or credentialed individuals trained in the evidence-based model. ~~(3-17-22)~~( )

05. Evidence-Informed Interventions. Interventions that use elements or components of evidence-based techniques and are delivered by a qualified individual who is not certified or credentialed in an evidence-based model. (7-1-24)

06. Human Services Field. A diverse field that is focused on improving the quality of life for participants. Areas of academic study include sociology, special education, counseling, and psychology, or other areas of academic study referenced in the Idaho Medicaid Provider Handbook. ~~(7-1-24)~~( )

07. School-Based Services. School-based services are health-related and rehabilitative services provided by Idaho public school districts and charter schools under the Individuals with Disabilities Education Act (IDEA). (3-17-22)

~~**08. The Psychiatric Rehabilitation Association (PRA)**. An association that works to improve and promote the practice and outcomes of psychiatric rehabilitation and recovery. The PRA also maintains a certification program to promote the use of qualified staff to work with individuals with mental illness. http://www.psychrehabassociation.org. (7-1-24)~~

~~**09. Serious Mental Illness (SMI)**. Under 42 CFR 483.102(b)(1), a person with SMI: (7-1-24)~~

~~**a.** Currently or at any time during the year, must have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified in the DSM-5-TR; and (7-1-24)~~

~~**b.** Must have a functional impairment that substantially interferes with or limits one (1) or more major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning with an individual's basic daily living skills, instrumental living skills, and functioning in social, family, vocational, or educational contexts. Instrumental living skills include maintaining a household, managing money, getting around the community, and taking prescribed medication. An adult who met the functional impairment criteria during the past year without the benefit of treatment or other support services is considered to have a serious mental illness. (7-1-24)~~

~~1~~0~~8~~. **Serious and Persistent Mental Illness (SPMI)**. A participant must meet the criteria for SMI, have at least one (1) additional functional impairment, and have a diagnosis under DSM-5-TR with one (1) of the following: Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days

without a conclusive diagnosis. (7-1-24)

851. SCHOOL-BASED SERVICE: PARTICIPANT ELIGIBILITY.
To be eligible for ~~medical assistance~~ Medicaid reimbursement ~~for covered services, school districts and charter schools~~ providers must ensure: ~~(3-17-22)~~( )

~~**01. Medicaid Eligibility**. Eligible for Medicaid and the service for which the school district or charter school is seeking reimbursement;~~ ~~(3-17-22)~~

~~**02. School Enrollment**. Enrolled in an Idaho school district or charter school;~~ ~~(3-17-22)~~

0~~3~~1. **Age**. Twenty-one (21) years of age or younger and the semester in which their twenty-first birthday falls is not finished; (3-17-22)

~~**04. Educational Disability**. Identified as having an educational disability under the Department of Education standards in IDAPA 08.02.03, "Rules Governing Thoroughness."~~ ~~(3-17-22)~~

0~~5~~2. **Parental Consent**. Providers must obtain a one-time parental consent to access public benefits or insurance from a parent or legal guardian for school-based Medicaid reimbursement. (3-17-22)

852. SCHOOL-BASED SERVICE: SERVICE-SPECIFIC PARTICIPANT ELIGIBILITY.
~~Skills Building/Community Based Rehabilitation Services (CBRS). CHIS and Personal Care Services (PCS) have additional eligibility requirements.~~ ~~(3-17-22)~~

01. Skills Building/Community Based Rehabilitation Services (CBRS). To be eligible for Skills Building/CBRS, the student must meet one (1) of the following: (3-17-22)

a. A student ~~who is a child~~ under eighteen (18) years of age ~~must~~ meeting the Serious Emotional Disturbance (SED) eligibility criteria ~~for children~~ in ~~accordance with~~ the Children's Mental Health Services Act, Section 16-2403, Idaho Code. ~~A~~ The child ~~who meets the criteria for SED~~ must experience a substantial impairment in functioning. The ~~child's~~ level and type of ~~functional~~ impairment must be documented in the school record. A Department-approved assessment must be used ~~to obtain the child's~~ for an initial functional impairment score. Subsequent scores must be obtained ~~at least~~ annually ~~in order~~ to determine ~~the child's~~ changes in functioning ~~that occurs~~ as a result of mental health treatment. ~~(3-17-22)~~( )

b. A student ~~who is~~ eighteen (18) years old or older ~~must~~ meeting the criteria of Serious and Persistent Mental Illness (SPMI). This requires that a student participant meet the criteria for SMI, as described in 42 CFR 483.102(b)(1), have at least one (1) additional functional impairment, and have a diagnosis under DSM-V, or later edition, with one (1) of the following: Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a conclusive diagnosis. In addition, the psychiatric disorder must be of sufficient severity to affect the participant's functional skills negatively, causing a substantial disturbance in role performance or coping skills in at least two (2) of the areas listed below on either a continuous or intermittent basis, at least once per year. The skill areas that are targeted must be consistent with the participant's ability to engage and benefit from treatment. The detail of the participant's level and type of functional impairment must be documented in the medical record in the following areas: ~~(3-17-22)~~( )

i. Vocational or educational; (3-17-22)

ii. Financial; (3-17-22)

iii. Social relationships or support; (3-17-22)

iv. Family; (3-17-22)

v. Basic living skills; (3-17-22)

vi. Housing; (3-17-22)

vii. Community or legal; or (3-17-22)

viii. Health or medical. (3-17-22)

02. CHIS. Students are eligible to receive ~~habilitative skill building, behavioral intervention, behavioral consultation, crisis intervention, and interdisciplinary training services must have a standardized Department-approved assessment to identify functional, or behavioral needs, or both, that interfere with the student's ability to access an education or require intervention services to correct or ameliorate their condition~~ CHIS services in accordance with Section 880, and behavioral consultation of these rules. ~~(3-17-22)~~( )

~~**a.** A functional need is determined when the student exhibits a deficit in an overall adaptive composite or deficits in three (3) or more of the following areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. A deficit is defined as one point five (1.5) or more standard deviations below the mean for all functional areas. (3-17-22)~~

~~**b.** A behavioral need is determined when the student exhibits maladaptive behaviors that include frequent disruptive behaviors, aggression, self-injury, criminal or dangerous behavior evidenced by a score of at least one point five (1.5) standard deviations from the mean in at least two (2) behavior domains and by a rater familiar with the student, or at least two (2) standard deviations from the mean in one (1) composite score that consists of at least three (3) behavior domains by a rater familiar with the student, on a standardized behavioral assessment approved by the Department. (3-17-22)~~

03. Personal Care Services. To be eligible for personal care services (PCS), the student must have a completed children's PCS assessment and allocation tool approved by the Department~~. To determine eligibility for PCS, the assessment results must~~ that finds the student requires PCS due to a medical condition that impairs ~~the~~ physical or functional abilities ~~of the student~~. ~~(3-17-22)~~( )

853. SCHOOL-BASED SERVICE: COVERAGE AND LIMITATIONS.
The Department will pay ~~school districts and charter schools~~ for ~~covered rehabilitative and health related~~ services~~. Services~~ includeing medical or remedial services provided by school districts or other cooperative service agencies, as defined in Section 33-317, Idaho Code. ~~(3-17-22)~~( )

01. Excluded Services. ~~The following services are excluded from Medicaid payments to school-based programs:~~ ~~(3-17-22)~~( )

~~**a.** Vocational Services. (3-17-22)~~

~~**b.** Educational Services. Educational services (other than health related services) or education based costs normally incurred to operate a school and provide an education. Evaluations completed for educational services only cannot be billed. (7-1-24)~~

~~**c.** Recreational Services. (3-17-22)~~

~~**d**~~**a.** Payment for school-related services will not be provided to students who are inpatients in nursing homes or hospitals. (3-17-22)

b. Services provided more than thirty (30) days prior to the signed and dated recommendation or referral. ( )

02. Evaluation and Diagnostic Services. Evaluations to determine eligibility or the need for health-related services may be reimbursed even if the student is not found eligible for health-related services. Evaluations completed for educational services only cannot be billed. Evaluations completed must: (3-17-22)

~~**a.** Be recommended or referred by a physician or other licensed practitioner of the healing arts. A~~

~~school district or charter school may not seek reimbursement for services provided more than thirty (30) days prior to the signed and dated recommendation or referral;~~ ~~(3-17-22)~~

~~b~~a. Be conducted by ~~qualified professionals~~ providers for the respective discipline as defined in Section 855 of these rules; ~~(3-17-22)~~( )

~~c~~b. Be directed toward a diagnosis; (3-17-22)

~~d~~c. Include recommended interventions to address each need; and (3-17-22)

~~e~~d. Include name, title, and signature of the person conducting the evaluation. (3-17-22)

03. Reimbursable Services. ~~School districts and charter schools~~ Providers can bill for the following health-related services provided ~~to eligible students when the services are provided~~ under the recommendation of a ~~physician or other practitioner of the healing arts for the Medicaid services~~ provider for ~~which the school district or charter school is seeking~~ reimbursement. ~~A school district or charter school may not seek reimbursement for services provided more than thirty (30) days prior to the signed and dated recommendation or referral.~~ The recommendations or referrals are valid up to three hundred sixty-five (365) days. ~~(7-1-24)~~( )

a. ~~Behavioral Intervention.~~ Behavioral Intervention is a direct intervention used to promote positive, meaningful changes in behavior that incorporate functional replacement behaviors and reinforcement-based strategies, while also addressing any identified habilitative skill building needs and the student's ability to participate in educational services~~, as defined in Section 850 of these rules,~~ through a consistent, assertive, and continuous intervention process to address behavior goals identified on the IEP. Behavioral intervention includes conducting a functional behavior assessment and developing a behavior implementation plan ~~with the purpose of~~ for preventing or treating behavioral conditions. This service is provided to students who exhibit maladaptive behaviors. Services include individual or group behavioral interventions. ~~(3-17-22)~~( )

i. Group services ~~must be~~ provided by one (1) qualified staff providing direct services for two (2) or three (3) students. ~~(7-1-24)~~( )

ii. As the ~~number and~~ severity of the students with behavioral issues increases, the student ratio in the group must be adjusted from three (3) to two (2). ~~(7-1-24)~~( )

iii. Group services should only be delivered when the student's goals relate to benefiting from group interaction. (3-17-22)

b. ~~Behavioral Consultation.~~ Behavioral consultation assists other service professionals by consulting with the IEP team during the assessment process, performing advanced assessment, coordinating the implementation of the behavior implementation plan and providing ongoing training to the behavioral interventionist and other team members. ~~(3-17-22)~~( )

i. Behavioral consultation cannot be provided as a direct intervention service. (3-17-22)

ii. Behavioral consultation must be limited to thirty-six (36) hours ~~per student~~ per year. ~~(3-17-22)~~( )

c. ~~Crisis Intervention.~~ Crisis intervention ~~services may include providing training to staff directly involved with the student, delivering intervention directly with the eligible student, and developing a crisis plan that directly addresses the behavior occurring and the necessary intervention strategies to minimize the behavior and future occurrences~~ as defined in Section 573. This service is provided on a short-term basis, typically not exceeding thirty (30) school days~~, and is available for students who have an unanticipated event, circumstance, or life situation that places a student at risk of at least one (1) of the following:~~ ~~(7-1-24)~~( )

~~i. Hospitalization;~~ ~~(3-17-22)~~

~~ii. Out-of-home placement;~~ ~~(3-17-22)~~

iii. Incarceration; or (3-17-22)

iv. Physical harm to self or others, including a family altercation or psychiatric relapse. (3-17-22)

d. Habilitative Skill Building. Habilitative skill building is a direct intervention service that includes techniques used to develop, improve and maintain, to the maximum extent possible, the developmentally appropriate functional abilities and daily living skills needed by a student. This service may include teaching and coordinating methods of training with family members or others who regularly participate in caring for the eligible student. Services include individual or group interventions as defined in Section 573. (3-17-22)( )

i. Group services must be provided by one (1) qualified staff providing direct services for two (2) or three (3) students. (7-1-24)

ii. As the number and needs of the students increase, the student ratio in the group must be adjusted accordingly. (3-17-22)

iii. Group services should only be delivered when the student's goals relate to benefiting from group interaction. (3-17-22)

e. Interdisciplinary Training. Interdisciplinary training is a companion service to behavioral intervention and habilitative skill building and is used to assist with implementing a student's health and medication monitoring, positioning and physical transferring, use of assistive equipment, and intervention techniques in a manner that meets the student's needs. This service is to be utilized for collaboration, with the student present, during the provision of services between the intervention specialist or professional and a Speech Language and Hearing Professional (SLP), Physical Therapist (PT), Occupational Therapist (OT), medical professional, or behavioral or mental health professional as defined in Section 573. (3-17-22)( )

f. Durable Medical Equipment and Supplies. Medical equipment and supplies that are covered by Medicaid must be medically necessary, ordered by a physician or non-physician practitioner, and prior authorized. Authorized items must be fFor use at the school where the service is provided. Equipment that is too large or unsanitary to transport from home to school and back may be covered, if prior authorized. The equipment and supplies must be for the student's exclusive use and must be transferred with the student if the student changes schools. All equipment purchased by Medicaid belongs to the student. (3-17-22)( )

g. Nursing Services. Skilled nNursing services must be provided by a licensed nurse, within the scope of their practice. including Eemergency, first aid, or non-routine medications not identified on the plan as a health-related service are not reimbursed. (7-1-24)( )

h. Occupational Therapy and Evaluation. These services for vocational assessment, training or vocational rehabilitation are not reimbursed. (7-1-24)( )

i. Personal Care Services (PCS). School-based PCS include medically oriented tasks having to do with the student's physical or functional requirements. PCS do not require a goal on the plan of service. The provider must deliver at least one (1) of the following services: (7-1-24)( )

i. Basic personal care and grooming to include bathing, hair care, assistance with clothing, and basic skin care; (7-1-24)

ii. Assistance with bladder or bowel requirements that may include helping the student to and from the bathroom or assisting the student with bathroom routines; (3-17-22)

iii. Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need; (3-17-22)

iv. Assisting the student with physician provider-ordered medications that are ordinarily self-administered, under IDAPA 24.34.01, "Rules of the Idaho Board of Nursing,;" Subsection 490.05; (7-1-24)( )

v. Non-nasogastric gastrostomy tube feedings~~, if the task is not complex and can be safely performed in the given student care situation, and~~ meeting the requirements under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 303.01. ~~(7-1-24)~~( )

j. Physical Therapy~~ and Evaluation~~. ~~(3-17-22)~~( )

k. Psychological Evaluation. (3-17-22)

l. Psychotherapy. (3-17-22)

m. Skills Building/Community-Based Rehabilitation Services (CBRS)~~. Skills Building/CBRS~~ are interventions to reduce the student's disability by assisting in gaining and utilizing skills necessary to participate in school. They are designed to build competency and confidence while increasing mental health and/or decreasing behavioral symptoms. Skills Building/CBRS provides training in behavior control, social skills, communication skills, appropriate interpersonal behavior, symptom management, activities of daily living, and coping skills~~. These services are intended~~ to prevent placement~~ of the student~~ in~~to~~ a more restrictive~~ educational~~ situation. ~~(7-1-24)~~( )

n. Speech/Audiological Therapy and Evaluation. (3-17-22)

o. Social History and Evaluation. (3-17-22)

p. Transportation Services.~~ School districts and charter schools~~ Providers can receive reimbursement for mileage for transporting a student~~ to and from~~ between home and school when: ~~(3-17-22)~~( )

i. The student requires special transportation assistance, a wheelchair lift~~,~~ or an attendant,~~ or both,~~ when medically necessary~~ for the health and safety of the student~~; ~~(3-17-22)~~( )

ii. The~~ transportation occurs in a~~ vehicle is specifically adapted to meet the needs of~~ a student with~~ a disability; ~~(3-17-22)~~( )

iii. The student~~ requires and~~ receives~~ another~~ Medicaid-reimbursable service~~s~~ billed by the~~ school-based services~~ provider, other than transportation, on the day~~ that~~ transportation is~~ being~~ provided; ~~(7-1-24)~~( )

iv. ~~Both the Medicaid-covered service and the need for the special~~The transportation~~ are~~ is included on the student's plan; and ~~(3-17-22)~~( )

v. The mileage, as well as the services performed by the attendant, are documented.~~ See Section 855 of these rules for documentation requirements.~~ ~~(3-17-22)~~( )

q. ~~Interpretive Services.~~ Interpretive services~~ needed by~~ for a student~~ who is deaf or does not adequately speak or understand English and~~ requires~~ing~~ an interpreter to communicate with the professional or paraprofessional providing~~ the student with~~ a health-related service may be billed~~ with the following limitations~~ when services are: ~~(3-17-22)~~( )

i. ~~Payment for interpretive services is l~~Limited to the specific time~~ that the student is receiving~~ the health-related service~~;~~ is received. ~~d~~Documentation~~ for interpretive service~~ must include the~~ Medicaid-reimbursable health-related~~ service~~ being~~ provided~~ while the interpretive service is provided~~. ~~(7-1-24)~~( )

ii. ~~Both the Medicaid-covered service and the need for interpretive services must be i~~Included on the student's plan; and ~~(3-17-22)~~( )

iii. ~~Interpretive services are not covered if the~~Provided by a professional or paraprofessional~~ providing services is~~ unable to communicate in the student's primary language. ~~(3-17-22)~~( )

854. SCHOOL-BASED SERVICE: PROCEDURAL REQUIREMENTS.
The following documentation must be maintained by the provider and retained for a period of five (5) years:

(3-17-22)

01. Individualized Education Program (IEP) and Other Service Plans. ~~School districts and charter schools~~ Providers may bill for ~~Medicaid~~ services covered by a current Individualized Education Program (IEP), transitional Individualized Family Service Plan (IFSP), or Services Plan (SP) defined in the Idaho Special Education Manual ~~on the State Department of Education website~~ for parentally placed private school students with disabilities when designated funds are available for special education and related services. The plan must be ~~developed~~ within the previous three hundred sixty-five (365) days ~~which indicates~~ and the need for one (1) or more medically-necessary health-related service, and lists all the Medicaid reimbursable services for which the ~~school district or charter school~~ provider is requesting reimbursement. The IEP and transitional IFSP must include: ~~(3-17-22)~~( )

a. Type, frequency, and duration of the service~~(s)~~ provided; ~~(3-17-22)~~( )

b. Title of the provider~~(s)~~, including the direct care staff delivering services under the supervision of the professional; ~~(3-17-22)~~( )

c. Measurable goals, when goals are required for the service; and (3-17-22)

d. Specific place of service, if provided in a location other than school. (3-17-22)

02. Evaluations and Assessments. ~~Evaluations and assessments must:~~ ~~(3-17-22)~~( )

~~**a.** Support services billed to Medicaid; and (3-17-22)~~

~~**b.** Accurately reflect the student's current status. (3-17-22)~~

03. Service Detail Reports. A service detail report that includes: (3-17-22)

a. Name of student; (3-17-22)

b. Name, title, and signature of the person providing the service; (3-17-22)

c. Date, time, and duration of service; (3-17-22)

d. Place of service, if provided in a location other than school; (3-17-22)

e. Category of service and brief description of the specific areas addressed; and (3-17-22)

f. Student's response to the service when required for the service. (3-17-22)

04. One Hundred Twenty Day Review. A documented review of progress toward each service plan goal completed at least every one hundred twenty (120) days from the date of the annual plan. (3-17-22)

05. Documentation of Qualifications of Providers. (3-17-22)

06. ~~Copies of~~ Required Referrals and Recommendations. ~~Copies of required referrals and recommendations.~~ School-based services must have: ~~(3-17-22)~~( )

a. ~~School-based services must be r~~Recommend~~ed~~ations or referr~~ed~~als by a ~~physician or other licensed practitioner of the healing arts for all Medicaid services for which the school district or charter school is receiving reimbursement~~ provider. ~~(3-17-22)~~( )

b. A recommendation or referral ~~must be~~ obtained within thirty (30) days of the provision of services ~~for which the school district or charter school is seeking reimbursement. Therapy requirements for the order are identified in Section 733 of these rules~~. ~~(3-17-22)~~( )

c. A recommendation or referral must be obtained for the service at least every three hundred sixty-

five (365) days. (3-17-22)

~~07. Parental Notification. School districts and charter schools must document that parents were notified of the health-related services and equipment for which they will bill Medicaid. Notification must comply with the requirements in Subsection 854.08 of this rule.~~ ~~(3-17-22)~~

0~~8~~7. **Requirements for Cooperation with and Notification of Parents and Agencies**. Each ~~school district or charter school billing for Medicaid services~~ provider must act in cooperation with students' parent or guardian, and with community and state agencies and professionals who provide like Medicaid services to the student. ~~(3-17-22)~~( )

a. ~~Notification of Parents. For all students who are receiving Medicaid reimbursed services, school districts and charter schools~~Providers must document that parents are notified of the ~~Medicaid~~ services ~~and equipment for which they will~~ billed to Medicaid. Notification must describe the service~~(s), service~~ provider~~(s)~~, and ~~state~~ the type, location, frequency, and duration of the service~~(s)~~. The school district must document that they provided the student's parent or guardian with a current copy of the child's plan and any pertinent addenda; and ~~(3-17-22)~~( )

b. ~~Primary Care Provider (PCP).~~ School districts and charter schools must request the name of the student's Primary Care Provider (PCP) and request a written consent to release and obtain information between the PCP and the school from the parent or guardian. ~~(3-17-22)~~( )

c. ~~Other Community and State Agencies.~~ Upon receiving a request for a copy of the evaluations or the current plan, the ~~school district or charter school~~ provider must furnish the requesting agency or professional with a copy of the plan or appropriate evaluation after obtaining consent for release of information from the student's parent or guardian. ~~(3-17-22)~~( )

855. SCHOOL-BASED SERVICE: PROVIDER QUALIFICATIONS AND DUTIES.
Medicaid will only reimburse for services provided by ~~qualified~~ staff~~.~~ with ~~T~~the following ~~are the minimum~~ qualifications ~~for providers of covered services~~: ~~(3-17-22)~~( )

01. Behavioral Intervention. Must be provided by, or under the supervision of, an intervention specialist or professional. Individuals providing behavioral intervention must be one (1) of the following: (7-1-24)

a. Intervention Paraprofessional. Provides direct services. The specialist or professional must observe and review the direct services performed by the paraprofessional monthly, or more often as necessary, to ensure the paraprofessional demonstrates the necessary skills to correctly provide the direct service. An intervention paraprofessional under the direction of a qualified intervention specialist or professional must: (7-1-24)

i. Be at least eighteen (18) years of age; (3-17-22)

ii. Demonstrate the knowledge, have the skills needed to support the program to which they are assigned; and (3-17-22)

iii. Meet the paraprofessional requirements under IDAPA 08.02.02, "Rules Governing Uniformity." (7-1-24)

b. Intervention Technician. ~~A provisional position intended to allow an individual to gain the necessary degree, competency, or experience needed to qualify as an intervention specialist or higher. Provisional status is limited to a single eighteen (18) successive month period. The specialist or professional must observe and review the direct services performed by the technician monthly, or more often as necessary, to ensure the technician demonstrates the necessary skills to correctly provide the direct service. An intervention technician under the direction of a qualified intervention specialist or professional, must:~~ As defined by Section 575.03 of these rules, but does not need to be the employee of a DDA. ~~(7-1-24)~~( )

~~i. Be an individual who is currently enrolled and is within twenty four (24) semester credits, or equivalent, to complete their bachelor's degree or higher from an accredited institution in a human services field and~~

~~working towards meeting the experience and competency requirements; or~~ ~~(3-17-22)~~

~~ii. Hold a bachelor's degree from an accredited institution in a human services field or has a bachelor's degree and a minimum of twenty-four (24) semester credits, or equivalent, in a human services field and working towards meeting the experience and competency requirements.~~ ~~(7-1-24)~~

c. Intervention Specialist. Provides direct services, completes assessments, and develops implementation plans. Intervention specialists who will complete assessments must have documented training and experience in completing assessments and designing and implementing comprehensive therapies for students with functional or behavioral needs, or both. The qualifications for this provider type can be met by one (1) of the following: (7-1-24)

i. An individual who holds an Idaho Standard Instructional Certificate who meets qualifications for an endorsement specific to special education as defined in State Board of Education Policy Section IV.B; (7-1-24)

ii. An individual who holds a Habilitative Intervention Certificate of Completion in Idaho with an expiration date of July 1, 2019, or later, and does not have a gap of more than three (3) years of employment as an intervention specialist; or (7-1-24)

iii. An individual who holds a bachelor's degree from an accredited institution in a human services field or has a bachelor's degree and a minimum of twenty-four (24) semester credits in a human services field, can demonstrate one thousand forty (1,040) hours of supervised experience working with children who demonstrate functional or behavioral needs, and meets the competency requirements by completing one (1) of the following: (3-17-22)

(1) A Department-approved competency checklist referenced in the Idaho Medicaid Provider Handbook; ~~(3-17-22)~~( )

(2) A minimum of forty (40) hours of applied behavior analysis training delivered by an individual who is certified or credentialed to provide the training; or (3-17-22)

(3) Other Department-approved competencies as defined in the Idaho Medicaid Provider Handbook. ~~(3-17-22)~~( )

d. Intervention Professional. ~~Provides direct services, completes assessments, and develops implementation plans. Intervention professionals who will complete assessments must have documented training and experience in completing assessments and designing and implementing comprehensive therapies for students with functional or behavioral needs, or both.~~ The services and qualifications for this provider type can be met by one (1) of the ~~following:~~ requirements under Subsection 575.04 of these rules. ~~(7-1-24)~~( )

~~i. An individual who holds a master's degree or higher from an accredited institution in psychology, education, applied behavior analysis, or have a related discipline with one thousand five hundred (1,500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis psychology, education, or behavior analysis which may be documented within the individual's degree program, other coursework, or training; and~~ ~~(3-17-22)~~

~~ii. Have one thousand two hundred (1,200) hours of relevant experience in completing and implementing comprehensive behavioral therapies for participants with functional or behavioral needs, which may be documented within the individual's degree program, other coursework, or training.~~ ~~(3-17-22)~~

e. Evidence-Based Model (EBM) Intervention Paraprofessional. ~~Provides direct services and must be supervised under the evidence-based model in which they are certified or credentialed. The EBM intervention specialist or professional must observe and review the direct services performed by the paraprofessional to ensure the paraprofessional demonstrates the necessary skills to correctly provide the direct service. An EBM intervention paraprofessional must:~~ As defined under Subsection 575.05 of these rules. ~~(7-1-24)~~( )

~~i. Hold a high school diploma; and~~ ~~(3-17-22)~~

~~ii. Hold a para-level certification or credential in an evidence-based model approved by the Department.~~ ~~(3-17-22)~~

f. Evidence Based Model (EBM) Intervention Specialist. ~~Provides direct services, completes assessments, and develops implementation plans and must be supervised under the evidence-based model in which they are certified or credentialed. The EBM intervention professional must observe and review the direct services performed by the specialist to ensure the specialist demonstrates the necessary skills to correctly provide the direct service. The specialist may supervise the EBM intervention paraprofessional working within the same evidence-based model. An EBM intervention specialist must:~~ As defined under Subsection 575.06 of these rules. ~~(7-1-24)~~( )

~~i. Hold a bachelor's degree from an accredited institution in accordance with their certification or credentialing requirements; and~~ ~~(3-17-22)~~

~~ii. Hold a bachelors-level certification or credential in an evidence-based model approved by the Department.~~ ~~(3-17-22)~~

g. Evidence-Based Model (EBM) Intervention Professional. As defined under Subsection 575.07 of these rules ~~P~~provides direct services, completes assessments, develops implementation plans, and may supervise EBM intervention paraprofessionals or specialists working within the same evidence-based model in which they are certified or credentialed. ~~An EBM intervention professional must:~~ ~~(7-1-24)~~( )

~~i. Hold a master's degree or higher from an accredited institution in accordance with their certification or credentialing requirements; and~~ ~~(3-17-22)~~

~~ii. Hold a masters-level certification or credential in an evidence-based model approved by the Department.~~ ~~(3-17-22)~~

02. Behavioral Consultation. Must be provided by a professional who has a Doctoral or Master's degree in psychology, education, applied behavioral analysis, or has a related discipline with one thousand five hundred (1,500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis psychology, education, or behavior analysis (may be included as part of degree program), and who meets one (1) of the following: (7-1-24)

a. An individual who holds an Idaho Standard Instructional Certificate who meets qualifications for an endorsement specific to special education as defined in State Board of Education Policy Section IV.B; (7-1-24)

b. An individual with a Pupil Personnel Certificate who meets the qualifications defined under IDAPA 08.02.02, "Rules Governing Uniformity," excluding an RN or audiologist; (7-1-24)

c. An occupational therapist ~~who is qualified and registered to practice in Idaho~~; ~~(3-17-22)~~( )

d. An intervention professional~~, as defined in Subsection 855.01 of this rule~~; or ~~(3-17-22)~~( )

e. An EBM intervention professional~~, as defined in Subsection 855.01 of this rule~~. ~~(3-17-22)~~( )

03. Crisis Intervention. Must be provided by, or under the supervision of, an intervention specialist or professional. Individuals providing crisis intervention must be one (1) of the following: (7-1-24)

a. An intervention paraprofessional~~, under Subsection 855.01 of this rule~~; ~~(7-1-24)~~( )

b. An intervention technician~~, under Subsection 855.01 of this rule~~; ~~(7-1-24)~~( )

c. An intervention specialist~~, under Subsection 855.01 of this rule~~; ~~(7-1-24)~~( )

d. An intervention professional~~, under Subsection 855.01 of this rule~~; ~~(7-1-24)~~( )

e. An EBM intervention paraprofessional~~, under Subsection 855.01 of this rule~~; ~~(7-1-24)~~( )

f. An EBM intervention specialist~~, under Subsection 855.01 of this rule~~; ~~(7-1-24)~~( )

g. An EBM intervention professional~~, under Subsection 855.01 of this rule~~; ~~(7-1-24)~~( )

h. A licensed physician, licensed practitioner of the healing arts; (3-17-22)

i. An advanced practice registered nurse; (3-17-22)

j. A licensed psychologist; (3-17-22)

k. A licensed clinical professional counselor or professional counselor; (3-17-22)

l. A licensed marriage and family therapist; (3-17-22)

m. A licensed masters social worker, licensed clinical social worker, or licensed social worker; (3-17-22)

n. A psychologist extender ~~registered with the Division of Occupational and Professional Licenses~~; ~~(7-1-24)~~( )

o. An RN; (7-1-24)

p. A licensed occupational therapist; or (3-17-22)

q. An endorsed or certified school psychologist. (3-17-22)

04. Habilitative Skill Building. Must be provided by, or under the supervision of, an intervention specialist or professional. Individuals providing habilitative skill building must be one (1) of the following under Subsection 855.01 of this rule: (7-1-24)

a. An intervention paraprofessional; (7-1-24)

b. An intervention technician; (7-1-24)

c. An intervention specialist; (7-1-24)

d. An intervention professional; (7-1-24)

e. An EBM intervention paraprofessional; (7-1-24)

f. An EBM intervention specialist; or (7-1-24)

g. An EBM intervention professional. (7-1-24)

05. Interdisciplinary Training. Must be provided by one (1) of the following under Subsection 855.01 of this rule: (7-1-24)

a. An intervention specialist; (7-1-24)

b. An intervention professional; (7-1-24)

c. An EBM intervention specialist; (7-1-24)

d. An EBM intervention professional. (7-1-24)

06. Medical Equipment and Supplies. See Subsection 853.03 of these rules. (7-1-24)

07. Nursing Services. ~~Must be provided by an RN or by a licensed practical nurse (LPN) licensed to practice in Idaho.~~ ~~(7-1-24)~~( )

08. Occupational Therapy and Evaluation. For therapy-specific rules, refer to Sections 730 through 739 of these rules. (3-17-22)

09. Personal Care Services (PCS). Must be provided by or under the direction of an RN. (7-1-24)

a. Providers of PCS must have at least one (1) of the following qualifications: (3-17-22)

i. Licensed Registered Nurse (RN). (7-1-24)

ii. Licensed Practical Nurse (LPN). ~~A person currently licensed by the Idaho State Board of Nursing as a licensed practical nurse;~~ ~~(3-17-22)~~( )

iii. Certified Nursing Assistant (CNA). ~~A person currently certified by the State of Idaho; or~~ ~~(3-17-22)~~( )

iv. Personal Assistant. A person who meets the standards of Section 39-5603, Idaho Code, and receives training to ensure the quality of services. The assistant must be at least age eighteen (18) years of age. (3-17-22)

b. The RN must review or complete, or both, the PCS assessment and develop or review, or both, the written plan of care annually. Oversight provided by the RN must include all of the following: (7-1-24)

i. Development of the written PCS plan of care; (3-17-22)

ii. Review of the treatment given by the personal assistant through a review of the student's PCS service detail reports as maintained by the provider; and (3-17-22)

iii. Reevaluation of the plan of care as necessary, but at least annually. (3-17-22)

c. The RN must conduct supervisory visits on a quarterly basis, or more frequently as determined by the IEP team and defined as part of the PCS plan of care. (3-17-22)

10. Physical Therapy and Evaluation. For therapy-specific rules, refer to Sections 730 through 739 of these rules. (3-17-22)

11. Psychological Evaluation. ~~Must be p~~Provided by a~~:~~ licensed professional within the scope of their practice. ~~(7-1-24)~~( )

~~**a.** Licensed psychiatrist; (3-17-22)~~

~~**b.** Licensed physician; (3-17-22)~~

~~**c.** Licensed psychologist; (3-17-22)~~

~~**d.** Psychologist extender registered with the Division of Occupational and professional Licenses; or (7-1-24)~~

~~**e.** Endorsed or certified school psychologist. (3-17-22)~~

12. Psychotherapy. ~~Provision of psychotherapy services must have, one (1) or more of the following credentials:~~ Provided by a licensed professional within the scope of their practice. ~~(7-1-24)~~( )

~~a. Psychiatrist, MD; (7-1-24)~~

~~b. Physician, MD; (7-1-24)~~

~~c. Licensed psychologist; (3-17-22)~~

~~d. Licensed clinical social worker; (3-17-22)~~

~~e. Licensed clinical professional counselor; (3-17-22)~~

~~f. Licensed marriage and family therapist; (3-17-22)~~

~~g. Certified psychiatric nurse (RN), under Subsection 707.13 of these rules; (7-1-24)~~

~~h. Licensed professional counselor whose provision of psychotherapy is supervised under with IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; (7-1-24)~~

~~i. Licensed masters social worker whose provision of psychotherapy is supervised under IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; (7-1-24)~~

~~j. Licensed associate marriage and family therapist whose provision of psychotherapy is supervised under IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; or (7-1-24)~~

~~k. Psychologist extender, registered with the Division of Occupational and Professional Licenses, whose provision of diagnostic services is supervised under IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (7-1-24)~~

13. Skills Building/Community-Based Rehabilitation Services (CBRS). Skills Building/CBRS must be provided by one (1) of the following~~. Skills Building/Community-Based Rehabilitation Services (CBRS) provider who is not required to have a PRA credential or credential required for CBRS specialists must be one (1) of the following~~: ~~(7-1-24)~~( )

a. Licensed physician, licensed practitioner of the healing arts; (3-17-22)

b. Advanced practice registered nurse; (3-17-22)

c. Licensed psychologist; (3-17-22)

d. Licensed clinical professional counselor or professional counselor; (3-17-22)

e. Licensed marriage and family therapist; (3-17-22)

f. Licensed masters social worker, licensed clinical social worker, or licensed social worker; (3-17-22)

g. Psychologist extender registered with the Division of Occupational and professional Licenses; (7-1-24)

h. Licensed registered nurse (RN); (3-17-22)

i. Licensed occupational therapist; (3-17-22)

j. Endorsed or certified school psychologist; (3-17-22)

k. Skills Building/Community Based Rehabilitation Services specialist who must: (7-1-24)

~~i. Be an individual who has a bachelor's degree and holds a current PRA credential; or (3-17-22)~~

~~i~~ii. Be an individual who has a bachelor's degree or higher and is under the supervision of a licensed behavioral health professional, a physician, nurse, or an endorsed or certified school psychologist. The supervising practitioner is required to have regular one-to-one (1:1) supervision of the specialist monthly to review treatment provided to student participants on an ongoing basis. ~~The frequency of the one-to-one (1:1) supervision must occur at least monthly.~~ Supervision can be conducted using synchronous virtual care when it is equally effective as direct on-site supervision; and ~~(7-1-24)~~( )

ii~~i~~. Have a credential required for CBRS specialists. (3-17-22)

14. Speech/Audiological Therapy ~~and Evaluation~~. For therapy-specific rules, refer to Sections 730 through 739 of these rules. ~~(3-17-22)~~( )

15. Social History and Evaluation. ~~Must be provided by a RN, psychologist, M.D, school psychologist, certified school social worker, or by a person who is licensed and qualified to provide social work in the state of Idaho.~~ Provider licensed and within the scope of their practice. ~~(7-1-24)~~( )

16. Transportation. Must be provided by an individual who has a current Idaho driver's license and is covered under vehicle liability insurance that covers passengers for business use. (7-1-24)

17. Therapy Paraprofessionals. The schools may use paraprofessionals to provide occupational therapy, physical therapy, and speech therapy ~~if they are under the supervision of the appropriate professional. The services provided by paraprofessionals must be delegated and supervised by a professional therapist under the appropriate licensure and certification rules~~. The portions of the treatment plan ~~that can be~~ delegated to the paraprofessional must be identified in the IEP or transitional IFSP. ~~(7-1-24)~~( )

~~**a.** Occupational Therapy (OT). Refer to IDAPA 24.06.01, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants," for qualifications, supervision, and service requirements. (3-17-22)~~

~~**b.** Physical Therapy (PT). Refer to IDAPA 24.13.01, "Rules Governing the Physical Therapy Licensure Board," for qualifications, supervision, and service requirements. (7-1-24)~~

~~**c.** Speech-Language Pathology (SLP). Refer to IDAPA 24.23.01, "Rules of the Speech, Hearing and Communication Services Licensure Board," and the American Speech Language Hearing Association (ASHA) guidelines for qualifications, supervision, and service requirements for speech-language pathology as incorporated in Section 004 of these rules. (7-1-24)~~

~~i. Supervision must be provided by an SLP professional in Section 734 of these rules. (7-1-24)~~

~~ii. The professional must observe and review the direct services performed by the paraprofessional monthly, or more often as necessary, to ensure the paraprofessional demonstrates the necessary skills to correctly provide the SLP service. (3-17-22)~~

856. SCHOOL-BASED SERVICE: PROVIDER REIMBURSEMENT.
~~Payment for health-related services provided by~~Only school districts ~~must be in accordance with rates established by the Department~~ can be reimbursed for school-based services. ~~(3-17-22)~~( )

~~**01. Payment in Full**. Providers of services must accept as payment in full the school district or charter school payment for such services and must not bill Medicaid or Medicaid participants for any portion of any charges. (3-17-22)~~

~~**02. Third Party**. For requirements regarding third party billing, see Section 215 of these rules. (3-17-22)~~

031. Recoupment of Federal Share. Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of the Federal share of payments for services, sanctions, or both. (3-17-22)

042. Matching Funds. Federal funds cannot be used as the State's portion of match for Medicaid service reimbursement. School districts and charter schools Providers must, for their own internal record keeping, calculate and document the non-federal funds (maintenance of effort assurance) that have been designated as their certified match. This documentation needs to include the source of all funds that have been submitted to the State and the original source of those dollars. The appropriate matching funds will be handled in the following manner: (3-17-22)( )

a. Schools will estimate the amount needed to meet match requirements based on their anticipated monthly billings. (3-17-22)

b. School districts and charter schoolsProviders will send the Department the matching funds, either by check or automated clearing house (ACH) electronic funds transfers. (3-17-22)( )

c. The Department will hold matching funds in an interest-bearing trust account. The average daily balance during a month must exceed one hundred dollars ($100) in order to receive interest for that month. (3-17-22)

d. The payments to the districts will include both the federal and non-federal share (matching funds). (3-17-22)

e. Matching fund payments must be received and posted in advance of the weekly Medicaid payment cycle. (3-17-22)

f. If sufficient matching funds are not received in advance, all Medicaid payments to the school district will be suspended and the school district will be notified of the shortage. Once sufficient matching funds are received, suspended payments will be processed and reimbursement will be made during the next payment cycle. (3-17-22)

g. The Department will provide the school districts a monthly statement that will show the matching amounts received, interest earned, total claims paid, the matching funds used for the paid claims, and the balance of their funds in the trust account. (3-17-22)

h. The school districts will estimate the amount of their next billing and the amount of matching funds needed to pay the Department. (3-17-22)

i. The estimated match requirement may be adjusted up or down based on the remaining balance held in the trust account. (3-17-22)

857. SCHOOL-BASED SERVICE: QUALITY ASSURANCE AND IMPROVEMENT.
The provider will grant the Department immediate access to all information required to review compliance with these rules. (3-17-22)

01. Quality Assurance. Quality Assurance consists of reviews to assure compliance with the Department's rules and regulations. If problems are identified during the review, the provider must implement a corrective action plan within forty-five (45) days after the results are received. The Department will work with the school to answer questions and provide clear direction regarding the corrective action plan. (3-17-22)

02. Quality Improvement. The Department may gather and utilize information from providers to evaluate student satisfaction, outcomes monitoring, quality assurance, quality improvement activities, and health and safety. These findings may lead to quality improvement activities to improve provider processes and outcomes for the students. (3-17-22)

858. -- 859. (RESERVED)

SUB AREA: MEDICAL TRANSPORTATION SERVICES
(Sections 860-879)

860. (RESERVED)

861. EMERGENCY TRANSPORTATION SERVICES: PARTICIPANT ELIGIBILITY.
Ambulance services are medically necessary when an emergency condition exists. For purposes of reimbursement, an emergency condition exists when a participant manifests acute symptoms or signs, or both, which, by reasonable medical judgment of the Department, represent a condition of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in death, serious impairment of a bodily function or major organ, or serious jeopardy to the overall health of the participant. If such condition exists, and treatment is required at the participant's location, or transport of the participant for treatment in another location by ambulance is the only appropriate mode of travel, the Department will review such claims and consider authorization for emergency ambulance services. (3-17-22)

862. EMERGENCY TRANSPORTATION SERVICES: COVERAGE AND LIMITATIONS.

~~**01. Prior Authorization**. Medically necessary ambulance services are reimbursable in emergency situations or when prior authorization has been obtained from the Department. (3-17-22)~~

02~~1~~. Local Transport Only. Only local transportation by ambulance is covered. In exceptional situations where the ambulance transportation originates beyond the locality to which the participant was transported, payment may be made for such services only if the evidence clearly establishes that such institution is the nearest one with appropriate facilities and the service is authorized by the Department. (3-17-22)

03~~2~~. Air Ambulance Service. In some areas, transportation by airplane or helicopter may qualify as ambulance services. Air ambulance services are covered only when: (3-17-22)

a. The point of pickup is inaccessible by land vehicle; or (3-17-22)

b. Great distances or other obstacles are involved in getting the participant to the nearest appropriate facility and speedy admission is essential; and (3-17-22)

c. Air ambulance service will be covered where the participant's condition and other circumstances necessitate the use of this type of transportation; however, where land ambulance service will suffice, payment will be based on the amount payable for land ambulance, or the lowest cost. (3-17-22)

04~~3~~. Co-Payments. When the Department determines that the participant did not require emergency transportation, the provider can bill the participant for the co-payment amount as described in IDAPA 16.03.18, "Medicaid Cost-Sharing." (3-17-22)

863. EMERGENCY TRANSPORTATION SERVICES: PROCEDURAL REQUIREMENTS.

01. Services Subject to Review. Ambulance services are subject to review by the Department prior to the service being rendered, and on a retrospective basis. Ambulance service review is governed by provisions of the Transportation Policies and Procedures Manual as amended. ~~(3-17-22)~~( )

02. Non-Emergency Transport Prior Authorization Required. If an emergency does not exist, prior written authorization to transport by ambulance must be secured from the Department. (3-17-22)

03. Air Ambulance. Air ambulance services must be approved in advance by the Department, except in emergency situations. Emergency air ambulance services will be authorized by the Department on a retrospective basis. (3-17-22)

864. EMERGENCY TRANSPORTATION SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Medically Necessary. For purposes of reimbursement, in non-emergency situations, the provider must provide justification to the Department that ~~travel by ambulance is medically necessary due to the medical condition of the participant, and that~~ any other mode of travel would, by reasonable medical judgment of the Department, result in death, serious impairment of a bodily function or major organ, or serious jeopardy to the overall health of the participant. ~~(3-17-22)~~( )

02. Licensure Required. All Emergency Medical Services (EMS) Providers that provide services to Medicaid participants in Idaho must hold a current license issued by the Emergency Medical Services Bureau of the Department in accordance with IDAPA 16.01.03, "Emergency Medical Services (EMS) Agency Licensing Requirements," and IDAPA 16.01.07, "Emergency Medical Services (EMS) Personnel Licensing Requirements." Ambulances based outside the state of Idaho must hold a current license issued by their states' EMS licensing authority when the transport is initiated outside the state of Idaho. Payment will not be made to ambulances that do not hold a current license. (3-17-22)

~~**03. Usual Charges**. Ambulance services providers cannot charge Medicaid participants more than is charged to the general public for the same service.~~ ~~(3-17-22)~~

043. Air Ambulance. The operator of the air service must bill the air ambulance service rather than the hospital or other facility receiving the participant. (3-17-22)

865. EMERGENCY TRANSPORTATION SERVICES: PROVIDER REIMBURSEMENT.

~~**01. Scope of Coverage and General Requirements for Ambulance Services**. Ambulance service review is governed by provisions of the Transportation Policies and Procedures Manual as amended.~~ If ~~such~~ an ambulance service review identifies that a~~n ambulance~~ service is not covered, then no ~~Medicaid~~ payment will be made ~~for the ambulance service~~. Reimbursement ~~for ambulance services~~ originally denied by the Department will be made if such decision is reversed by the appeals process ~~required in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings."~~ Payment for ambulance services is subject to the following ~~limitations~~: ~~(3-17-22)~~( )

021. Ambulance Reimbursement Base Rate. ~~(3-17-22)~~( )

a. The base rate for ambulance services includes customary patient care equipment and items such as stretchers, clean linens, reusable devices and equipment. The base rate also includes nonreusable items, and disposable supplies such as oxygen, triangular bandages and dressings that may be required for the care of the participant during transport. In addition to the base rate, the Department will reimburse mileage. (3-17-22)

~~**b.** Charges for extra attendants are not covered except for justified situations and must be authorized by the Department.~~ ~~(3-17-22)~~

~~**c.** If a physician is in attendance during transport, they are responsible for the billing of their services.~~ ~~(3-17-22)~~

~~**d.** Reimbursement for waiting time will not be considered unless documentation submitted to the Department identifies the length of the waiting time and establishes its medical necessity or indicates that it was physician ordered. Limited waiting time will be allowed for round trips.~~ ~~(3-17-22)~~

~~e~~**b.** Ambulance units are licensed by the EMS Bureau of the Department, or other states' EMS licensing authority according to the level of training and expertise its personnel maintain. At least this level of personnel is required to be in the patient compartment of the vehicle for every ambulance trip. The Department will reimburse a base rate according to the following: (3-17-22)

i. The level of personnel required to be in the patient compartment of the ambulance; (3-17-22)

ii. The level of ambulance license the unit has been issued; and (3-17-22)

iii. The level of life support authorized by the Department. (3-17-22)

~~f~~**c.** Units with Emergency Medical Technician - Basic (EMT-B) or equivalent personnel in the patient compartment of the vehicle will be reimbursed up to the Basic Life Support (BLS) rate. Units with Advanced Emergency Medical Technician-Ambulance (AEMT-A) or equivalent personnel in the patient compartment of the vehicle will be reimbursed up to the Advanced Life Support, Level I (ALSI) rate. Units with Emergency Medical Technician - Paramedic (EMT-P) or equivalent personnel in the patient compartment of the vehicle will be reimbursed up to the Advanced Life Support, Level II (ALSII) rate. When a participant's condition requires hospital-to-hospital transport with ongoing care that must be furnished by one (1) or more health care professionals in an appropriate specialty area, including emergency or critical care nursing, emergency medicine, or a paramedic with additional training, Specialty Care Transport (SCT) may be authorized by the Department. (3-17-22)

~~g~~**02. Multiple Providers**. If multiple licensed EMS providers are involved in the transport of a participant, only ~~the ambulance~~ provider~~s~~ who ~~actually~~ transport~~s~~ the participant will be reimbursed for ~~the~~ services. ~~(3-17-22)~~( )

~~i~~**a.** In situations where personnel and equipment from a licensed ALSII provider boards an ALSI or BLS ambulance, the transporting ambulance may bill for ALSII services as authorized by the Department. (3-17-22)

~~ii~~**b.** In situations where personnel and equipment from a licensed ALSI provider boards an ALSII or BLS ambulance, the transporting ambulance may bill for ALSI services as authorized by the Department. (3-17-22)

~~iii~~**c.** In situations where medical personnel and equipment from a medical facility are present during the transport of the participant, the transporting ambulance may bill at the ALSI or ALSII level of service. The transporting provider must arrange to pay the other provider for their services. ~~The only exception to the preceding policy is in situations where medical personnel employed by a licensed air ambulance provider boards an ALSI, ALSII, or BLS ground ambulance at some point, and the air ambulance medical personnel also accompany and treat the participant during the air ambulance trip. In this situation, the air ambulance provider may bill the appropriate base rate for the air ambulance trip, and may also bill the charges associated with their medical personnel and equipment as authorized by the Department.~~ ~~(3-17-22)~~( )

~~iv. The ground ambulance provider may also bill for their part of the trip as authorized by the Department.~~ ~~(3-17-22)~~

~~h~~**d.** If multiple licensed EMS providers transport a participant for different legs of a trip, each provider must bill their base rate and mileage~~, as authorized by the Department~~. ~~(3-17-22)~~( )

~~i. If a licensed transporting EMS provider responds to an emergency situation and treats the participant, but does not transport the participant, the Department may reimburse for the treat and release service. The Department will reimburse the appropriate base rate. This service requires authorization from the Department, usually on a retrospective basis.~~ ~~(3-17-22)~~

e. Charges for extra attendants are not covered except for justified situations and must be authorized by the Department. ( )

f. If a physician is in attendance during transport, they are responsible for the billing of their services. ( )

03. Monthly Trips and Standby. ( )

~~j~~**a.** If an ambulance ~~vehicle and crew have~~ return~~ed~~s to a base station after having transported a participant to a facility and the participant's ~~physician~~ provider orders the participant to be transferred from this facility to another facility because of medical need, two (2) base rate charges, in addition to the mileage, will be considered for reimbursement. If an ambulance vehicle and crew do not return to a base station and the patient is transferred from one (1) facility to another facility, charges for only one (1) base rate, waiting time, and mileage will be considered. ~~(3-17-22)~~( )

~~k~~**b.** Round trip charges will be allowed only in circumstances when a facility in-patient is transported to another facility to obtain specialized services not available in the facility in which the participant is an in-patient. The

transport must be to and from a facility that is the nearest one with the specialized services. (3-17-22)

c. Reimbursement for waiting time will not be considered unless documentation submitted to the Department identifies the length of the waiting time and established its medical necessity or indicates that it was physician ordered. Limited waiting time will be allowed for round trips. ( )

04. Treat and Release. The Department may reimburse the EMS provider at the appropriate base rate if they respond to an emergency situation, and treat and release the participant without transport. ( )

~~I~~**05. Response and Evaluation**. ~~If a licensed transporting EMS provider responds to a participant's location and upon examination and evaluation of the participant, finds that their condition is such that no treatment or transport is necessary, the Department will pay for the response and evaluation service. This service requires authorization by the Department, usually on a retrospective basis.~~The Department may reimburse the EMS provider if they respond to a participant's location, and no treatment or transport is necessary. No payment will be made if the EMS provider responds and no evaluation is done, or the participant has left the scene. No payment will be made to an EMS provider who is licensed as a non-transporting provider. ~~(3-17-22)~~( )

866. -- 869. (RESERVED)

870. NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES: DEFINITIONS.
For the purposes of Sections 870 through 879 of these rules, the following definitions apply. (3-17-22)

01. Contracted Transportation Provider. A non-emergency medical transportation provider who is under contract with the transportation broker to provide non-emergency medical transportation for Medicaid participants. (3-17-22)

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. (3-17-22)

03. Non-Emergency Medical Transportation. Non-emergency medical transportation is transportation that is: (3-17-22)

a. Not of an emergency nature; and (3-17-22)

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. ~~(3-17-22)~~( )

04. Transportation Broker. An entity under contract with the Department to administer, coordinate, and manage a statewide network of non-emergency medical transportation providers. (3-17-22)

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. (3-17-22)

871. NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES: DUTIES OF THE TRANSPORTATION BROKER.
The transportation broker under contract with the Department is required to: (3-17-22)

01. Coordinate and Manage. Coordinate and manage all non-emergency medical transportation services for Medicaid participants statewide. (3-17-22)

02. Contract With Transportation Providers. Contract with transportation providers throughout the state to provide non-emergency medical transportation services for Medicaid participants. (3-17-22)

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. (3-17-22)

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. (3-17-22)

05. Reimburse Contracted Transportation Providers. Reimburse contracted transportation providers for non-emergency medical transportation services meeting the requirements in Section 872 of these rules. (3-17-22)

06. Safe and Professional Transportation. Assure that contracted transportation providers deliver non-emergency medical transportation services in a safe and professional manner. (3-17-22)

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

01. Non-Emergency Medical Transportation Services. The transportation broker will reimburse contracted transportation providers for non-emergency medical transportation services under the following conditions: (3-17-22)

a. The travel is essential to get to or from a ~~medically necessary Medicaid~~ covered service; ~~(3-17-22)~~( )

b. The mode of transportation is the least costly that is appropriate for the medical needs of the participant; (3-17-22)

c. The transportation is to the nearest medical provider appropriate to perform the needed services, and transportation is by the most direct route practicable; (3-17-22)

d. Other modes of transportation, including personal vehicle, assistance by family, friends, and charitable organizations, are unavailable or impractical under the circumstances; (3-17-22)

e. The travel is authorized and scheduled by the transportation broker; and (3-17-22)

f. The contracted transportation provider is in compliance with the terms of its contract with the transportation broker. (3-17-22)

02. Travel-Related Services. The transportation broker will reimburse a contracted transportation provider for travel-related services under the following circumstances: (3-17-22)

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. (3-17-22)

b. The reasonable cost for lodging actually incurred for the participant will be reimbursed when: (3-17-22)

i. The round trip and the needed medical service cannot be completed in the same day; and (3-17-22)

ii. No less costly alternative is available. (3-17-22)

c. The reasonable cost of wages for an attendant will be reimbursed when: (3-17-22)

i. An attendant is medically necessary or when the vulnerability of the participant requires accompaniment for safety; and (3-17-22)

ii. No family member or other unpaid attendant is available to accompany the participant. (3-17-22)

d. The reasonable cost of meals actually incurred in transit will be reimbursed for one (1) family

member or one (1) attendant, when: (3-17-22)

i. Attendant care is medically necessary or when the vulnerability of the participant requires accompaniment for safety; and (3-17-22)

ii. There is no other practical means of obtaining food. (3-17-22)

e. The reasonable cost of lodging actually incurred will be reimbursed for one (1) family member or one (1) attendant when: (3-17-22)

i. An overnight stay is required to receive the service; (3-17-22)

ii. It is medically necessary or the vulnerability of the participant requires accompaniment for safety; and (3-17-22)

iii. No less costly alternative is available. (3-17-22)

873. NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES: REIMBURSEMENT METHODOLOGY.
The Department will reimburse the ~~NEMT services~~ transportation broker a fixed, actuarially sound amount per member per month based on the cost of efficiently delivered, timely, and safe non-emergency medical transportation for eligible Idaho Medicaid participants and the cost for efficient administration of the brokerage program.
~~(3-17-22)~~( )

874. -- 879. (RESERVED)

SUB AREA: EPSDT SERVICES
(Sections 880-889)

880. EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SERVICES: DEFINITION.
Medically necessary services for eligible Medicaid participants under the age of twenty-one (21) are health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act (SSA) necessary to correct or ameliorate defects, physical and mental illness, and conditions discovered by the screening services as defined in Section 1905(r) of the SSA, whether or not such services are covered under the State Plan. Services must be considered safe, effective, and meet acceptable standards of medical practice. (3-17-22)

881. EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES: PARTICIPANT ELIGIBILITY.
EPSDT services are available to ~~child~~ participants from birth through the month of their twenty-first birthday.
~~(3-17-22)~~( )

882. EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES: COVERAGE AND LIMITATIONS.

01. Additional Services. Any service required as a result of an EPSDT screen and which is currently covered under the scope of the Idaho Medicaid program will not be subject to the existing amount, scope, and duration, but must meet any applicable Department criteria and will be subject to the authorization requirements of those rules.
~~(3-17-22)~~( )

02. Medically Necessary. The need for additional services must be documented by the attending physician as medically necessary. (3-17-22)

03. Prior Authorization. Any service requested, that is covered under Title XIX or Title XXI of the Social Security Act, that is not identified in these rules specifically as a Medicaid-covered service will require prior authorization prior to payment for that service. (3-17-22)

~~**04. Services Not Covered**. The Department will not cover services for cosmetic, convenience, or comfort reasons.~~ ~~(3-17-22)~~

054. Hearing Aids Under EPSDT. (3-17-22)

a. When binaural aids are requested they will be authorized if documented to the Department's satisfaction, that the child's ability to learn would be severely restricted. (3-17-22)

b. When replacement hearing aids are requested, they may be authorized if the requirements in Subsections 742.01.a., 742.01.b., and 742.03 are met. (3-17-22)

~~**c.** The Department will purchase additional ear molds after the initial six (6) months to one (1) year period if medically necessary. Requests in excess of every six (6) months will require prior authorization and documentation of medical need from either the attending physician or audiologist.~~ ~~(3-17-22)~~

065. Eyeglasses Under EPSDT. (3-17-22)

a. In the case of a major visual change, the Department can authorize purchase of a second pair of eyeglasses and can authorize a second eye examination to determine that visual change. (3-17-22)

b. The Department may pay for replacement of lost glasses or replacement of broken frames or lenses. New frames will not be purchased if the broken frame can be repaired for less than the cost of new frames if the provider indicates one (1) of these reasons on their claim. If repair costs are greater than the cost of new frames, new frames may be authorized. (3-17-22)

883. -- 889. (RESERVED)

SUB AREA: SPECIFIC PREGNANCY-RELATED SERVICES
(Sections 890-899)

890. PREGNANCY-RELATED SERVICES: DEFINITIONS.

01. Individual and Family Social Services. Services directed at helping a participant to overcome social or behavioral problems that may adversely affect the outcome of the pregnancy. (3-17-22)

02. Maternity Nursing Visit. Office visits by a licensed registered nurse, acting within the limits of the Nurses Practices Act, for the purpose of checking the progress of the pregnancy. (3-17-22)

03. Nursing Services. Home visits by a licensed registered nurse to assess the participant's living situation and provide appropriate education and referral during the covered period. (3-17-22)

04. Nutritional Services. Nutritional services are described in Sections 630 through 635 of these rules. (3-17-22)

05. Risk Reduction Follow-Up. Services to assist the participant in obtaining medical, educational, social and other services necessary to assure a positive pregnancy outcome. (3-17-22)

891. (RESERVED)

892. PREGNANCY-RELATED SERVICES: COVERAGE AND LIMITATIONS.
When ordered by the participant's attending ~~physician or licensed practitioner of the healing arts~~ provider, payment of the following services is available after confirmation of pregnancy and extending through the end of the month in which the sixtieth day following delivery occurs. ~~(3-17-22)~~( )

01. Individual and Family Social Services. Limited to two (2) visits during the covered period. (3-17-22)

02. Maternity Nursing Visit. These services are only available to women unable to obtain a ~~physician or licensed practitioner of the healing arts~~ provider to provide prenatal care. This service is to end immediately when a primary physician is found. A maximum of nine (9) visits can be authorized. ~~(7-1-24)~~( )

03. Nursing Services. Limited to two (2) visits during the covered period. (3-17-22)

04. Nutrition Services. As described in Sections 630 through 632 of these rules. (7-1-24)

05. Qualified Provider Risk Assessment and Plan of Care. When prior authorized by the Department, payment is made for qualified provider services in completion of a standard risk assessment and plan of care for women unable to obtain a primary care ~~physician, nurse practitioner, or nurse midwife~~ provider for the provision of antepartum care. ~~(3-17-22)~~( )

06. Risk Reduction Follow-Up. (7-1-24)

893. ~~PREGNANCY-RELATED SERVICES: PROCEDURAL REQUIREMENTS.~~(RESERVED)
~~Pregnancy related services described in Sections 890 through 892 of these rules must be prior authorized by the Department.~~ ~~(3-17-22)~~

894. PREGNANCY-RELATED SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Covered ~~S~~services ~~must be~~ are: ~~(3-17-22)~~( )

01. Risk Reduction Follow-Up. Provided by a licensed social worker, RN, nurse midwife, physician, NP, or PA either in independent practice or as employees of entities that have current provider agreements with the Department. (7-1-24)

02. Individual and Family Social Services. Provided by a licensed social worker qualified to provide individual counseling (7-1-24)

895. PREGNANCY-RELATED SERVICES: PROVIDER REIMBURSEMENT.

~~**01. Rates**. Rate of payment for pregnancy related services is established under the provisions of Section 230 of these rules.~~ ~~(3-17-22)~~

~~**02. Risk Reduction Followup Services**.~~ A single payment will be made for each month of risk reduction follow-up service~~s~~ provided. ~~(3-17-22)~~( )

896. -- 899. (RESERVED)

INVESTIGATIONS, AUDITS, AND ENFORCEMENT
(Sections 900 - 999)

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

900. LIENS AND ESTATE RECOVERY.
In accordance with Sections 55-819, 56-218, 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, the filing of liens against the property of permanently institutionalized participants, and the recording of requests for notice. (3-17-22)

01. Medical Assistance Incorrectly Paid. The Department may, in accordance with 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. (3-17-22)

~~**02. Administrative Appeals**. Permanent institutionalization determination, undue hardship waiver, and request for notice hearings are governed by the fair hearing provisions of IDAPA 16.05.03, "Contested Case~~

~~Proceedings and Declaratory Rulings."~~ ~~(3-17-22)~~

901. LIENS AND ESTATE RECOVERY: DEFINITIONS.
The following terms are applicable to Sections 900 through 909 of these rules: (3-17-22)

01. Adequate Consideration. An act, object, services, or other benefit which has a tangible and/or intrinsic value that is equivalent to or greater than the fair market value of the transferred asset. ( )

0~~1~~2. 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. ~~(3-17-22)~~( )

0~~2~~3. Discharge From a Medical Institution. A medical decision made by a competent~~ medical professional~~ provider that the Medicaid participant no longer needs nursing home care because the participant's condition has improved, or the discharge is not medically contraindicated. ~~(3-17-22)~~( )

~~**03. Equity Interest in a Home**. Any equity interest in real property recognized under Idaho law. (3-17-22)~~

~~**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. (3-17-22)~~

0~~5~~4. Home. The dwelling in which the participant has an ownership interest, and which the participant occupied as their primary dwelling prior to, or subsequent to, their admission to a medical institution. (3-17-22)

0~~6~~5. Institutionalized Participant. An inpatient in a nursing facility (NF), intermediate care facility for people with intellectual disabilities (ICF/IID), or other medical institution, who is a Medicaid participant subject to post-eligibility treatment of income in IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind and Disabled (AABD)." (3-17-22)

0~~7~~6. Lawfully Residing. Residing in a manner not contrary to or forbidden by law, and with the participant's knowledge and consent. (3-17-22)

0~~8~~7. 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~~ provider that the participant is physically able to leave the institution and return to live at home. ~~(3-17-22)~~( )

0~~9~~8. Personal Property. Any property that is not real property, including cash, jewelry, household goods, tools, life insurance policies, boats, and wheeled vehicles. ~~(3-17-22)~~( )

~~1~~09. Real Property. Any land, including buildings or immovable objects attached permanently to the land. (3-17-22)

1~~1~~0. Residing in the Home on a Continuous Basis. Occupying~~ the home as the primary dwelling~~ and continuing to occupy~~ such dwelling~~ the home as the primary residence. ~~(3-17-22)~~( )

1~~2~~1. Termination of a Lien. The release or dissolution of a lien from property. (3-17-22)

1~~3~~2. Undue Hardship. Conditions that justify waiver or deferral of all or a part of the Department's claim against an estate, described in Subsections 905.06 through 905.10 of these rules. ~~(3-17-22)~~( )

1~~4~~3. 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. (3-17-22)

902. LIENS AND ESTATE RECOVERY - NOTIFICATION TO DEPARTMENT.
All notification regarding liens, estate claims, and requests for notice must be directed to the Department of Health and Welfare, Estate Recovery Unit, 450 W. State Street, 6th Floor, Boise, Idaho 83702. (3-17-22)

903. LIENS AND ESTATE RECOVERY: LIEN DURING LIFETIME OF PARTICIPANT.

01. Lien Imposed During Lifetime of Participant. During the lifetime of the permanently institutionalized participant, and subject to the restrictions set forth in Subsection 903.04 of this rule, the Department may impose a lien against the real property of the participant for medical assistance correctly paid on their 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. ~~(3-17-22)~~( )

02. 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 they are reasonably expected to be discharged to return home. The following factors must be considered when making the determination of permanent institutionalization: (3-17-22)

a. The participant must meet the criteria for nursing facility or ICF/IID 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; (3-17-22)

b. The medical records must be reviewed to determine if the participant's condition is expected to improve to the extent that they will not require nursing facility or ICF/IID level of care; and (3-17-22)

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. (3-17-22)

03. Notice of Determination of Permanent Institutionalization and Hearing Rights. The Department must notify the participant or their authorized representative, in writing, of its intention to make a determination that the participant is permanently institutionalized, and that they have the right to a fair hearing in accordance with Subsection 900.02 of these rules. This notice must inform the participant of the following information, at a minimum: (3-17-22)

a. The Department's decision that they 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 them from returning home with services necessary to support nursing facility or ICF/IID level of care; and (3-17-22)

b. They or their authorized representative may request a fair hearing prior to the Department's final determination that they are 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. (3-17-22)

c. If they or their authorized representative does not request a fair hearing within the time limits specified, their real property, including their home, may be subject to a lien, contingent upon the restrictions in Subsection 903.04 of this rule. (3-17-22)

04. 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: (3-17-22)

a. The spouse of the participant; (3-17-22)

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 (3-17-22)

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. (3-17-22)

05. 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: (3-17-22)

a. The participant has no surviving child who is under age twenty-one (21); (3-17-22)

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 (3-17-22)

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: (3-17-22)

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 (3-17-22)

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 they provided necessary care to the participant, and the care they provided allowed the participant to remain at home rather than in a medical institution. (3-17-22)

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 903.05 of this rule. 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 904.01 of these rules. ~~(3-17-22)~~( )

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: (3-17-22)

a. The name and last known address of the participant; and (3-17-22)

b. The name and address of the official or agent of the Department filing the lien; and (3-17-22)

c. A brief description of the medical assistance received by the participant; and (3-17-22)

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. (3-17-22)

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 903.07 of this rule, or as required by Idaho law. (3-17-22)

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 Sections 904 and 905 of these rules. (3-17-22)

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: (3-17-22)

a. The costs of all medical assistance correctly paid on or after July 1, 1995, on behalf of a participant who was permanently institutionalized; and ~~(3-17-22)~~( )

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~~. ~~(3-17-22)~~( )

~~**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.~~ ~~(3-17-22)~~

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. (3-17-22)

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. (3-17-22)

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. (3-17-22)

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 they had an ownership interest, including the following: ~~(3-17-22)~~( )

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. (3-17-22)

b. The deceased participant's ownership interest in another person's estate, probated or not probated, is an asset of their estate when: ~~(3-17-22)~~( )

i. Documents show the deceased participant is an eligible devisee or donee of property of another deceased person; or (3-17-22)

ii. The deceased participant received income from property of another person; or (3-17-22)

iii. State intestacy laws award the deceased participant a share in the distribution of the property of another estate. (3-17-22)

c. Any trust instrument that 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. (3-17-22)

d. Life insurance is considered an asset when it has reverted to the estate. (3-17-22)

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. (3-17-22)

f. Checking and savings accounts that hold and accumulate funds designated for the deceased participant are assets of the estate, including joint accounts that accumulate funds for the benefit of the participant. (3-17-22)

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 their 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. (3-17-22)

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.~~ ~~(3-17-22)~~( )

06. Value of Estate Assets. The Department will use fair market value as the value of the estate assets. (3-17-22)

905. LIENS AND ESTATE RECOVERY: LIMITATIONS AND EXCLUSIONS.

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 903.05 of these rules.~~ No recovery will be made if the participant received medical assistance as the result of a crime committed against the participant. ~~(3-17-22)~~( )

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: (3-17-22)

a. ~~Burial~~Funeral 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~~ reasonably necessary for burial or cremation services approved on a case by case basis at the discretion of the Department. ~~(3-17-22)~~( )

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~~Administrative expenses of the estate may be deducted in accordance with Section 56-218, Idaho Code. ~~(3-17-22)~~( )

03. Interest on Claim. The Department's claim does not bear interest ~~except as otherwise provided by statute or agreement~~ until the claim becomes recoverable. Interest on the claim accrues at the legal rate of interest. ~~(3-17-22)~~( )

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. (3-17-22)

05. Certain Life Estates. The value of a life estate owned by a Medicaid participant or their spouse will not be subject to estate recovery if: (3-17-22)

a. Neither the Medicaid participant or their spouse ever owned the remainder interest; or (3-17-22)

b. The life estate was created prior to July 1, 1995. (3-17-22)

06. Marriage Settlement Agreement or Other Such Agreement. A marriage settlement agreement

or other such agreement that 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. (3-17-22)

~~**07. 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:~~ ~~(3-17-22)~~

~~**a.** When an undue hardship waiver as defined in Subsection 905.07 of this rule has been granted; or~~ ~~(3-17-22)~~

~~**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.~~ ~~(3-17-22)~~

0~~8~~7. **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. (3-17-22)

0~~9~~8. **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. (3-17-22)

~~1~~09. **Basis for Undue Hardship Waiver**. Undue hardship waivers will be considered in the following circumstances: (3-17-22)

a. The estate subject to recovery is income-producing property that provides the ~~primary~~ sole source of support for ~~other family members~~ heirs; or ~~(3-17-22)~~( )

b. Payment of the Department's claim would cause heirs of the deceased participant to be eligible for public assistance; or (3-17-22)

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. (3-17-22)

~~**d.** The participant received medical assistance as the result of a crime committed against the participant.~~ ~~(3-17-22)~~

1~~1~~0. **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 or deferred by the Department, partially or fully, because of undue hardship. An undue hardship does not exist if action taken by the participant prior to their death, or by their 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. ~~(3-17-22)~~( )

1~~2~~1. **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. (3-17-22)

906. LIENS AND ESTATE RECOVERY: REQUEST FOR NOTICE.

01. ~~**Request for Notice —**~~**Notice - Hearing**. The Department must notify the participant or their authorized representative, in writing, of its intention to record a request for notice, and that they have 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~~: ~~(3-17-22)~~( )

a. The Department's determination that they are the record titleholder or purchaser under a land sale contract of real property subject to a request for notice; (3-17-22)

b. They or their 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 (3-17-22)

c. If they or their authorized representative do not request a fair hearing within the time limits specified, a request for notice applying to their real property, including their home, may be recorded. (3-17-22)

02. ~~Request for Notice —~~ Forms - Content. The notices must include~~, at a minimum,~~ the following information: ~~(3-17-22)~~( )

a. The name of the public assistance recipient and the spouse of such public assistance recipient, if any; (3-17-22)

b. The Medicaid number for the public assistance recipient and spouse, if any; (3-17-22)

c. The legal description of the real property affected or to be affected; (3-17-22)

d. The mailing address at which the Department is to receive notice as provided in Section 902 of these rules; (3-17-22)

e. If the document is a Notice of Transfer or Encumbrance, the name and address of the transferee or lien holder; and (3-17-22)

f. A fully executed acknowledgment as required for recording under Section 55-805, Idaho Code. (3-17-22)

03. Webpages for Forms. The forms may be found at: (3-17-22)

a. Notice of Transfer or Encumbrance at http://healthandwelfare.idaho.gov. (3-17-22)

b. Request for Notice at http://healthandwelfare.idaho.gov. (3-17-22)

c. Termination of Request for Notice at http://healthandwelfare.idaho.gov. (3-17-22)

907. -- 909. (RESERVED)

SUB AREA: PARTICIPANT LOCK-IN
(Sections 910 - 918)

910. PARTICIPANT UTILIZATION CONTROL PROGRAM.
This Program is ~~designed~~ to promote improved and cost-efficient medical management of essential health care by monitoring participant activities and taking action to correct abuses. Participants demonstrating unreasonable patterns of utilization or exceeding reasonable levels of utilization~~, or both,~~ will be reviewed for restriction. The Department may require a participant to designate a primary ~~physician~~ provider or a single pharmacy ~~or both~~ for exclusive provider services in an effort to protect the individual's health and safety, provide continuity of medical care, avoid duplication of services by providers, avoid inappropriate or unnecessary utilization of medical assistance~~, and avoid excessive utilization of prescription medications~~. ~~(3-17-22)~~( )

911. LOCK-IN DEFINED.
Lock-in is the process of restricting the access of a participant to a specific provider or providers. (3-17-22)

912. DEPARTMENT EVALUATION FOR LOCK-IN.
The Department will ~~review participants to~~ determine if services are being utilized at a frequency or amount that ~~results in a level of utilization or a pattern of services that~~ is not medically necessary. Evaluation~~s of utilization~~

~~patterns~~ can include review ~~by the Department staff~~ of medical records or computerized reports~~, or both, generated by the Department~~ reflecting claims ~~submitted for physician visits, drugs/prescriptions, outpatient and emergency room visits, lab or diagnostic procedures, or both, hospital admissions, and referrals~~. ~~(3-17-22)~~( )

913. CRITERIA FOR LOCK-IN.
~~Since it is impossible to identify all possible patterns of over utilization, and since a particular pattern may be justified based on individual conditions,~~There is no specific criteria for lock-in ~~will be developed~~ as each case is unique. ~~However, t~~The Department may develop non-binding guidelines for purposes of uniformity. ~~The guidelines will not be binding on the Department and will not limit or restrict the ability of the Department to impose lock-in when any pattern of over utilization is identified.~~ The following utilization patterns may be considered abusive, not medically necessary, potentially endangering the participant's health and safety, or over utilization of Medicaid services, and may result in the restriction of Medicaid reimbursement for a participant to a single provider or providers:
~~(3-17-22)~~( )

01. Unnecessary Use of Providers or Services, Including Excessive Provider Visits. ~~Unnecessary use of providers or Medicaid services, including excessive provider visits.~~ ~~(3-17-22)~~( )

02. Demonstrated Abusive Patterns. Recommendation from a ~~medical professional or the participant's primary care physician~~ provider that the participant has demonstrated abusive patterns and would benefit from the lock-in program. ~~(3-17-22)~~( )

03. Use of Emergency Room ~~Facilities~~. Frequent use of emergency room ~~facilities~~ for non-emergent conditions. ~~(3-17-22)~~( )

04. Multiple Providers. ~~Use of multiple providers.~~ ~~(3-17-22)~~( )

05. Controlled Substances. ~~Use of multiple controlled substances.~~ ~~(3-17-22)~~( )

06. Use of Multiple Prescribing ~~Physicians~~ Providers or Pharmacies. ~~Use of multiple prescribing physicians or pharmacies, or both.~~ ~~(3-17-22)~~( )

07. Overlapping Prescription Drugs ~~and~~ With the Same Therapeutic Classes. ~~Overlapping prescription drugs with the same therapeutic class.~~ ~~(3-17-22)~~( )

08. Drug Abuse. ~~Diagnosis of drug abuse or drug withdrawal, or both.~~ ~~(3-17-22)~~( )

09. Drug-Seeking Behavior. ~~Drug-seeking behavior a~~As identified by a ~~medical professional~~ provider. ~~(3-17-22)~~( )

10. Other Abusive Utilization. ~~Use of drugs or other Medicaid services determined to be abusive~~ As determined by the Department's medical or pharmacy consultant. ~~(3-17-22)~~( )

914. LOCK-IN PARTICIPANT NOTIFICATION.
A participant ~~who has been~~ designated by the Department for the Participant Utilization Control Program will be notified in writing by the Department of the action and the participant's right of appeal by means of a fair hearing.
~~(3-17-22)~~( )

915. LOCK-IN PROCEDURES.

01. Participant Responsibilities. The participant will be given thirty-five (35) days to contact the Regional Program Manager ~~or designee~~ and complete and sign the lock-in agreement form and select designated provider(s) in each area of misuse. ~~(3-17-22)~~( )

02. Appeal Stays Restriction. The Department will not implement the participant restriction if a valid appeal is noted in accordance with Section 917 of these rules. (3-17-22)

03. Lock-In Duration. The Department will restrict participants to their designated providers for a

time period determined by the Department. Upon review at the end of that period, lock-in may be extended for an additional period determined by the Department. (3-17-22)

04. Payment to Providers. Payment to provider~~(s)~~ other than the designated lock-in ~~physician~~ provider or pharmacy is limited to documented emergencies or written referrals from the primary ~~physician~~ provider. ~~(3-17-22)~~( )

05. Regional Programs Manager. The Regional Programs Manager~~, or designee~~ will: ~~(3-17-22)~~( )

a. Clearly describe the participant's appeal rights ~~in accordance with the provisions in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings"~~; ~~(3-17-22)~~( )

b. Specify the effective date and length of the restriction; (3-17-22)

c. Have the participant choose a designated provider or providers; and (3-17-22)

d. Mail the completed lock-in agreement to the Surveillance and Utilization Unit. Upon receipt of the lock-in agreement, the participant's Medicaid services will be immediately restricted to the designated providers. (3-17-22)

916. PENALTIES FOR LOCK-IN NONCOMPLIANCE.
If a participant fails to respond to the notification of medical restriction~~(s)~~, fails to sign the lock-in agreement, or fails to select a primary ~~physician~~ provider within the specified time period, the Medicaid benefits will be restricted to documented emergencies only. If a participant continues to abuse or over-utilize items or services after being identified for lock-in, the Department may terminate medical assistance benefits for a specified period of time as determined by the Department. ~~(3-17-22)~~( )

917. APPEAL OF LOCK-IN.
Department determinations to lock-in a participant may be appealed ~~in accordance with the fair hearings provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings," of the Department~~. ~~(3-17-22)~~( )

918. RECIPIENT EXPLANATION OF MEDICAID BENEFITS (REOMBS).

~~**01. Monthly Surveys**. The Department will conduct monthly surveys of services rendered to medical assistance participants using REOMBs.~~ ~~(3-17-22)~~

0~~2~~1. Participant Response. A ~~medical assistance~~ participant is required to respond to the Department's explanation of medical benefits survey whenever they are aware of discrepancies. ~~(3-17-22)~~( )

0~~3~~2. Participant Unable to Respond. If the participant is unable, because of medical or physical limitations, to respond to the survey personally, then a responsible family member or friend can respond on their behalf. (3-17-22)

~~**04. Medicare-to-Medicaid Cross-Over Claims**. All claims processed through the cross-over system will be subject to these rules. All providers submitting cross-over claims must comply with the terms of their provider agreements.~~ ~~(3-17-22)~~

919. -- 999. (RESERVED)

~~**APPENDIX A**~~

~~**IDAHO MEDICAID HANDICAPPING MALOCCLUSION INDEX**~~

OVERBITE:	**MEASUREMENT/POINTS:**	**SCORE:**
Lower incisors: striking lingual of uppers at incisal	1/3 = 0	
Striking lingual of uppers at middle	1/3 = 1	
Striking lingual of uppers at gingival	1/3 = 2	
OPENBITE: (millimeters) *a,b		
Less than……	2 mm = 0	
	2-4 mm = 1	
	4+ mm = 2	
OVERJET: (millimeters) *a		
Upper……	2-4 mm = 0	
Measure horizontally parallel to occlusal plane.	5-9 mm = 1	
	9+ mm = 2	
Lower……	0-1 mm = 0	
	2 mm = 1	
	3+ mm = 2	
POSTERIOR X-BITE: (teeth) *b		
Number of teeth in x-bite:	0-2 = 0	
	3 = 1	
	4 = 2	
TOOTH DISPLACEMENT: (teeth) *c, d, e		
Number of teeth rotated 45 degrees or displaced 2mm from normal position in arch.	0-2 = 0 3-6 = 1 7+ = 2	
BUCCAL SEGMENT RELATIONSHIP:		
One side distal or mesial ½ cusp	= 0	
Both sides distal or mesial or one side full cusp	= 1	
Both sides full cusp distal or mesial	= 2	

OVERBITE:	MEASUREMENT/POINTS:	SCORE:
		TOTAL SCORE:

Scoring Definitions:

a. Impacted or blocked cuspids are scored 1 open bite and 1 over jet for two teeth. Score 2 for open bite and 2 for over jet for 4 blocked cuspids.

b. Cross bites are scored for the teeth in cross bite, not the teeth in the opposing arch.

c. Missing teeth count as 1, if the space is still present.

d. Do not score teeth that are not fully erupted.

e. Displaced teeth are based on where they are in their respective arch line, not their relationship with the opposing arch.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.13 – CONSUMER-DIRECTED SERVICES

DOCKET NO. 16-0313-2401 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202, Idaho Code, and Sections 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

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

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 4th, 2024, Idaho Administrative Bulletin, Vol. 24-9, pages 303 through 334.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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 will not be a negative fiscal impact exceeding $10,000 to the state by this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at 208-334-5500.

DATED this 26th day of September, 2024.

Alex J. Adams, PharmD, MPH
Director
Idaho Department of Health & Welfare
450 W. State Street, 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5500 phone; (208) 334-6558 fax
Alex.Adams@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 Section 56-202, Idaho Code, and Sections 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

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

VIRTUAL TELECONFERENCE Via WebEx
Tuesday, September 17, 2024 **3:00-4:00pm (MT)**
Join from the meeting link https://idhw.webex.com/idhw/j.php?MTID=m972f893ca3d602dc4789422a7d9645b8 **Join by meeting number** **Meeting number (access code): 2824 593 1654** Meeting password: **afJ7MM3knT8** **Meeting password from phone: 23576635** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

VIRTUAL TELECONFERENCE Via WebEx
Friday, September 20, 2024 **1:00-2:00pm (MT)**
Join from the meeting link https://idhw.webex.com/idhw/j.php?MTID=m5a02962a5e30ebdbeded877a70e4f485 **Join by meeting number** **Meeting number (access code): 2822 493 8845** Meeting password:**24TMmJaWM3a** **Meeting password from phone: 24866529** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

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:

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language.

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:

There is no fiscal impact to the state General Fund or any other funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the May 1, 2024, Idaho Administrative Bulletin, Volume 24-5, pages 202 through 203.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jared Larsen at 208-334-5500.

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 25th, 2024.

DATED this 22nd day of July, 2024.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0313-2401

16.03.13 – CONSUMER-DIRECTED SERVICES

000. LEGAL AUTHORITY.
~~In accordance with~~ Sections 56-202, 56-203, Sections 56-250 through 257, and Sections 56-260 through 56-266, Idaho Code~~, the Idaho Legislature has authorized the Department of Health and Welfare to adopt and enforce rules for the provision of consumer-directed services~~. ~~(3-17-22)~~( )

001. ~~TITLE AND~~ SCOPE.

~~01.~~ ~~Title~~. ~~These rules are titled IDAPA 16.03.13, "Consumer-Directed Services."~~ ~~(3-17-22)~~

~~02.~~ ~~Scope~~. Consumer-Directed Community Supports (CDCS) is a flexible program option for participants eligible for the Children's Home and Community Based Services (HCBS) 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 CDCS option allows the eligible participant to: choose the type and frequency of supports they want, negotiate the rate of payment, and hire the person or agency they prefer to provide those supports. (3-17-22)

~~002. WRITTEN INTERPRETATIONS.~~
~~This agency may have written statements that pertain to the interpretations of the rules of this chapter. These documents are available for public inspection.~~ ~~(3-17-22)~~

00~~3~~2. -- 00~~7~~8. (RESERVED)

~~008. AUDIT, INVESTIGATION AND ENFORCEMENT.~~

~~In addition to any actions specified in these rules, the Department may audit, investigate and take enforcement action under the provisions of IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse, and Misconduct."~~
~~(3-17-22)~~

009. BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Background Check. The ~~fiscal employer agent~~ FEA must verify that each ~~support broker~~ SB and ~~community support worker~~ CSW~~, whose background check has not been waived by the participant,~~ has ~~complied with~~ received a clearance under IDAPA 16.05.06, "Criminal History and Background Checks." ~~When a~~ A participant may choose~~s~~ to waive the background check requirement for a ~~community support worker,~~CSW. ~~the~~ A waiver must be completed under~~in accordance with Section 150 of~~ these rules. ~~(7-1-24)~~( )

02. Availability to Work or Provide Service. Participants may review the completed application and allow the ~~community support worker~~ CSW to provide services on a provisional basis if no disqualifying offenses under IDAPA 16.05.06, "Criminal History and Background Checks," are disclosed. ~~(7-1-24)~~( )

~~**03. Additional Criminal Convictions**. Once clearances have been received, any additional criminal convictions must be immediately reported by the worker to the participant and by the participant to the Department.~~
~~(7-1-24)~~

043. ~~Notice of Pending~~ Additional Convictions, Investigations, or Charges. Once clearances have been received, any additional criminal, adult or child protection convictions, charges or investigations ~~for abuse, neglect or exploitation of any vulnerable adult or child, criminal charges, or substantiated adult protection or child protection complaints~~, must be immediately reported by the worker to the participant and by the participant to the Department. ~~(7-1-24)~~( )

054. Providers Subject to Background Check Requirements. ~~A community support worker,~~ CSWs who ~~has~~ have not had the requirement waived by the participant~~, and a support broker as defined in Section 010 of these rules~~ and SBs. ~~(7-1-24)~~( )

010. DEFINITIONS.

~~**01. Circle of Supports**. People who encourage and care about the participant and provide unpaid supports.~~
~~(3-17-22)~~

021. Community Support Worker (CSW). An individual, agency, or vendor selected and paid by the participant to provide ~~community support worker~~ CSW services. ~~(3-17-22)~~( )

~~**03. Community Support Worker Services**. Community support worker services are those identified supports listed in Section 110 of these rules.~~
~~(3-17-22)~~

042. Consumer-Directed Community Supports (CDCS). A flexible program option for participants eligible for the Children's Home and Community Based Services (HCBS) State Plan Option, and Adult Developmental Disabilities (DD) waiver. ~~For the purposes of this chapter, consumer directed s~~ Supports include ~~Self-Directed Community Supports (~~ SDCS~~)~~ and ~~Family-Directed Community Supports (~~ FDCS program options described in IDAPA 16.03.10. "Medicaid Enhanced Plan Benefits." ~~(3-17-22)~~( )

053. 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~~ HCBS State Plan Option described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ~~(3-17-22)~~( )

064. Financial Management Services (FMS). Services provided by an FEA. ~~fiscal employer agent that include:~~
~~(3-17-22)~~

~~**a.** Financial guidance and support to the participant by tracking individual expenditures and monitoring overall budgets;~~
~~(3-17-22)~~

~~**b.** Performing payroll services; and~~ ~~(3-17-22)~~

~~**c.** Handling billing and employment related documentation responsibilities.~~ ~~(3-17-22)~~( )

0~~7~~5. **Fiscal Employer Agent (FEA)**. An agency that provides ~~financial management services~~ FMS to participants who have chosen the 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).~~ ~~(3-17-22)~~( )

0~~8~~6. **Goods**. Tangible products or merchandise that are authorized on the ~~support and spending plan~~ SSP. ~~(3-17-22)~~( )

0~~9~~7. **Guiding Principles for the CDCS Option**. ~~Consumer-Directed Community Supports is based upon the concept of self-determination and has the following guiding principles:~~ ~~(3-17-22)~~( )

a. Freedom for the participant to make choices and plan their own life; (3-17-22)

b. Authority for the participant to control resources allocated to them to acquire needed supports; (3-17-22)

c. Opportunity for the participant to choose their own supports; (3-17-22)

d. Responsibility for the participant to make choices and take responsibility for the result of those choices; and (3-17-22)

e. Shared responsibility between the participant and their community to help the participant become an involved and contributing member of that community. (3-17-22)

~~1~~08. **Home and Community Based Services (HCBS)**. ~~HCBS are those l~~ Long-term services and supports that assist ~~eligible~~ participants to remain in their home and community. ~~(3-17-22)~~( )

09. Medical Necessity (Medically Necessary). A service or item is medically necessary if: ( )

a. It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; ( )

b. There is no other equally effective course of treatment available or suitable for the participant requesting the service that is more conservative or substantially less costly; and ( )

c. It meets any applicable Department criteria. Services that do not meet criteria require a prior authorization; and ( )

d. Medical services must be: ( )

i. Of a quality that meets professionally recognized standards of health care; and ( )

ii. Substantiated by records including evidence of such medical necessity and quality. ( )

~~**11. Participant**. A person eligible for and enrolled in the Consumer-Directed Services Programs.~~ ~~(3-17-22)~~

1~~2~~0. **Readiness Review**. A review conducted by the Department to ensure that each ~~fiscal employer agent~~ FEA is prepared to enter into and comply with the requirements of the provider agreement and this chapter of rules. ~~(3-17-22)~~( )

11. Restrictive Intervention. Any intervention that is used to restrict the rights or freedom of movement of a person and includes chemical, mechanical, and physical restraints or seclusion. ( )

132. 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." ~~(3-17-22)~~( )

143. Support and Spending Plan (SSP). 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 ~~consumer-directed service~~ CDCS option. This document identifies the goods, ~~or~~ services, and supports ~~or both,~~ selected by a participant, including those ~~goods, services, and supports~~ available outside of Medicaid-funded services that can help the participant meet desired goals, and the cost of each one ~~of the identified goods and services~~. The participant uses this document to manage their individualized budget. ~~(3-17-22)~~( )

154. 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~~ CSW, 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.~~ ~~(3-17-22)~~( )

165. Support Broker (SB). An individual who advocates on behalf of the participant and who is hired by the participant to provide ~~support broker S~~ SB services. ~~(3-17-22)~~( )

~~**17. Support Broker Services**. Services provided by a support broker to assist the participant with planning, negotiating, and budgeting.~~ ~~(3-17-22)~~

186. Traditional Adult DD Waiver Services. A program option for participants eligible for the Adult ~~Developmental Disabilities (~~ DD~~)~~ Waiver consisting of the specific Medicaid Enhanced Plan Benefits described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ~~(3-17-22)~~( )

~~**19. 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."~~ ~~(3-17-22)~~

2017. 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." ~~(3-17-22)~~( )

~~**21. Waiver Services**. A collective term that refers to services provided under a Medicaid Waiver program.~~ ~~(3-17-22)~~

~~**011. -- 019. (RESERVED)**~~

~~**020. RESPONSIBILITY FOR DECISION-MAKING.**~~
~~Under this chapter of rules, decisions are to be made as follows:~~ ~~(3-17-22)~~

~~**01. Children**. The parent or legal guardian is responsible for decisions made on behalf of a child participant.~~ ~~(3-17-22)~~

~~**02. Adults**. The participant, or legal guardian if one exists, is responsible for decisions made on behalf of an adult participant.~~ ~~(3-17-22)~~

021. -- 099100. (RESERVED)

~~**100. CONSUMER-DIRECTED COMMUNITY SUPPORTS (CDCS) OPTION.**~~
~~The CDCS 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 their own supports. The participant must use a fiscal employer agent to provide Financial Management Services (FMS) for payroll and reporting functions.~~ ~~(3-17-22)~~

101. PARTICIPANT ELIGIBILITY.

01. Eligibility Determination ~~of Medicaid and Home and Community Based Services - DD Requirements~~. In order to choose the CDCS option, the participant must first be determined Medicaid-eligible and determined to meet existing Adult DD waiver ~~programs~~ or Children's HCBS State Plan Option requirements as outlined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ~~(3-17-22)~~( )

02. Participant Agreement ~~Form~~. The participant, if able, and their legal representative, if one exists, must agree in writing using a Department-approved form to the following: ~~(3-17-22)~~( )

a. Accept the guiding principles for the CDCS option, as defined in ~~Section 010 of~~ these rules; ~~(3-17-22)~~( )

b. Agree to meet the participant responsibilities outlined in ~~Section 120 of~~ these rules; ~~(3-17-22)~~( )

c. Take responsibility for and accept potential risks, and any resulting consequences, for their support choices. If the participant is unable to give consent, this falls to their legal representative; and ~~(3-17-22)~~( )

d. Acknowledge and follow the applicable HCBS rules in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits.". ~~Sections 310 through 317.~~ ~~(3-17-22)~~( )

~~**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 CDCS option.~~ ~~(3-17-22)~~

03. Participants involuntarily removed from the CDCS option will be ineligible for this option for a period of five years. Re-application will be reviewed on a case-by-case basis and will include consideration of the previous conditions for removal. ( )

102. -- 109. (RESERVED)

110. PAID CONSUMER-DIRECTED COMMUNITY SUPPORTS (CDCS).
~~The p~~Participants must purchase ~~Financial Management Services (~~ FMS~~)~~ and ~~support broker~~ SB services to participate in the CDCS option~~, except for under the family directed services option where the qualified parent or legal guardian may act as an unpaid support broker. The p~~ Participants must purchase goods and community supports through ~~the fiscal employer agent~~ an FEA who is providing the FMS. ~~(3-17-22)~~( )

01. ~~Financial Management Services~~FMS. The Department will enter into a provider agreement with ~~a~~ qualified ~~fiscal employer agent~~ FEAs, as defined in ~~Section 010 of~~ these rules, to provide ~~financial management services~~ FMS for payroll and reporting functions to ~~a~~ participants who choose~~s~~ the ~~consumer directed~~ CDCS option. ~~(3-17-22)~~( )

02. ~~Support Broker~~SB Services. ~~Support broker s~~ Services ~~are~~ provided by a qualified ~~support broker~~ SB to assist in making informed choices, participate in a person-centered planning process, and become skilled at managaing their own supports such as negotiating and budgeting. SBs have to apply for requalification annually. ~~(3-17-22)~~( )

03. ~~Community Support Worker~~CSW Services. The ~~community support worker~~ CSWs provide~~s~~ identified supports to the participant. If the identified support requires specific licensing or certification within the state of Idaho, the identified ~~community support worker~~ CSW must obtain the applicable license or certification. Identified supports include activities that address the participant's preference in both FDCS and SDCS, unless otherwsie specified, for: ~~(3-17-22)~~( )

a. Job support for SDCS to help the participant secure and maintain employment or attain job advancement; ~~(3-17-22)~~( )

b. Personal support to help the participant maintain health, safety, and basic quality of life; (3-17-22)

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; (3-17-22)

d. Emotional support to help the participant learn and practice behaviors consistent with their goals and wishes while minimizing interfering behaviors; (3-17-22)

e. Learning support for SDCS to help the participant learn new skills or improve existing skills that relate to their identified goals; ~~(3-17-22)~~( )

f. Transportation support to help the participant accomplish their identified goals; and ~~(3-17-22)~~( )

~~**g.** Adaptive equipment identified in the participant's plan that meets a medical or accessibility need and promotes their increased independence; and (3-17-22)~~

~~**h**~~**g.** Skilled nursing support for SDCS identified in the participant's plan that is within the scope of the Nurse Practice Act and is provided by a licensed registered nurse (RN) or licensed practical nurse (LPN) under the supervision of an RN, licensed to practice in Idaho. ~~(3-17-22)~~( )

04. Medically Necessary Equipment. Adaptive and therapeutic equipment is medically necessary, meets a medical or accessibility need, and promotes increased independence. FDCS may substitute medical necessity for minimizing the participant's need for institutionalization. Items may be covered when: ( )

a. Not available through another source; ( )

b. Identified in the participant's plan; ( )

c. Safe and effective treatment that meets evidence – based treatment criteria; ( )

d. Optimal for the participant's health, safety and welfare; ( )

e. Least costly alternative that reasonably meets the identified need; ( )

f. For the sole benefit of the participant; and ( )

g. Meets at lease one (1) of the following: ( )

i. Assist the ability of the participant to remain in the community; ( )

ii. Enhance community inclusion and family involvement; and ( )

iii. Decrease dependency on formal support services. ( )

05. Limitations. Services have the following limitations: ( )

a. CDCS Purchased items and services must meet needs related to a developmental disability diagnosis. The use of CDCS and FDCS purchased items by an individual other than the participant is prohibited. The following types of items or services are not covered: ( )

i. For the convenience of a caregiver; ( )

ii. Educational; ( )

iii. Recreational; or ( )

iv. Vocational except pre-vocational and job supports. ( )

b. CDCS services may only be rendered by (1) staff to one (1) participant at a time. Staff may not: ( )

i. Render any other support, service, or supervision, paid or unpaid, to any other individual; or( )

ii. Perform multiple services concurrently. ( )

c. CDCS and FDCS transportation support is limited to one thousand eight hundred (1,800) miles annually, unless otherwise authorized. ( )

111. UNPAID COMMUNITY SUPPORTS AND SERVICES.
The Department requires that participants and their ~~support broker~~ SB identify and prioritize the use of any goods, services and supports available outside of Medicaid-funded services~~through an unpaid volunteer support or service, or those goods, services, and supports~~ that can be provided by an unpaid natural support such as a family member, a friend, a neighbor or other volunteer. ~~(3-17-22)~~( )

112. -- 119. (RESERVED)

120. PARTICIPANT RESPONSIBILITIES.
With the assistance of the ~~support broker~~ SB, and the legal representative, if one exists, the participant is responsible for the following: ~~(3-17-22)~~( )

01. Guiding Principles. Accepting and honoring the guiding principles for the CDCS option ~~found in Section 010 of~~ defined in these rules. ~~(3-17-22)~~( )

02. Person-Centered Planning. Directing the person-centered planning process in order to identify and document paid and unpaid support and service needs, wants, and preferences. (3-17-22)

03. Rates. Negotiating payment rates for all paid community supports they want to purchase~~,~~. They must also ensur~~ing~~e rates negotiated for supports and services do not exceed the prevailing market rate, ~~and that~~ are cost-effective when comparing them to reasonable alternatives, and includ~~ing~~e the details in the employment agreements. ~~(3-17-22)~~( )

04. Agreements. Completing and implementing agreements for the ~~fiscal employer agent~~ FEA, the ~~support broker~~ SB and ~~community support worker~~ CSWs, and submitting the agreements to the ~~fiscal employer agent~~ FEA. These agreements must be submitted on Department-approved forms~~.~~ and must 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 services; includes a statement signed by the hired worker that they possess 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; services must be delivered consistent with the HCBS rules in IDAPA 16.03.10. "Medicaid Enhanced Plan Benefits;" and no employer-related claims will be filed against the Department. ~~(3-17-22)~~( )

~~**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 they possess 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; services must be delivered consistent with the rules in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 311 through 317; and no employer-related~~

~~claims will be filed against the Department.~~ ~~(3-17-22)~~

0~~6~~5. ~~Plan~~SSP. Developing a comprehensive ~~support and spending plan~~ SSP, based on the information gathered during ~~the~~ person-centered planning. ~~(3-17-22)~~( )

0~~7~~6. **Time Sheets and Invoices**. Reviewing and verifying that ~~supports~~ goods and services being billed were provided and indicating that they approve of the bill by signing the timesheet or invoice. ~~(3-17-22)~~( )

0~~8~~7. **Quality Assurance and Improvement**. Providing feedback to the best of their ability regarding their satisfaction with the ~~supports~~ goods and services they receive and the performance of their workers. ~~(3-17-22)~~( )

08. Sufficient Staffing. Hiring enough CSWs to ensure services are rendered in a manner for the health and safety of the participant. ( )

09. Required Classes. The participant must attend classes on Guide Training by the Department and FEA Training. ( )

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

~~**130. FISCAL EMPLOYER AGENT REQUIREMENTS AND LIMITATIONS.**~~

~~**01. Requirements**. The fiscal employer agent must meet the requirements outlined in its provider agreement with the Department, and Section 3504 of the Internal Revenue Code (26 USC 3504).~~ ~~(3-17-22)~~

~~**02. Limitations**. The fiscal employer agent must not:~~ ~~(3-17-22)~~

~~**a.** Provide any other direct services to the participant, to ensure there is no conflict of interest; or~~ ~~(3-17-22)~~

~~**b.** Employ the guardian, parent, spouse, payee or conservator of the participant or have direct control over the participant's choice.~~ ~~(3-17-22)~~

~~**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:~~ ~~(3-17-22)~~

~~**01. Payroll and Accounting**. Providing payroll and accounting supports to participants that have chosen the Consumer-Directed Community Supports option;~~ ~~(3-17-22)~~

~~**02. Financial Reporting**. Performing financial reporting for employees of each participant.~~ ~~(3-17-22)~~

~~**03. Information Packet**. Preparing and distributing a packet of information, including Department-approved forms for agreements, for the participant hiring their own staff.~~ ~~(3-17-22)~~

~~**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.~~ ~~(3-17-22)~~

~~**05. Taxes**. Managing and processing payment of required state and federal employment taxes for the participant's community support worker and support broker.~~ ~~(3-17-22)~~

~~**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.~~ ~~(3-17-22)~~

~~**07. Spending Information**. Providing each participant with reporting information that will assist the~~

~~participant with managing the individualized budget.~~ ~~(3-17-22)~~

~~**08. Quality Assurance and Improvement**. Participating in Department quality assurance activities.~~ ~~(3-17-22)~~

1~~32~~21. -- 134. (RESERVED)

135. SUPPORT BROKER (SB) REQUIREMENTS AND LIMITATIONS.

01. ~~Initial Application to Become a Support Broker~~SB Requirements. Individuals interested in becoming ~~a~~ an SB ~~support broker~~ must ~~complete the Department approved application to document that they~~: ~~(3-17-22)~~( )

a. ~~Are~~Be eighteen (18) years of age or older; ~~(7-1-24)~~( )

b. Have 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 (7-1-24)

c. Have at least two (2) years verifiable experience with the target population and ( )

d. ~~k~~Knowledge of services and resources in the developmental disabilities field. ~~(7-1-24)~~( )

02. Application Exam. Applicants that meet the minimum requirements under this rule will receive training materials and resources to prepare for the application exam. Under ~~Family Directed Community Supports (~~ FDCS~~)~~, children's ~~support broker~~ SBs must attend ~~the~~ an 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 under these rules, will be eligible to enter into a ~~provider~~ Medicaid Support Broker ~~a~~ Agreement with the Department. ~~(7-1-24)~~( )

03. Required Ongoing Training. All ~~support broker~~ SBs must document a minimum of twelve (12) hours per year of ongoing, relevant training in the provision of ~~support broker~~ SB 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. ~~(3-17-22)~~( )

04. Termination. The Department may terminate the ~~provider~~ Medicaid Support Broker~~a~~ Agreement in accordance with Idaho Code 56-209h(6) or when the ~~support broker~~ SB: ~~(3-17-22)~~( )

a. Is no longer able to pass a background check under ~~Section 009 of~~ these rules. ~~(7-1-24)~~( )

b. Puts the health or safety of the participant at risk by failing to perform job duties under the employment agreement. (7-1-24)

c. Does not receive and document the required ongoing training and requalification. ~~(3-17-22)~~( )

05. Limitations. The ~~support broker~~ SB must: ~~(7-1-24)~~( )

a. Not provide, or be employed by an agency that provides CSW services~~paid community supports under Section 150 of these rules~~ to the same participant; and ~~(7-1-24)~~( )

b. For ~~Self-Directed Community Supports (~~ SDCS~~)~~, meet the conflict of interest standards under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ~~(7-1-24)~~( )

c. SBs are limited to reimbursement for three thousand one hundred twenty (3,120) hours per calendar year across all participants served unless otherwise authorized by the Department. ( )

06. Time Sheets and Invoices. SBs must submit accurate time sheets and invoices for reimbursement

or be subject to recoupment. ( )

136. SUPPORT BROKER (SB) DUTIES AND RESPONSIBILITIES.

01. ~~Support Broker~~ Initial Documentation. Prior to beginning employment for the participant, the ~~support broker~~ SB must type and complete and submit to the participant, the packet of information provided by the ~~fiscal employer agent~~ FEA ~~and submit it to the fiscal employer agent~~. This packet must include documentation of: ~~(3-17-22)~~( )

a. ~~Support broker~~SB application approval by the Department; ~~(3-17-22)~~( )

b. A completed ~~criminal history~~ background check, including clearance in accordance with ~~Section 009~~ of these rules and IDAPA 16.05.06, "Criminal History and Background Checks"; and ~~(3-17-22)~~( )

c. A completed employment agreement in accordance with these rules.~~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~~ SB services established by the Department. ~~(3-17-22)~~( )

02. Documentation. SB must complete all documentation required by the Department including documentation of the date and type of service provided and billed for. All documentation for services will be retained by the SB for five (5) years. ( )

0~~2~~3. Required ~~Support Broker~~ Duties. ~~Support broker~~SB 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~~ SB must: ~~(3-17-22)~~( )

a. Assist in facilitating the person-centered planning process as directed by the participant and consistent with the HCBS rules in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits~~,~~;" ~~Sections 313, 316, and 317,~~ ~~(3-17-22)~~( )

b. Develop a written ~~support and spending plan~~ SSP with the participant that includes the paid and unpaid 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~~ The SSP must be authorized by the Department; ~~(3-17-22)~~( )

c. Assist the participant to monitor and review their budget; (3-17-22)

d. Submit documentation regarding the participant's satisfaction with identified supports as requested by the Department; (3-17-22)

e. ~~Participate with~~ Adhere to Department quality assurance measures~~, as requested~~; ~~(3-17-22)~~( )

f. Assist the participant to complete the annual re-determination process as needed, including updating the ~~support and spending plan~~ SSP and submitting it to the Department for authorization; ~~(3-17-22)~~( )

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 their own health and safety; ~~(3-17-22)~~( )

h. Complete the Department-approved ~~criminal history~~ background check waiver form when a participant chooses to waive the ~~criminal history~~ background check requirement for a ~~community support worker~~ CSW. Completion of this form requires that the ~~support broker~~ SB provide education and counseling to the participant and their ~~circle of support~~ COS regarding the risks of waiving a ~~criminal history~~ background check and assist with detailing the rationale for waiving the ~~criminal history~~ background check and how health and safety will be protected; ~~and~~ ~~(3-17-22)~~( )

i. Assist children enrolled in the ~~Family-Directed Community Supports (~~ FDCS~~)~~ ~~O~~ option as they transition to adult DD services. ~~(3-17-22)~~( )

j. Sign the written ~~support and spending plan~~ SSP as required in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits,"~~:~~ and ~~Section 317.~~ ~~(3-17-22)~~( )

k. Report concerns or discrepancies in documentation and services provided to the Department immediately. ( )

0~~3~~4. Additional ~~Support Broker~~ Duties. In addition to the required ~~support broker~~ SB duties, each ~~support broker~~ SB must be able to provide the following services when requested by the participant: ~~(3-17-22)~~( )

a. Assist the participant to develop and maintain a ~~circle of support~~ COS; ~~(3-17-22)~~( )

b. Help the participant learn and implement the skills needed to recruit, hire, and monitor community supports; (3-17-22)

c. Assist the participant to negotiate rates for paid ~~community support workers~~ CSW;~~(3-17-22)~~( )

d. Maintain documentation of supports provided by each ~~community support worker~~ CSW and participant's satisfaction with these supports; ~~(3-17-22)~~( )

e. Assist the participant to monitor community supports; (3-17-22)

f. Assist the participant to resolve employment-related problems; (3-17-22)

g. Assist the participant to identify and develop community resources to meet specific needs; and (3-17-22)

h. Assist the participant in distributing the ~~support and spending plan~~ SSP to ~~community support workers~~ CSWs or vendors as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits~~.~~." ~~Section 317.~~ ~~(3-17-22)~~( )

0~~4~~5. Termination of ~~Support Broker~~ Services. If ~~a support broker~~ an SB decides to end services with a participant, they must give the participant and the Department at least thirty (30) days' written notice prior to terminating services. The ~~support broker~~ SB must assist the participant to identify a new ~~support broker~~ SB and provide the participant and new ~~support broker~~ SB with a written service transition plan by the date of termination. The transition plan must include an updated ~~support and spending plan~~ SSP that reflects current supports being received, details about the existing ~~community support workers~~ CSWs, and unmet needs. ~~(3-17-22)~~( )

137. -- 139. (RESERVED)

140. COMMUNITY SUPPORT WORKER (CSW) LIMITATIONS.
A paid ~~community support worker~~ CSW must not be the spouse of the participant~~., and, f~~ For FDCS, they must: 1) not be the parent or legal guardian of the participant, ~~and must~~ 2) not have direct control over the participant's choices, ~~must~~ 3) avoid any conflict of interest, and ~~must~~ 4) not receive undue financial benefit from the participant's choices. ~~(3-17-22)~~( )

01. Work Limit. A CSW for SDCS cannot work more than twelve (12) hours in a day without authorization from the Department. ( )

0~~1~~2. ~~Self-Directed Community Supports (~~SDCS~~)~~. SDCS CSW cannot be younger than seventeen (17) years of age except when providing chore services and then may be sixteen (16) years of age. ~~A legal guardian can be a paid community support worker but must not be paid from the individualized budget for the following:~~ ~~(3-17-22)~~( )

~~**a.** 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.~~ ~~(3-17-22)~~

~~**b.** The legal guardian must not be paid to fulfill any obligations they are legally responsible to fulfill as outlined in the guardianship or conservator order from the court.~~ ~~(3-17-22)~~

02~~3~~. ~~**Family-Directed Community Supports (**~~**FDCS)**. ~~A parent or legal guardian cannot be a paid community support worker.~~ A paid ~~community support worker~~ CSW may provide unskilled supervision, but cannot: ~~(3-17-22)~~( )

a. ~~Must not s~~Supplant the role of the parent or legal guardian; ~~(3-17-22)~~( )

b. ~~Cannot b~~Be paid to fulfill any obligations that the parent or legal guardian is legally responsible to fulfill for their child.: ~~(3-17-22)~~( )

c. Be under the age of sixteen (16) years old; or ( )

d. Transport or be left alone with a participant under the age of eighteen (18) years old. ( )

141. -- 149. (RESERVED)

150. PAID COMMUNITY SUPPORT WORKER (CSW) DUTIES AND RESPONSIBILITIES.

01. Initial Documentation. Prior to providing goods or services to the participant, the ~~community support worker~~ CSW must type and complete the packet of information provided by the ~~fiscal employer agent and submit it to the fiscal employer agent~~ FEA and submit to the FEA. When the ~~community support worker~~ CSW will be providing services, this packet must include documentation of: ~~(3-17-22)~~( )

a. A completed ~~criminal history~~ background check, including clearance in accordance with ~~Section 009 of~~ these rules and IDAPA 16.05.06, "Criminal History and Background Checks," or documentation that this requirement has been waived by the participant in accordance with these rules. ~~This documentation must be provided on a Department-approved form and include the rationale for waiving the criminal history check and describe how health and safety will be ensured in lieu of a completed criminal history check.~~ Individuals listed on a state or federal provider exclusion list must not provide paid supports; ~~(3-17-22)~~( )

b. A completed employment agreement with the participant in accordance with these rules ~~that specifically defines the type of support being purchased, the negotiated rate, and the frequency and duration of the support to be provided~~. If the ~~community support worker~~ CSW is provided through an agency, the employment agreement must include the specific individual who will provide the support and the agency's responsibility for tax-related obligations; ~~(3-17-22)~~( )

c. Current state licensure or certification if identified support requires certification or licensure; and (3-17-22)

d. A statement of qualifications to provide supports identified in the employment agreement. (3-17-22)

02. Employment Agreement. The ~~community support worker~~ CSW must deliver supports as defined in the employment agreement. ~~(3-17-22)~~( )

03. Documentation ~~of Supports~~. The ~~community support worker~~ CSW must track and document the time required to perform the identified supports and accurately report the time on the time sheets provided by the participant's ~~fiscal employer agent~~ FEA or complete an invoice that reflects the type of support provided, the date the support was provided, and the negotiated rate for the support provided, for submission to the participant's ~~fiscal employer agent~~ FEA. Failure to do so may result in recoupment. ~~(3-17-22)~~( )

04. Time Sheets and Invoices. The ~~community support worker~~ CSW must obtain the signature of the participant or their legal representative on each completed timesheet or invoice prior to submitting the document to

the ~~fiscal employer agent~~ FEA for payment. Time sheets or invoices that are not signed by the ~~community support worker~~ CSW and the participant or their legal representative will not be paid. ~~(3-17-22)~~( )

151. -- 159. (RESERVED)

160. SUPPORT AND SPENDING PLAN (SSP) DEVELOPMENT.

01. ~~Support and Spending Plan~~ Requirements. The participant, with the help of their ~~support broker~~ SB, must develop a comprehensive ~~support and spending plan~~ SSP based on the information gathered during ~~the~~ person-centered planning. The person-centered planning process must meet all HCBS requirements as defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." The ~~support and spending plan~~ SSP is not valid until authorized by the Department. ~~and~~ The SSP must include ~~the following~~: ~~(3-17-22)~~( )

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 their community. (3-17-22)

b. Paid or non-paid ~~consumer directed community~~ supports that focus on the participant's wants, needs, and goals in the following areas: ~~(3-17-22)~~( )

i. Personal health and safety including quality of life preferences; (3-17-22)

ii. Securing and maintaining employment for SDCS; ~~(3-17-22)~~( )

iii. Establishing and maintaining relationships with family, friends and others to build the participant's ~~circle of supports~~ COS; ~~(3-17-22)~~( )

iv. Learning and practicing ways to recognize and minimize interfering behaviors for SDCS; and ~~(3-17-22)~~( )

v. Learning new ~~skills~~ or improving existing ~~ones~~ skills to accomplish set goals for SDCS. ~~(3-17-22)~~( )

c. Support needs such as: (3-17-22)

i. Medical care and medicine for SDCS; ~~(3-17-22)~~( )

ii. Skilled care including therapies or nursing needs for SDCS; ~~(3-17-22)~~( )

iii. Community involvement; (3-17-22)

iv. Preferred living arrangements including possible roommate(s); and (3-17-22)

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. (3-17-22)

d. Risks or safety concerns in relation to the identified support needs on the participant's ~~plan~~ SSP. The plan must be active and specify the goods, 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; ~~(3-17-22)~~( )

e. Sources of payment for the listed supports and services, including the frequency, duration, and main task of the listed supports and services; (3-17-22)

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~~ FEA will compare and match the employment agreements to the appropriate support categories identified on the initial

~~spending plan~~ SSP prior to processing time sheets or invoices for payment; and ~~(3-17-22)~~( )

~~**g.** Additional HCBS person-centered plan requirements as defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 313, 316, and 317.~~ ~~(3-17-22)~~

02. ~~Support and Spending Plan~~ Limitations. ~~Support and spending plan limitations include:~~ ~~(3-17-22)~~( )

a. Traditional ~~Medicaid~~ Adult DD waiver services, ~~and traditional~~ rehabilitative, or habilitative services must not be purchased under the CDCS option. Because a participant cannot receive these traditional services and ~~consumer directed services~~ CDCS at the same time, the participant, the ~~support broker~~ SB, and the Department must all work together to ensure that there is no interruption of required services when moving between traditional services and the CDCS option; ~~(3-17-22)~~( )

b. Paid community supports must not be provided in a group setting with recipients of traditional ~~Medicaid~~ Adult DD waiver services, rehabilitative, or habilitative services. This ~~limitation~~ does not ~~preclude~~ prevent a participant who has selected the ~~consumer directed~~ CDCS option from choosing to live with recipients of traditional ~~Medicaid~~ Adult DD waiver, rehabilitative, or habilitative services; ~~(3-17-22)~~( )

c. All paid community supports must fit into ~~one (1) or more~~ a type~~s~~ of community support~~s~~ described in ~~Section 110 of~~ these rules. The ~~support and spending plan~~ SSP 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; ~~(3-17-22)~~( )

d. ~~Support and spending plans~~SSPs that exceed the approved budget amount will not be authorized; and ~~(3-17-22)~~( )

e. Time sheets or invoices ~~that are submitted to the fiscal employer agent for payment that~~ exceed~~ing~~ the authorized ~~support and spending plan~~ SSP amount will not be paid by the ~~fiscal employer agent~~ FEA. ~~(3-17-22)~~( )

~~**161. -- 169. (RESERVED)**~~

~~**170. PERSON-CENTERED PLANNING.**~~

~~**01. Direction of the Person-Centered Planning Process**. The participant agrees to direct the person-centered planning process in order to identify and document their support and service needs, wants, and preferences.~~ ~~(3-17-22)~~

~~**02. Participant Choice**. The participant decides who they want to participate in the planning sessions in order to ensure the participant's choices are honored and promoted.~~ ~~(3-17-22)~~

~~**03. Facilitation of Person-Centered Planning Meetings**. The participant may facilitate their person-centered planning meetings, or these meetings may be facilitated by the chosen support broker.~~ ~~(3-17-22)~~

~~**04. Focus of Person-Centered Planning**. The person-centered planning should focus on identifying strengths, capacities, preferences, needs, and desired goals of the participant for all life areas.~~ ~~(3-17-22)~~

~~**05. Timeframes of Person-Centered Planning**. The person-centered planning should be completed as timely as possible in order to provide the necessary information required to develop the participant's support and spending plan. Time limitations are not currently mandated in order to allow for extensive, comprehensive planning and thoughtful support and spending plan development.~~ ~~(3-17-22)~~

~~**06. HCBS Person-Centered Planning Requirements**. The person-centered planning process must meet all HCBS requirements as defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 316.~~ ~~(3-17-22)~~

17~~6~~1. -- 179. (RESERVED)

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.~~ ~~(3-17-22)~~

01. Focus ~~of the Circle of Support~~. The participant's ~~circle of support~~ COS ~~should be~~ is built and operates 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~~ an SSP, along with and on behalf of the participant, to help the participant accomplish their personal goals. ~~(3-17-22)~~( )

02. Members ~~of the Circle of Support~~. A ~~circle of support~~ COS is unpaid, selected by the participant, and may include family members, friends, neighbors, co-workers, and other community members. For the SDCS, when the participant's legal guardian is selected as a ~~community support worker~~ CSW, the ~~circle of support~~ COS must include at least one (1) non-family member ~~that~~ who is not the ~~support broker~~ SB. For the purposes of this chapter a family member is anyone related by blood or marriage to the participant or ~~to the~~ legal guardian. ~~(3-17-22)~~( )

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: ~~(3-17-22)~~( )

a. ~~Help p~~Promote and improve the life of the participant in accordance with the participant's choices and preferences; and ~~(3-17-22)~~( )

b. Meet ~~on a regular basis~~ regularly to assist the participant to accomplish their expressed goals. ~~(3-17-22)~~( )

04. Natural Supports. ~~A n~~Natural supports may perform any duty of the ~~support broker~~ SB as long as the ~~support broker~~ SB still completes the required responsibilities listed in ~~Subsection 136.02 of~~ these rules. Additionally, any ~~community support worker~~ CSW 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~~ SSP, but time worked does not need to be recorded or reported to the ~~fiscal employer agent~~ FEA. ~~(3-17-22)~~( )

181. -- 189. (RESERVED)

190. INDIVIDUALIZED BUDGET.
The Department will assign budgets based on the criteria under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-24)

~~**01. Budget Amount Notification**. The Department notifies each participant of their set budget amount as part of the eligibility determination or annual redetermination process. The notification will include how the participant may appeal the set budget amount.~~ ~~(3-17-22)~~

~~**02. Annual Re-Evaluation of Adult 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 condition that results in a need for services that meet medical necessity criteria, and that is not reflected on the current inventory of individual needs.~~ ~~(3-17-22)~~

~~**03. Annual Re-Evaluation of Children's 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 that may support placement in a different budget category under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 527.~~ ~~(7-1-24)~~

191. -- 199. (RESERVED)

200. QUALITY ASSURANCE.
The Department will implement quality assurance processes to ensure: access to ~~consumer-directed services~~ CDCS,

participant direction of ~~plans~~ SSPs and services, participant choice and direction of providers, safe and effective environments, and participant satisfaction with services and outcomes. ~~(3-17-22)~~( )

01. ~~**Participant Experience Survey (PES)**~~**Adult Services Outcome Review (ASOR)**. Each participant will have the opportunity to provide feedback to the Department about their satisfaction with consumer-directed services utilizing the ~~PES~~ ASOR. ~~(3-17-22)~~( )

02. ~~**Participant Experience**~~**Adult Service Outcomes**. Participant experience information will be gathered at least annually in an interview by the Department, and will address the following participant outcomes: ~~(3-17-22)~~( )

a. Access to care; (3-17-22)

b. Choice and control; (3-17-22)

c. Respect and dignity; (3-17-22)

d. Community integration; and (3-17-22)

e. Inclusion. (3-17-22)

~~**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.~~ ~~(3-17-22)~~

0~~4~~3. ~~**Community Support Workers and Support Brokers**~~**CSWs and SBs Quality Assurance Activities**. ~~Community support workers~~ CSWs and ~~support brokers~~ SBs 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. ~~(3-17-22)~~( )

0~~5~~4. **Participant Choice of Paid ~~Community Support Worker~~ CSW**. Paid ~~community support workers~~ CSWs must be selected by the participant, or their chosen representative, and meet the qualifications identified in ~~Section 150 of~~ this rule. ~~(3-17-22)~~( )

0~~6~~5. **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. (3-17-22)

0~~7~~6. **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. (3-17-22)

0~~8~~7. **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~~ SSP. ~~(3-17-22)~~( )

0~~9~~8. **H~~ome and~~ C~~ommunity~~ B~~ased~~ S~~ervice~~ Specific Reviews**. The Department will implement quality assurance and improvement activities to ensure compliance with the rules in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits~~.~~." ~~Sections 310 through 317.~~ ~~(3-17-22)~~( )

201. -- 209. (RESERVED)

210. CONTINUATION OF THE CONSUMER-DIRECTED COMMUNITY SUPPORTS (CDCS) OPTION.

The following requirements must be met or the Department may require the participant to discontinue the CDCS option: (3-17-22)

01. Required Supports. The participant is willing to work with ~~a support broker~~ an SB. ~~and a fiscal employer agent~~. ~~(3-17-22)~~( )

a. The participant can only change FEA services by providing a written request to their 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. (3-17-22)

b. When a participant provides a written request to their 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. (3-17-22)

02. ~~Support and Spending Plan~~SSP. The participant's ~~support and spending plan~~ SSP is ~~being~~ followed. ~~(3-17-22)~~( )

03. Risk and Safety Back-Up Plans. Back-up plans to manage risks and safety are ~~being~~ followed. ~~(3-17-22)~~( )

04. Health and Safety Choices. The participant's choices do not directly endanger their health, welfare and safety or endanger or harm others. (3-17-22)

211. -- 299. (RESERVED)

FISCAL EMPLOYER AGENTS ~~DUTIES AND RESPONSIBILITIES~~
(Sections 300-314)

300. FISCAL EMPLOYER AGENT ~~DUTIES AND RESPONSIBILITIES~~ (FEA): DEFINITIONS.
For purposes of Sections 300 through 3146, the following definitions apply: ~~(3-17-22)~~( )

01. Employee. A ~~community support worker~~ CSW employed by a participant receiving services under the CDCS option. ~~(3-17-22)~~( )

02. Employer. A participant receiving services under the CDCS option. (3-17-22)

03. Provider. The term "provider" specifically refers to the ~~fiscal employer agent~~ FEA providing ~~financial management services~~ FMS to individuals participating in ~~consumer-direction~~ the CDCS option. ~~(3-17-22)~~( )

04. Secure File Transfer Protocol (SFTP). ~~Secure File Transfer Protocol.~~ A secure means of transferring data that allows certain Department staff to access information regarding ~~consumer-direction~~ CDCS participants. ~~(3-17-22)~~( )

05. Vendor. ~~Provides goods and services rendered by a~~ Agencies and independent contractors that provide goods and services in accordance with a participant's ~~support and spending plan~~ SSP. ~~(3-17-22)~~( )

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. (3-17-22)

301. FISCAL EMPLOYER AGENT: REQUIREMENTS AND LIMITATIONS.

01. Limitations. The FEA must not: ( )

a. Provide any other direct services to the participant, to ensure there is no conflict of interest; or

( )

b. Employ the guardian, parent spouse, payee or conservator of the participant or have direct control over the participant's choice. ( )

302. FISCAL EMPLOYER AGENT: DUTIES AND RESPONSIBILITIES.
The FEA performs FMS for each participant. Prior to providing FMS the participant and the FEA must enter into a written agreement. FMS include: ( )

01. Payroll and Accounting. Providing supports to participants that have chosen the CDCS option including: ( )

a. An online electronic time sheet entry for participants; ( )

b. Processing time sheets for CSWs and SBs, as authorized by the participant, according to the participant's Department-authorized SSP; and ( )

c. Issuing payroll checks after receipt of completed, approved time sheets. ( )

02. Recoupment. Recoup payments made in error when identified by the FEA or the Department by either deducting from future payments or requiring repayment. ( )

03. Financial Reporting. Performing financial reporting for employees of each participant. ( )

04. Information Packet. Preparing and distributing a packet of information, including Department-approved forms for agreement, for the participant hiring their own staff. ( )

05. Labor Laws. Ensure each participant's compliance with all applicable labor laws. ( )

06. Taxes. Ensure each participant's compliance with regulations for both federal and state taxes, including preparation and submission of all federal and state forms for each participant and their employees. Manage and process payment of required state and federal employment taxes for the participant's CSWs and SB. ( )

07. Payments of Goods and Services. Process and pay invoices for goods and services, as authorized by the participant, according to the participant's SSP. ( )

08. Spending Information. Providing each participant with reporting information that will assist the participant with managing the individualized budget. ( )

09. Quality Assurance and Improvement. Participating in Department quality assurance activities. ( )

30~~1~~3. FISCAL EMPLOYER AGENT (FEA) ~~DUTIES AND RESPONSIBILITIES~~: CONSUMER-DIRECTED COMMUNITY SUPPORTS (CDCS).

01. Federal Tax ID Requirement. The ~~fiscal employer agent~~ FEA 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: ~~(3-17-22)~~( )

a. Maintain copies of the participant's FEIN, IRS FEIN notification letter, and Form SS-4 Request for FEIN in the participant's file. (3-17-22)

b. Retire participant's FEIN when the participant is no longer an employer under ~~consumer-directed community supports (~~ CDCS~~)~~. ~~(3-17-22)~~( )

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; (3-17-22)

~~**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 DD waiver or Children's HCBS State Plan Option participant for whom it also provides any other services funded by the Department.~~ ~~(3-17-22)~~

043. 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. (3-17-22)

054. 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. ~~(3-17-22)~~( )

065. 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. The face-to-face encounter may occur via ~~synchronous interaction telehealth~~ virtual care, as defined in Title 54, Chapter 57, Idaho Code. ~~(3-17-22)~~( )

076. SFTP Site. The provider must provide an SFTP site for the Department to access~~. The site must have~~ with 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. ~~(3-17-22)~~( )

087. 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: (3-17-22)

a. IRS Form 2678; (3-17-22)

b. IRS Approval Letter; (3-17-22)

c. IRS Form 2678 revocation process; (3-17-22)

d. Initial IRS Form 2848; and (3-17-22)

e. Renewal IRS Form 2848. (3-17-22)

098. Requirement to Obtain and Revoke Power of Attorney. The provider must obtain an Idaho State Tax Commission Power of Attorney (~~Form TC00110~~ID-POA) from each participant it represents ~~and~~, revoke the Form ID-POA when the provider no longer represents the participant, and maintain the relevant documentation in each participant's file. (3-17-22)

~~**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 maintain the relevant documentation in the participant's file.~~ ~~(3-17-22)~~

~~**11. Home and Community Based Person Centered Service Plan Requirements**. The provider must sign the written support and spending plan as required in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 317.~~ ~~(3-17-22)~~

3024. FISCAL EMPLOYER AGENT ~~DUTIES AND RESPONSIBILITIES~~ (FEA): 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: (3-17-22)

a. Provide staff with customer service training with an emphasis on consumer-direction. (3-17-22)

b. Ensure staff are trained and have the skills to assist participants with enrollment and to help them understand their account statements. (3-17-22)

c. Ensure that ~~fiscal employer agent~~ FEA personnel are available during regular business hours. ~~(7-1-24)~~( )

d. Provide translation and interpreter services. ~~(i.e., American Sign Language and services for persons with limited English proficiency).~~ ~~(3-17-22)~~( )

e. Provide prompt and consistent response to verbal and written communication. Specifically: (3-17-22)

i. All calls and voice mails must be responded to within one (1) business day; and (7-1-24)

ii. All written and electronic correspondence must be responded to within five (5) business days. (3-17-22)

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~~. ~~(3-17-22)~~( )

g. Maintain a toll-free fax line that is available ~~all day, every day~~ at any time, exclusively for participants and their employees. ~~(3-17-22)~~( )

h. Maintain an e-mail address. ( )

02. Complaint Resolution and Tracking System. The provider is responsible for receiving, responding to, and tracking all complaints from any source under this agreement and corrective actions. A complaint is defined as a verbal or written expression of dissatisfaction about ~~fiscal employer agent~~ FEA services. The provider must: ~~(3-17-22)~~( )

a. Respond to all written and electronic correspondence within five business (5) days. (7-1-24)

b. Respond to all calls and voicemails within one (1) business day. (7-1-24)

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. ~~(3-17-22)~~( )

d. Log and track complaints received from the Department pertaining to ~~fiscal employer agent~~ FEA services. ~~(3-17-22)~~( )

e. Compile a quarterly summary report ~~and~~ analyzeing complaints ~~received on a quarterly basis~~ to determine the quality of services to participants and to identify any corrective action necessary. ~~(3-17-22)~~( )

f. Implement corrective action within one (1) business day of the complaint response. ( )

~~f~~g. 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~~ one (1) business day. Failure to comply will result in a fifty dollar ($50) penalty payable to Medicaid within ninety (90) days of incident. ~~(3-17-22)~~( )

30~~3~~5. FISCAL EMPLOYER AGENT ~~DUTIES AND RESPONSIBILITIES~~ (FEA): PERSONAL AND CONFIDENTIAL INFORMATION.

The provider must implement and enforce policies and procedures regarding documents that are mailed, faxed, or e-mailed to and from the provider to ensure documents are tracked and that confidential information is not compromised, is stored appropriately and not lost, and is traceable for historical research purposes. ~~(3-17-22)~~( )

3046. FISCAL EMPLOYER AGENT~~ DUTIES AND RESPONSIBILITIES~~ (FEA): ENROLLMENT PROCESS.

01. Submission of Participant Enrollment and Employee Packets for Department Approval. The provider must submit the following for participant enrollment and employee packets to the Department for approval. (3-17-22)

a. The participant enrollment packet must include: (3-17-22)

i. ~~Fiscal employer agent~~FEA authorization form; ~~(3-17-22)~~( )

ii. Employer Appointment of Agent - IRS Form; (3-17-22)

iii. Tax Information Form; and (3-17-22)

iv. Employer information~~. The employer information must include:~~ including; ~~(3-17-22)~~( )

(1) Instructions for completing forms; (3-17-22)

(2) Payroll schedule, including deadlines for submission of time cards; (3-17-22)

(3) Sample employment agreements; (3-17-22)

(4) Sample Request for Vendor Payment form; (3-17-22)

(5) Sample independent provider agreement; and (3-17-22)

(6) Other sample employment agreements as needed. (3-17-22)

b. The employee enrollment packet must contain: (3-17-22)

i. Employee Information Form; (3-17-22)

ii. I-9 Employment Eligibility Form; (3-17-22)

iii. W-4 Employee Withholding Allowance Certificate; (3-17-22)

iv. Pay selection agreement; (3-17-22)

v. Direct deposit authorization (optional); and ~~(3-17-22)~~( )

vi. Sample time sheets and instructions for completion~~; and~~. ~~(3-17-22)~~( )

~~vii. IRS Form W-5.~~ ~~(3-17-22)~~

02. Distribution of Participant Enrollment and Employee Packets to Participant after Department Approval. The provider must distribute Department-approved participant enrollment packets and employment packets to the participant within two (2) business days after the participant requests the packets. (3-17-22)

a. To enroll a participant, the provider must: (3-17-22)

i. Enroll the participant within two (2) business days of receipt of completed paperwork; and

(3-17-22)

ii. Log and maintain an electronic record of all enrollment paperwork, which includes participant ~~support and spending plan~~ SSP cost and authorization sheets. ~~(3-17-22)~~( )

b. To enroll an employee, the provider must: (3-17-22)

i. Enroll the employee within two (2) business days of receipt of completed paperwork; and (3-17-22)

ii. Log and maintain an electronic record of all the employee's paperwork that includes the employment agreements. (3-17-22)

30~~5~~7. FISCAL EMPLOYER AGENT ~~DUTIES AND RESPONSIBILITIES~~ (FEA): PAYMENT PROCESS.

01. Process Payroll. The provider must process payroll, including time sheets and taxes, in accordance with the participant's ~~support and spending plan~~ SSP. The payroll process must include: ~~(3-17-22)~~( )

a. Payment of employer and withholding taxes to State Tax Commission and Internal Revenue Service. (3-17-22)

b. Payment of invoices to vendors. (3-17-22)

c. Management of participant budget funds as per authorized ~~support and spending plan~~ SSP. ~~(3-17-22)~~( )

d. Garnishment of wages as per court orders. (3-17-22)

e. Preparation of year-end federal and state tax forms. (3-17-22)

f. Payment of worker's compensation insurance premiums. (3-17-22)

02. Requirement to Track and Log Time Sheet Billing Errors. The provider must track and log time sheet billing errors or time sheets that cannot be paid due to late arrival, missing, or erroneous information. The provider must notify the employee and participant within one (1) business day of when errors are identified on the time sheets. (3-17-22)

03. Requirement to Track and Log Improperly Cashed or Improperly Issued Checks. The provider must track and log occurrences of improperly cashed or improperly issued checks and stop payment on checks when necessary. The provider must reissue lost, stolen, or improperly issued checks at no expense to the participant or the Department within fourteen (14) calendar days of when the error occurred. (3-17-22)

04. Process Employee Payments. The provider must verify ~~employees'~~ documentation and process ~~employees'~~ payments via ~~check, direct deposit, or pay cards as per~~ the preference of employees. The employee payment process includes: ~~(3-17-22)~~( )

a. Receipt of time cards from employees via mail, fax, or website by specified due dates. (3-17-22)

b. Review time cards for accuracy and verify that timecards contain the following information: (3-17-22)

i. Employer name and ID number. (3-17-22)

ii. Employee name and ID number. (3-17-22)

iii. Hours of work. (3-17-22)

iv. Code for service. (3-17-22)

c. Match codes to employment agreement to verify rate of pay. (3-17-22)

d. Verify that rate of pay multiplied by the hours worked per each pay period is equal to the gross pay. (3-17-22)

e. Calculate all taxes and other withholding. (3-17-22)

f. Pay employees every two (2) weeks or semi-monthly. (3-17-22)

g. Contact participant and representative ~~if there are~~ to resolve problems with timecards or other documents ~~in order to resolve issues~~ prior to pay-date, if possible. ~~(3-17-22)~~( )

h. Maintain an electronic complaint log of payroll issues and resolutions. (3-17-22)

i. ~~The provider must verify there is~~Verification of any money remaining in each participant's budget and specific service category prior to issuing ~~a check~~ payment. ~~(3-17-22)~~( )

05. Process Vendor Payments. When participants submit requests for payment to vendors, the provider must: (3-17-22)

a. Review, and maintain on file, the vendor payment request with attached voided vendor receipt submitted by the participant. (3-17-22)

b. Ensure item or payment is authorized on the participant's ~~support and spending plan~~ SSP. ~~(3-17-22)~~( )

c. Issue ~~a check made out~~ payment to the vendor ~~and mail to participant for distribution. Vendor payments are made~~ on the same schedule as payroll. ~~(3-17-22)~~( )

06. Process Independent Contractor or Outside Agency Payments. When the participant hires an independent contractor or outside agency, in accordance with the ~~support and spending plan~~ SSP, the provider must: ~~(3-17-22)~~( )

a. Obtain a W-9 from the contractor or agency. (3-17-22)

b. Review, and maintain on file, the independent contractor or agency agreement submitted by the participant. (3-17-22)

c. Review, and maintain on file, the independent contractor or agency invoice for services submitted by the participant. (3-17-22)

d. Ensure service or payment is authorized on the ~~support and spending plan~~ SSP. ~~(3-17-22)~~( )

e. Issue payment directly to the independent contractor or agency. (3-17-22)

07. End-of-Year Processing. For purposes of end-of-year processing, the provider must maintain relevant documentation and must: (3-17-22)

a. Refund over-collected Federal Insurance Contributions Act tax (FICA) to applicable employees, or to state government; (3-17-22)

b. Prepare, file, and distribute IRS Form W-2 for each employee; (3-17-22)

c. Prepare and file IRS Form W-3 for each participant represented; (3-17-22)

d. Prepare and file State Form 95~~6~~67 for state income taxes withheld for each employer; ~~(3-17-22)~~( )

e. Report and pay any Unclaimed Property per Idaho State Tax Commission rules; and (3-17-22)

f. Report and pay all state and federal unemployment insurance premiums. (3-17-22)

08. Transition to New FEA. The following items must be addressed if a participant transitions to a new FEA provider. For the purposes of a smooth transition between FEA providers, the two providers must work closely with one another to transfer the participant from the services one is no longer providing to the services the other is providing. The following items must be transferred: (3-17-22)

a. Participant's ~~Federal Employer Identification Number (~~FEIN~~)~~ and FEIN mailing address. ~~(3-17-22)~~( )

~~**b.** Mailing address for FEIN. (3-17-22)~~

~~**e**~~**b.** IRS Form 2678 Agent/Payer Authorization. (3-17-22)

~~**d**~~**c.** Depositing taxes and filing report. This includes Federal and State tax withholdings and Federal Unemployment Tax Act tax (FUTA). (3-17-22)

~~**e**~~**d.** Participant's FUTA Liability Status. (3-17-22)

~~**f**~~**e.** FICA and FUTA Exemption Status of Participant Employees. ~~(3-17-22)~~( )

~~**g.** FUTA Exemption Status of Participant Employees. (3-17-22)~~

~~**h**~~**f.** Unemployment Insurance (U/I). (3-17-22)

~~**i**~~**g.** Unemployment Insurance Experience Rate and Taxable Wage Base. (3-17-22)

~~**j.** Unemployment Insurance Taxable Wage Base. (3-17-22)~~

~~**k**~~**h.** State Unemployment Insurance Liability Status of the Participant and Exempt Employees. ~~(3-17-22)~~( )

~~**l.** State Unemployment Insurance Liability Status of Exempt Employees. (3-17-22)~~

~~**m**~~**i.** Unemployment Insurance Filing and Depositing. (3-17-22)

~~**n**~~**j.** State Income Tax - Account Number Agent Authorization, Filing and Depositing. ~~(3-17-22)~~( )

~~**o.** State Income Tax - Agent Authorization. (3-17-22)~~

~~**p.** State Income Tax - Filing and Depositing. (3-17-22)~~

~~**q**~~**k.** Budget Authorization - ~~a~~Authorized ~~s~~Services Spent and Remaining, Authorized Providers, and Authorized Provider Rates. ~~(3-17-22)~~( )

~~**r.** Budget Authorization - spent and remaining. (3-17-22)~~

~~**s.** Budget Authorization - authorized providers. (3-17-22)~~

~~**t.** Budget Authorization - authorized provider rates. (3-17-22)~~

~~**u**~~**l.** Participant's Representative, and Participant's Employee and Provider Demographic ~~i~~Information.

~~(3-17-22)~~( )

~~v.~~ ~~Participant's Representative demographic information.~~ ~~(3-17-22)~~

~~w.~~ ~~Participant's Employee and provider demographic information.~~ ~~(3-17-22)~~

~~x~~**m.** Participant's Employee New Hire Reporting, Liens and Garnishments, and ~~t~~Tax and ~~o~~Other ~~i~~Information. ~~(3-17-22)~~( )

~~y~~**n.** Participant's Independent contract and other information. (3-17-22)

~~z.~~ ~~Participant's Employee New Hire Reporting.~~ ~~(3-17-22)~~

~~aa.~~ ~~Participant's Employee Liens and Garnishments.~~ ~~(3-17-22)~~

3068. FISCAL EMPLOYER AGENT ~~DUTIES AND RESPONSIBILITIES~~ (FEA): ANNUAL PARTICIPANT SURVEY.

01. Requirement to Conduct Annual Participant Satisfaction Survey. Starting October 1 of each calendar year, each provider who has been providing services for at least six (6) months must conduct an annual participant satisfaction survey. (3-17-22)

a. Three (3) weeks prior to the survey launch, the provider must present the questions to the Department staff for approval. (3-17-22)

b. Once the questions are approved by the Department, the provider can send out the survey. (3-17-22)

c. The provider must survey its participants who receive services under ~~consumer directed services~~ the CDCS option, ~~such as participants with disabilities, family members of participants, and participants~~ including those whose primary language is other than English. ~~(3-17-22)~~( )

d. The provider must provide options for participants to respond to the surveys, other than by mail~~, for those participants who may not be able to respond by that method~~. ~~(3-17-22)~~( )

02. Requirement to Provide Results of Annual Participant Satisfaction Survey. The provider must provide the results of the surveys to the Department in a comprehensive report, along with the completed surveys, by the 15th of December ~~of~~ each calendar year. ~~(3-17-22)~~( )

3079. FISCAL EMPLOYER AGENT ~~DUTIES AND RESPONSIBILITIES~~ (FEA): QUALITY ASSURANCE.

01. Quality Assurance Activities. The FEA must participate in quality assurance activities identified by the Department such as readiness reviews, periodic audits, maintaining a list of background check waivers, and timely reporting of accounting and satisfaction data. ( )

0~~1~~2. ~~Required~~ Elements of Quality ~~In~~ Assurance Process. The provider must provide a quality assurance process that includes: ~~(3-17-22)~~( )

a. Implementation of a quality management plan; (3-17-22)

b. Preparation of a quarterly, quality management analysis report; (3-17-22)

c. Distribution, collection, and analysis of an annual participant satisfaction survey; and (3-17-22)

d. A review of the monthly complaint summary and resolutions, monitoring of standards, and implementation of program improvements as needed. (3-17-22)

02~~3~~. ~~Requirement for~~ Formal Quality Assurance Review. Every two (2) years, the provider must participate in a formal quality assurance review conducted in collaboration with the Department. ~~(3-17-22)~~( )

3~~08~~10. FISCAL EMPLOYER AGENT~~ DUTIES AND RESPONSIBILITIES~~ (FEA): DISASTER RECOVERY PLAN.

01. Disaster Recovery Plan. The provider must develop and maintain a Disaster Recovery Plan for electronic and hard copy files that includes restoring software and data files, and hardware backup if management information systems are disabled or servers are inoperative. The results of the Disaster Recovery Plan must ensure the continuation of payroll and invoice payment systems. The provider must submit the Disaster Recovery Plan for Department approval during the readiness review. (3-17-22)

02. Requirement to Report a Disaster. The provider must report to the Department if management information systems are disabled or servers are inoperative within twenty-four (24) hours of the event. (3-17-22)

3~~09~~11. FISCAL EMPLOYER AGENT~~ DUTIES AND RESPONSIBILITIES~~ (FEA): TRANSITION PLAN.

01. Transition Plan Objectives. The provider must provide a transition plan to the Department ~~within ninety (90) days after successful completion of~~ for the readiness review. The objectives of the transition plan are to minimize the disruption of services and provide an orderly and controlled transition of the provider's responsibilities to a successor at the conclusion of the agreement period or for any other reason the provider cannot complete responsibilities described in this chapter of rules. ~~(3-17-22)~~( )

02. Transition Plan Requirements. The transition plan must: (3-17-22)

a. Be updated at least ninety (90) days prior to termination of the provider agreement. (3-17-22)

b. Include tasks, and subtasks for transition, a schedule for transition, operational resource requirements, and training to be provided. (3-17-22)

c. Provide for transfer of data, documentation, files, and other records relevant to the agreement in an electronic format accepted by the Department. (3-17-22)

d. Provide for the transfer of any current, Idaho-specific policy and procedure manuals, brochures, pamphlets, and all other written materials developed in support of agreement activity to the Department. (3-17-22)

3~~10~~12. FISCAL EMPLOYER AGENT~~ DUTIES AND RESPONSIBILITIES~~ (FEA): PERFORMANCE METRICS.
~~The provider must do the following:~~ ~~(7-1-24)~~

01. Readiness Review. Complete a readiness review conducted by the Department with the provider prior to providing ~~fiscal employer agent~~ FEA services. ~~(7-1-24)~~( )

~~a.~~ ~~The provider must complete one hundred percent (100%) of the readiness review.~~ ~~(7-1-24)~~

~~b~~a. The Department will access SFTP site for review of provider documents and conduct an onsite review. (7-1-24)

~~02.~~ ~~Compliance with Tax Regulations and Labor Laws~~. ~~Ensure each participant's compliance with regulations for both federal and state taxes, and all applicable labor laws.~~ ~~(7-1-24)~~

02~~3~~. Fiscal Support and Financial Consultation. (3-17-22)

a. The provider must provide each participant with fiscal support and financial consultation. (3-17-22)

~~**b.** The provider must respond to ninety-five percent (95%) of calls and voicemails within two (2) business days and to written and electronic correspondence within five business (5) days. (7-1-24)~~

~~**04. Federal and State Forms Submitted**. Ensure each participant's compliance with regulations for both federal and state taxes, including preparation and submission of all federal and state forms for each participant and their employees. (7-1-24)~~

~~**05. Mandatory Reporting, Withholding, and Payment**. Perform all mandatory reporting, withholding, and payment actions according to the compliance requirements of the state and federal agencies. (7-1-24)~~

~~**06. Payroll Checks**. Issue payroll checks within the two (2) week or semi-monthly payroll cycle, after receipt of completed, approved time sheets. (7-1-24)~~

~~**07. Adherence to Support and Spending Plan**. Distribute payments to each participant employee under the participant's support and spending plan. (7-1-24)~~

~~**08. Record Activities**. Record all activities in an individual file for each participant and their employees. (7-1-24)~~

~~**09. Records in Participant File**. Maintain complete records in each participant's file. (7-1-24)~~

~~**10. Manage Phone, Fax, and E-Mail for Fiscal and Financial Questions**. (3-17-22)~~

~~**a.** The provider must manage toll-free telephone line, fax, and e-mail related to participant fiscal and financial questions. (3-17-22)~~

~~**b.** The provider must respond to ninety-five percent (95%) of calls and voicemails within two (2) business days and to written and electronic correspondence within five (5) business days. (7-1-24)~~

~~**11. Track Complaints and Complaint Resolution**. (7-1-24)~~

~~**a.** The provider must maintain a register of complaints from participants, participant employees, and others, with corrective action implemented by the provider within one (1) business day of the complaint response. (7-1-24)~~

~~**b.** The provider must respond to ninety-five percent (95%) of calls and voicemails within two (2) business days and to written and electronic complaints within five (5) business days. (7-1-24)~~

~~**12. Web Access to Electronic Time Sheet Entry**. Maintain web access to electronic time sheet entry for participants. (7-1-24)~~

~~**13. Participant Enrollment Packets and Employment Packets**. Prepare and distribute participant enrollment and employment packets to each participant. (7-1-24)~~

~~**14. Payroll Spending Summaries**. Provide each participant with payroll spending summaries and information about how to read the payroll spending summary each time payroll is executed. (7-1-24)~~

~~15~~03. **Quarterly Reconciliation**. Each fiscal quarter after initiating service, the provider must reconcile its Medicaid Billing Report to a zero-dollar ($0) balance with the Medicaid Bureau of Financial Operations. The provider has ninety (90) days to comply with reconciling each participant's ~~spending plan~~ SSP balance to a zero dollar ($0) balance with Medicaid's reimbursements. The provider must: ~~(7-1-24)~~( )

a. ~~Have~~Show one hundred percent (100%) compliance with the required quarterly reconciliation of the Medicaid Billing Report. ~~(7-1-24)~~( )

b. Notify the Department immediately if an issue is identified that may result in the provider not

reconciling the Medicaid Billing Report. The Department will notify the provider when a performance issue is identified. The Department may require the provider to submit a written corrective action plan for Department approval within two (2) business days after notification. If the provider fails to reconcile within ninety (90) days after the end of each quarter, the provider will be penalized fifty dollars ($50) each week until the provider has reconciled with Medicaid to a zero dollar ($0) balance. (7-1-24)

~~16~~04. **Cash Management Plan**. Each provider's cash management plan must equal one point five (1.5) times the monthly payroll cycle amount and can be forms of liquid cash and lines of credit. For example, if a provider's current payroll minimum has averaged one hundred thousand dollars ($100,000) per payroll cycle, the provider would be required to have one hundred fifty thousand dollars ($150,000) in a cash management plan. The Department must be on the notification list if any lines of credit are decreased in the amount accessible or terminated. The expectation is to provide a seamless payroll cycle to the participant, without loss of pay to their employees. (7-1-24)

31~~1~~3. FISCAL EMPLOYER AGENT ~~DUTIES AND RESPONSIBILITIES~~ (FEA): REPORTS.

01. Account Summary Statements. This report provides an overview of each participant account and includes the services accessed and the remaining dollar amount in the budget as well as information on how to read the report. In addition to ~~the provider~~ providing this monthly report ~~each month~~, a participant may request this report for a specified timeframe. Each month, the provider must at the participant's preference mail a hard copy of the report to each participant ~~and also~~ or make the report available on a secure website ~~for those who prefer to access the information electronically~~. The provider must generate the report after every payroll and post it on a secure SFTP site for the Department to access. This SFTP site must have a user name and password protection. ~~(3-17-22)~~( )

a. Report Format: ~~The provider must provide the account summary statement in~~ Microsoft Excel. ~~(3-17-22)~~( )

b. Report Due Date: ~~The provider must post the account summary statement by t~~ The 10th day of each month. ~~(3-17-22)~~( )

02. Medicaid Billing Report. This report provides a detailed breakdown of ~~community support worker~~ CSW services rendered by service date per employee, per employer. Each line on this report must provide ~~, at a minimum,~~ the following information: employee name ~~, employee~~ and ID number, hours worked, period start, and period end, pay rate, service date, check number ~~, check~~ and date, participant's name, participant's date of birth, participant's ID number, service code, taxes, and billing amount. This report collects information based on the timeframe specified by the user. The provider must generate the report after every payroll and post it on a secure SFTP site for the Department to access. ~~This SFTP site must have a user name and password protection.~~ ~~(3-17-22)~~( )

a. Report Format: ~~The provider must provide the Medicaid Billing Report in~~ Microsoft Excel. ~~(3-17-22)~~( )

b. ~~Report Due Date: The provider must post the Medicaid Billing Report by t~~The 10th day of each month. ~~(3-17-22)~~( )

03. Demographic Report. This report provides general client demographics in the region and the employee count per participant for each participant in the database. The provider must generate the report after every payroll and post it on a secure SFTP site for the Department to access. ~~This SFTP site must have a user name and password protection.~~ ~~(3-17-22)~~( )

a. Report Format: ~~The provider must provide the demographic report in~~ Microsoft Excel. ~~(3-17-22)~~( )

b. Report Due Date: ~~The provider must post the demographic report by t~~ The 10th day of each month. ~~(3-17-22)~~( )

04. ~~Criminal History~~Background Check Report. This report provides a breakdown, by participant,

of which employees the participant waived the background check, which employees passed or failed the background check, the ~~criminal history~~ background check reference number, and the date the background check was submitted. This report does not include ~~support broker~~ SBs. The provider must generate the report after every payroll and post it on a secure SFTP site for the Department to access. ~~This SFTP site must have a user name and password protection.~~ ~~(3-17-22)~~( )

a. Report Format: ~~The provider must provide the criminal history report in~~ Microsoft Word, Microsoft Excel, or PDF. ~~(3-17-22)~~( )

b. Report Due Date: ~~The provider must post the criminal history report by t~~ The 10th day of each month. ~~(3-17-22)~~( )

05. Medicaid Billing Report. This report provides a list and count of the unduplicated participants and expenditures by services code based on the time frame specified by the user. The provider must generate the report after every payroll and post it on a SFTP site. Additionally, the provider must provide a quarterly Medicaid Billing Report that can been reconciled quarterly and work with the Department to reconcile the annual report. (3-17-22)

a. Report Format: ~~The provider must provide the Medicaid Billing Report in~~ Microsoft Excel. ~~(3-17-22)~~( )

b. Report Due Date: The ~~provider must post the Medicaid Billing Report by~~ 10th day of each month. ~~(3-17-22)~~( )

06. Complaint and Resolution Summary Report. The provider must analyze complaints received on a quarterly basis to determine the quality of services to participants and identify any corrective actions and program improvements needed and implemented. The provider must post the report on a secure SFTP site for Department review. (3-17-22)

a. Report Format: ~~The provider must provide the complaint and resolution summary report in~~ Microsoft Word, Microsoft Excel, or PDF. ~~(3-17-22)~~( )

b. Report Due Date: ~~The provider must post the complaint and resolution summary report by t~~ The 10th day of the month following the end of each annual quarter. ~~(3-17-22)~~( )

07. Customer Satisfaction Survey Report. The provider must provide a comprehensive report summarizing the results of the customer satisfaction survey completed by each participant. (3-17-22)

a. Report Format: ~~The provider must provide the customer satisfaction survey report in~~ Microsoft Word, Microsoft Excel, or PDF. ~~(3-17-22)~~( )

b. Report Due Date: ~~The provider must post the customer satisfaction survey report by~~ December 1st of each year. ~~(3-17-22)~~( )

08. Quarterly Financial Statements. The provider must provide the Department a quarterly balance sheet and income statement that shows the provider's quarterly financial status and cash management plan cash reserve. (3-17-22)

a. Report Format: ~~The provider must provide the quarterly balance sheet and income statement in~~ Microsoft Word, Microsoft Excel, or PDF. ~~(3-17-22)~~( )

b. Report Due Date: ~~The provider must provide the quarterly balance sheet and income statement on t~~ The 25th day of the month following the end of each annual quarter. ~~(3-17-22)~~( )

31~~2~~4. FISCAL EMPLOYER AGENT ~~DUTIES AND RESPONSIBILITIES~~ (FEA): PAYMENT REQUIREMENTS.

01. ~~Requirement to Accept a~~ Per Member Per Month (PMPM) Payment. The Department will pay,

and the provider must accept a ~~per member per month (~~ PMPM~~)~~ payment that covers a comprehensive set of ~~fiscal employer agent~~ FEA services. The Department will set allowable reimbursement rates for PMPM based on a methodology approved by CMS in the Adult DD ~~HCBS~~ Waiver. The provider can only bill the PMPM rate for the months services are actually provided for participants, The provider must provide transition, training, and closeout services during the active agreement, at no additional cost to the Department. ~~(3-17-22)~~( )

02. PMPM Payment Process Requirements. The ~~payment (~~ PMPM~~)~~ payment must include all administrative costs, travel, transition, training, and closeout services. The Department will not pay for participants who do not have ~~a support and spending plan~~ an SSP. For the purposes of PMPM payment, one (1) month must include all payroll batch dates within that specific calendar month. ~~(3-17-22)~~( )

03. ~~Requirement to Complete a~~ Readiness Review. The provider must complete a readiness review prior to billing for services. ~~(3-17-22)~~( )

31~~3~~5. TERMINATION OF FISCAL EMPLOYER AGENT (FEA) PROVIDER AGREEMENTS.

~~01.~~ ~~Termination of the Provider Agreement~~. ~~The following must occur i~~In the event of termination of ~~the~~ a provider agreement, the provider must: ~~(3-17-22)~~( )

~~a~~01. Continuation of Services. ~~The provider must ensure~~ Ensure continuation of services to participants for the period in which a ~~Per Member per Month (~~ PMPM~~)~~ payment has been made, and submit the information, reports and records, including the Medicaid Billing Report ~~(reconciliation)~~ as specified in ~~Section 310 of~~ these rules. ~~(3-17-22)~~( )

~~b~~02. Advanced Notice. ~~The provider must p~~ Provide to the Department a written notice ninety (90) days in advance and the change notification must occur at the end of the next calendar quarter. ~~(3-17-22)~~( )

0~~2~~3. Termination of Service ~~to Participant~~. ~~In the event of termination of the provider agreement, the provider must p~~ Provide to the participant a written notice ninety (90) days in advance. The change notification must occur at the end of the next calendar quarter. ~~(3-17-22)~~( )

31~~4~~6. REMEDIES TO NONPERFORMANCE OF A FISCAL EMPLOYER AGENT (FEA) SERVICE PROVIDER.

01. Remedial Action. If any of the services do not comply with the performance metrics under ~~Section 310 of~~ these rules, the Department will consult with the provider and may, at its sole discretion, require any of the following remedial actions, taking into account the scope and severity of the noncompliance, compliance history, ~~the number of noncompliances,~~ the integrity of the program, and the potential risk to participants. ~~(3-17-22)~~( )

a. Require the provider to take corrective action to ensure that performance meets the performance metrics under Section 310 of these rules; (3-17-22)

b. Reduce payment to reflect the reduced value of services received; (3-17-22)

c. Require the provider to subcontract all or part of the service at no additional cost to the Department; or (3-17-22)

d. Terminate the provider agreement with notice. (3-17-22)

02. Direct Monetary Action. If any of the performance metrics under Section 310 of these rules are not met, the Department will enforce a fifty dollar ($50) a week penalty for each performance metric not met. The penalty will be captured prior to any payment from the Department to the provider. (3-17-22)

31~~5~~7. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.14 – HOSPITALS

DOCKET NO. 16-0314-2401 (ZBR CHAPTER REPEAL)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

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) 56-202, Idaho Code, and 39-1307.

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:

Hospital licensing requirements exist in Title 39 Chapter 13 of Idaho Code and IDAPA 16.03.14. To be eligible for funding from federal payors hospitals must also be certified through The Centers for Medicare and Medicaid Services (CMS). The certification process is comprehensive and requires an on-site survey to ensure compliance. Additionally, the health and safety standards for certification mirror state licensure requirements as described in 16.03.14. Given this duplication, the department will pursue a legislative proposal in 2025 to consolidate the licensing process, using the CMS certification standards as the benchmark for obtaining a hospital license.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 4th, 2024, Idaho Administrative Bulletin, Vol. 24-9, pages 335 through 336.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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 will not be a negative fiscal impact exceeding $10,000 to the state by this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at 208-334-5500.

DATED this 26th day of September, 2024.

Alex J. Adams, PharmD, MPH
Director
Idaho Department of Health & Welfare
450 W. State Street, 10th Floor
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(208) 334-5500 phone; (208) 334-6558 fax
Alex.Adams@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 Section(s) 56-202, Idaho Code, and 39-1307.

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 18th, 2024.

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:

Hospital licensing requirements exist in Title 39 Chapter 13 of Idaho Code and IDAPA 16.03.14. To be eligible for funding from federal payors hospitals must also be certified through The Centers for Medicare and Medicaid Services (CMS). The certification process is comprehensive and requires an on-site survey to ensure compliance. Additionally, the health and safety standards for certification mirror state licensure requirements as described in 16.03.14. Given this duplication, the department will pursue a legislative proposal in 2025 to consolidate the licensing process, using the CMS certification standards as the benchmark for obtaining a hospital license.

The proposal will incorporate by reference The Code of Federal Regulations (CFR). It establishes that a certified hospital is also approved as meeting standards for licensing by the State of Idaho. Providers will be required to follow only one set of rules and can obtain both certification and licensure in one single process. Hospitals may still elect to have a CMS approved accreditation organization, or the department determine compliance with CFRs.

State specific standards, such as building design and construction guidelines, background check requirements, and licensure enforcement actions have also been incorporated into this revision or already exist elsewhere in code. Pending legislative approval this bill will repeal chapter 16.03.14, as the amended statue will contain all the necessary regulations to ensure the health and safety of the public.

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

Fees will not be increased by the elimination of this chapter.

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 will not be an impact to the general fund greater than $10,000.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted as this is a repeal of the chapter and negotiated rulemaking is not necessary.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jared Larsen at 208-334-5500.

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 25th, 2024.

DATED this 24th day of July, 2024.

IDAPA 16.03.14 IS PROPOSED TO BE REPEALED IN ITS ENTIRETY.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.04.07 – FEES FOR STATE HOSPITAL NORTH AND STATE HOSPITAL SOUTH

DOCKET NO. 16-0407-2401 (CHAPTER REPEAL)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202, Idaho Code, as well as 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:

This proposed rule intends to repeal IDAPA 16.04.07 because this chapter repeats Centers for Medicare and Medicaid Services' (CMS) regulations, state Medicaid rules, and/or state waiver authority. By eliminating this chapter, the Department of Health and Welfare removes duplicative regulations and reverts direct control to elected policy makers by proposing enacting in code long-standing provisions found in this rules chapter.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 4th, 2024, Idaho Administrative Bulletin, Vol. 24-9, page 337.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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 will not be a negative fiscal impact exceeding $10,000 to the state by this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at 208-334-5500.

DATED this 26th day of September, 2024.

Alex J. Adams, PharmD, MPH
Director
Idaho Department of Health & Welfare
450 W. State Street, 10th Floor
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Alex.Adams@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 Section 56-202, Idaho Code, as well as 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 September 18, 2024.

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 proposed rule intends to repeal IDAPA 16.04.07 because this chapter repeats Centers for Medicare and Medicaid Services' (CMS) regulations, state Medicaid rules, and/or state waiver authority. By eliminating this chapter, the Department of Health and Welfare removes duplicative regulations and reverts direct control to elected policy makers by proposing enacting in code long-standing provisions found in this rules chapter.

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

Fees will not be increased by the elimination of this chapter.

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 will not be an impact to the general fund greater than $10,000.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted as this is a repeal of the chapter and the agency deems negotiated rulemaking as not necessary.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jared Larsen at 208-334-5500.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 25, 2024.

DATED this 11th day of July, 2024.

IDAPA 16.04.07 IS PROPOSED TO BE REPEALED IN ITS ENTIRETY.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.04.18 – CHILDREN'S AGENCIES AND RESIDENTIAL LICENSING

DOCKET NO. 16-0418-2401

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

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 39-1207, 39-1208, 39-1209, 39-1210, 39-1213, 56-1003, 56-1004A, and 56-1005(8), 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:

Because of the updates to 16.06.02, Foster Care Licensing, this rule makes corresponding changes to the children's agencies requirements for foster homes.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the July 3rd, 2024 Idaho Administrative Bulletin, Vol. 24-7, pages 80 through 86.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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 will not be a negative fiscal impact greater than $10,000.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at 208-334-5500.

DATED this 18th day of July, 2024.

Alex J. Adams, PharmD, MPH
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THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2024.

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. This rule chapter is promulgated pursuant to Sections 39-1207, 39-1208, 39-1209, 39-1210, 39-1213, 56-1003, 56-1004A, and 56-1005(8), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than July 17, 2024.

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:

Because of the updates to 16.06.02, Foster Care Licensing, this rule makes corresponding changes to the children's agencies requirements for foster homes.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(a) and (c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

OPE and the Child Protection Oversight Committee have highlighted significant challenges with the current child welfare system and these changes are necessary to protect public health, safety, and welfare and to increase the number and types of foster homes available to serve Idaho youth.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the shortage of foster homes is at a level in which urgent action is needed. Because the major substantive changes are part of a national model act developed in partnership with many organizations, the major changes have been vetted.

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 Alex Adams, Director, 208-334-5500.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 24, 2024.

DATED this 6th day of June, 2024.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0418-2401

300. POLICIES.
A children's agency that licenses foster homes must have policies that comply with IDAPA 16.06.02, "~~Child Care and~~ Foster ~~Home~~ Care Licensing," ~~Sections 400 through 499,~~ and may require that additional foster care rules be met if the agency deems appropriate. ~~(4-6-23)~~( )

~~**301. FOSTER FAMILY HOME STUDY.**~~
~~The agency must conduct and maintain an appropriate home study based on IDAPA 16.06.02, "Child Care and Foster Home Licensing," Sections 400 through 499, to determine if the family meets required licensing standards to be issued a foster care license.~~ ~~(4-6-23)~~

~~**302. TRAINING.**~~
~~The agency must have and follow a training policy that includes completing the orientation and ongoing training requirements of IDAPA 16.06.02, "Child Care and Foster Home Licensing," Sections 400 through 499. All foster care training must be documented in the foster parent's case file record.~~ ~~(4-6-23)~~

~~**303. EMERGENCY EVACUATION PLAN.**~~
~~An agency must have a policy requiring foster homes to have an agency-approved a written evacuation plan.(4-6-23)~~

301. – 303. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

306. COMPLAINT INVESTIGATION PROCESS.

01. Initiation of Complaint Investigation. When a complaint is received that relates to possible foster parent noncompliance with IDAPA 16.06.02, "~~Child Care and~~ Foster ~~Home~~ Care Licensing," ~~Sections 400 through 499,~~ an agency must initiate a complaint investigation as soon as is indicated, based on seriousness of the allegation received, and no later than seven (7) calendar days after receipt of the allegation. ~~(4-6-23)~~( )

02. Agency Report. Upon completion of the investigation, an agency must prepare a written report that includes: (4-6-23)

a. The specific allegations; (4-6-23)

b. Findings of fact, based on the investigation; (4-6-23)

c. Conclusions regarding noncompliance with IDAPA 16.06.02, "Child Care and Foster Care Licensing," ~~Sections 400 through 499~~; ~~(4-6-23)~~( )

d. Any changes in the agency's decision regarding placement specifications, based on the investigation's findings; and (4-6-23)

e. Recommendations regarding licensing action and any required corrective action. (4-6-23)

(BREAK IN CONTINUITY OF SECTIONS)

362. FAMILY HOME STUDY, APPLICATION PROCESS, AND CONTENT.
An agency must complete or obtain a home study and application before approving the home for the placement of a child. (4-6-23)

01. Required Information. The home study must meet the requirements outlined in IDAPA 16.06.01 and include the following: ~~(4-6-23)~~( )

a. When there is a change in persons residing in the home, the applicant must notify the agency of the change by the next working day, and the new adult member must complete a background check; (4-6-23)

~~**b.** Verification that the age of the applicant complies with Section 16-1502, Idaho Code; (4-6-23)~~

~~**c.** Names, including maiden or other names used; (4-6-23)~~

~~**d**~~**b.** Social Security Number; (4-6-23)

~~**e.** Education; (4-6-23)~~

~~**f.** Verification of marriages and divorces; (4-6-23)~~

~~**g.** Religious and cultural practices, including their willingness and ability to accommodate or provide care to a child of a different race, religion, or culture; (4-6-23)~~

~~**h.** A statement of income and financial resources and the family's management of these resources; (4-6-23)~~

~~**i.** Marital relationship, if applicable, including decision-making, communication, and roles within the family; (4-6-23)~~

~~**j**~~**c.** Description of individuals and family dynamics with each member of the household; (4-6-23)

~~**k**~~**d.** Documentation of any current or past family problems, including mental illness, substance abuse, addiction, and medical conditions; (4-6-23)

~~**l.** Previous criminal convictions of child abuse and neglect; (4-6-23)~~

~~**m.** Family history, including childhood experiences and the applicant's parents' methods of discipline and problem solving; (4-6-23)~~

~~**n**~~**e.** Special needs of the applicant's children and a description of how they will adjust to a new member of the household; (4-6-23)

~~**o.** Interests and hobbies; (4-6-23)~~

~~**p.** Adequacy of the house, property, and neighborhood as determined by onsite observations; (4-6-23)~~

~~**q.** Child care and parenting skills; (4-6-23)~~

~~**r.** Current methods of discipline; (4-6-23)~~

~~**s**~~**f.** Demonstrated understanding of the care that must be provided to the children served by the agency or express a willingness to learn how to provide that care; (4-6-23)

~~**t**~~**g.** The applicant has adequate time to provide care and supervision for children; (4-6-23)

~~**u**~~**h.** Demonstration of a home life that gives children the emotional stability they need. No marital or personal problems may exist within the family that would result in undue emotional strain in the home or be harmful

to the interest of children placed in the home; (4-6-23)

~~v. A medical statement for each applicant and members of the household, signed by a medical professional, within the twelve (12) month period prior to initial approval for adoption, indicating they are in such physical and mental health so as to not adversely affect either the health or quality of care for children placed in the home;~~ ~~(4-6-23)~~

~~w. Three (3) satisfactory references, one (1) of which may be from a person related to the applicant(s);~~ ~~(4-6-23)~~

~~x. Names of each member of the household; this includes any persons who reside at the applicant's address;~~ ~~(4-6-23)~~

~~y. Each adoptive parent's reasons for applying to be an adoptive parent and prior efforts to adopt;~~ ~~(4-6-23)~~

~~z. Understanding of the permanence of adoption;~~ ~~(4-6-23)~~

~~aa. The family's prior and current experiences with adoption;~~ ~~(4-6-23)~~

~~bb. The attitudes toward adoption by immediate and extended members of the family and other persons who reside in the home;~~ ~~(4-6-23)~~

~~cc. Family's attitudes toward the adoptive child's birth family and willingness to allow them contact with the child after adoption;~~ ~~(4-6-23)~~

~~dd~~i. Applicant's experience with other support agencies or resources in their communities and their comfort level in seeking help from services outside the family; (4-6-23)

~~ee~~j. Applicant's awareness of the potential for the child to have identity issues and loss regarding separation from birth parents; (4-6-23)

~~ff~~k. Applicant's ability to accept a child's background and help the child cope with their past; (4-6-23)

~~gg~~l. Applicant's understanding that the child will have questions about birth parents and other relatives; and ~~(4-6-23)~~( )

~~hh. Specifications of children preferred by the family that include the number of children, and the age, gender, race, ethnic background, social, emotional, and educational characteristics;~~ ~~(4-6-23)~~

~~ii. Information on the adoptive family's medical insurance coverage including insurance carrier, policy number, eligibility of new adoptive family member(s), limitations, and exclusions; and~~ ~~(4-6-23)~~

~~jj~~m. How the household will fulfill their transportation needs. (4-6-23)

02. Pre-Adoptive Parent to Inform Agency of Changes. The pre-adoptive parent is responsible to keep the agency that completed the home study informed of changes in the family's circumstances, or of any subsequent decision against adoption. (4-6-23)

03. Adoptive Placement Agreement. A home study is valid for the purposes of new adoptive placement for a period of one (1) year following the date of completion. Upon completion of an adoptive placement agreement, a home study remains valid for a period of two (2) years from the home study date of completion for the purpose of finalizing the adoption of the child(ren) for whom the adoptive placement agreement was written. (4-6-23)

363. SAFETY REQUIREMENTS.
The property, structure, premises, and furnishings of an adoptive home must be constructed and maintained in good

repair, in a clean condition, free from safety hazards and dangerous machinery and equipment. Areas and equipment that present a hazard to children must not be accessible by children. The safety requirements must be consistent with IDAPA 16.06.02, "Foster Care Licensing," and may require that additional safety rules be met if the agency deems appropriate. ~~(4-6-23)~~( )

~~01. Pools, Hot Tubs, and Ponds~~. ~~Homes must provide the following safeguards:~~ ~~(4-6-23)~~

~~a.~~ ~~Around any body of water, children have appropriate adult supervision consistent with the child's age, physical ability, and developmental level;~~ ~~(4-6-23)~~

~~b.~~ ~~The area surrounding access to a body of water for use by children will be secured by a fence and locked in a manner that prevents access by children, or have a secured protective covering that prevents access by a child;~~ ~~(4-6-23)~~

~~c.~~ ~~Pool or hot tub covers be completely removed when in use;~~ ~~(4-6-23)~~

~~d.~~ ~~When the pool or hot tub cover is in place, the cover is free from standing water;~~ ~~(4-6-23)~~

~~e.~~ ~~Covers are always secured when the pool or hot tub is not in use; and~~ ~~(4-6-23)~~

~~f.~~ ~~Exterior ladders on above ground pools be removed when the pool is not in use.~~ ~~(4-6-23)~~

~~02. Access by Children Five Years Old and Under~~. ~~Any home that has children five (5) years old or younger and chooses to prevent access to a body of water by fencing must provide the following:~~ ~~(4-6-23)~~

~~a.~~ ~~The fence be at least four (4) feet high with no vertical opening more than four (4) inches wide, be designed so that a young child cannot climb or squeeze under or through the fence, and surround all sides of the pool or pond;~~ ~~(4-6-23)~~

~~b.~~ ~~The gate be self-closing and have a self-latching mechanism in proper working order out of the reach of young children;~~ ~~(4-6-23)~~

~~c.~~ ~~If the house forms one (1) side of the barrier for the pool, doors that provide unrestricted access to the pool have alarms that produce an audible sound when the doors are opened; and~~ ~~(4-6-23)~~

~~d.~~ ~~Furniture or other large objects will not be left near the fence enabling a child to climb on the furniture and gain access to the pool.~~ ~~(4-6-23)~~

~~03. Irrigation Canals or Similar Bodies of Water~~. ~~A home that has a child five (5) years old or younger or a child who is physically or developmentally vulnerable, whose property adjoins an irrigation canal or similar body of water, must have fencing that prevents access to the canal or similar body of water.~~ ~~(4-6-23)~~

~~364. FLAME AND HEAT PRODUCING EQUIPMENT.~~
~~A home that has a furnace, fireplace, wood-burning stove, water heater, and other flame or heat-producing equipment must ensure that said equipment is installed and maintained as recommended by the manufacturer, and fireplaces protected by screens or other means.~~ ~~(4-6-23)~~

~~365. SMOKE AND CARBON MONOXIDE DETECTORS.~~
~~Each home must meet the following:~~ ~~(4-6-23)~~

~~01. Smoke Detectors~~. ~~There will be:~~ ~~(4-6-23)~~

~~a.~~ ~~At least one (1) single-station smoke detector that is installed and maintained as recommended by the manufacturer;~~ ~~(4-6-23)~~

~~b.~~ ~~One (1) smoke detector on each floor of the home, including the basement;~~ ~~(4-6-23)~~

c. One (1) smoke detector in each bedroom; and (4-6-23)

d. One (1) smoke detector in areas of the home that contain flame or heat-producing equipment other than domestic stoves and clothes dryers. (4-6-23)

02. Carbon Monoxide Detectors. There will be at least one (1) carbon monoxide detector installed and maintained as recommended by the manufacturer. A house that does not have equipment which produces carbon monoxide or does not have an attached garage is exempt from this requirement. (4-6-23)

366. EXITS.
There must be at least two (2) exits from each floor level used by a family member that are remote from each other, one (1) of which provides a direct, safe means of unobstructed travel to the outside at street or ground level. A window may be used as a second exit if in compliance with these rules. (4-6-23)

367. DANGEROUS AND HAZARDOUS MATERIALS.
Dangerous and hazardous materials, objects, or equipment that could present a risk to a child, including poisonous, explosive, or flammable substances must be stored securely and out of reach of a child for the child's age and functioning level. (4-6-23)

368. FIREARMS AND AMMUNITION.
Ammunition must be in a locked container and inaccessible to children. Firearms must be: (4-6-23)

01. Trigger Locks. Unloaded and equipped with a trigger lock; (4-6-23)

02. Unassembled and Inoperable. Unloaded, fully inoperable, and unassembled; (4-6-23)

03. Locked Cabinet or Container. Unloaded and locked in a cabinet or storage container that is inaccessible to children; or (4-6-23)

04. Gun Safe. Locked in a gun safe that is inaccessible to children. (4-6-23)

369. PETS AND DOMESTIC ANIMALS.
Any pet or domestic animal that is suspected or known to be dangerous must be kept in an area inaccessible to children. (4-6-23)

370. HEAT, LIGHT, AND VENTILATION.
A home must have adequate heat, light, and ventilation. (4-6-23)

371. BATHROOMS, WATER SUPPLY, AND SEWAGE DISPOSAL.
A home must meet the following: (4-6-23)

01. Bathrooms. A minimum of one (1) flush toilet, one (1) sink that has warm and cold running water, and one (1) bathtub or shower that has warm and cold running water, all in good working order. (4-6-23)

02. Water Supply. The water supply meets one (1) of the following requirements: (4-6-23)

a. It is water used for consumption that is bottled water from an acceptable source or water boiled for a period specified by the health authority under IDAPA 58.01.08, "Idaho Rules for Public Drinking Water Systems"; or (4-6-23)

b. Water used for consumption is from an acceptable source, bottled water from an acceptable source, or boiled for a period specified by the local health authority under IDAPA 58.01.08, "Idaho Rules for Public Drinking Water Systems." (4-6-23)

03. Sewage Disposal. Sewage will be disposed of through a public system, or in the absence of a public system, in a manner approved by the local health authority, under IDAPA 58.01.03 "Individual/Subsurface Sewage Disposal Rules." (4-6-23)

364. – 371. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.05.01 – USE AND DISCLOSURE OF DEPARTMENT RECORDS

DOCKET NO. 16-0501-2401

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202, Idaho Code, as well as Sections 39-242, 56-221, 56-222, 56-1003, and 561004, 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 rule adds language detailing that the Department will provide information to the maximum extent possible to protect children from abuse. This rule change also deletes unnecessary regulatory burden.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 4th, 2024, Idaho Administrative Bulletin, Vol. 24-9, page 339 through 341.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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 will not be a negative fiscal impact exceeding $10,000 to the state by this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at 208-334-5500.

DATED this 26th day of September, 2024.

Alex J. Adams, PharmD, MPH
Director
Idaho Department of Health & Welfare
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Boise, ID 83720-0036
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Alex.Adams@dhw.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is August 6th, 2024.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Section 56-202, Idaho Code, as well as Sections 39-242, 56-221, 56-222, 56-1003, and 56-1004, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 18th, 2024.

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

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

This rule adds language detailing that the Department will provide information to the maximum extent possible to protect children from abuse. This rule change also deletes unnecessary regulatory burden.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(a), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

The health and safety of the children of the State of Idaho is central to the mission of the Department of Health and Welfare. This temporary rule is necessary to detail the Department's position of being as transparent as possible in providing information to protect Idaho's children from abuse and neglect and to facilitate child and family services.

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

Fees are not increased as a result of this rulemaking.

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

There will not be a negative fiscal impact exceeding $10,000.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because of the immediate need to institute additional protections for Idaho's youth.

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 Jared Larsen at 208-334-5500.

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 25th, 2024.

DATED this 6th day of August, 2024.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0501-2401

16.05.01 – USE AND DISCLOSURE OF DEPARTMENT RECORDS

000. LEGAL AUTHORITY.
~~The Idaho Department of Health and Welfare and the Board of Health and Welfare have authority to promulgate rules governing the use and disclosure of Department records, according to~~ Sections 39-242, 56-221, 56-222, 56- 1003, and 56-1004, Idaho Code. ~~(3-17-22)~~( )

001. ~~TITLE AND~~ SCOPE.

~~01.~~ ~~Title~~. ~~These rules are titled IDAPA 16.05.01, "Use and Disclosure of Department Records."~~ ~~(3-17-22)~~

~~02.~~ ~~Scope~~. These rules govern the use and disclosure of information maintained by the Department, in compliance with applicable state and federal laws, and federal regulations. ~~(3-17-22)~~( )

~~a.~~ ~~These rules apply to all Department employees, contractors, providers of services, and other individuals or entities who request or use that information.~~ ~~(3-17-22)~~

~~b.~~ ~~These rules apply to all use and disclosure information, regardless of the form in which it is retained or disclosed.~~ ~~(3-17-22)~~

~~c.~~ ~~All individuals and entities must comply with any standards in state or federal law or regulation that contain additional requirements, or are more restrictive than the requirements of these rules.~~ ~~(3-17-22)~~

(BREAK IN CONTINUITY OF SECTIONS)

210. CHILD PROTECTION.
~~Unless allowed by these rules or other provision of law,~~It shall be the policy of the Idaho Department of Health and Welfare to provide information to the maximum extent possible to carry out the department's responsibility under law to protect children from abuse and neglect and to facilitate child and family services. ~~t~~The Department, upon request will disclose information from child protection records in its possession ~~upon a court order obtained in compliance with Subsection 075.02 of these rules~~ pursuant to Section 74-105(7), Idaho Code. Disclosure of Department records under the Child Protective Act is governed by Section 16-1629(6), Idaho Code, and Idaho Court Administrative Rule 32. Court records of Child Protective Act proceedings are governed by Section 16-1626, Idaho Code. Pertinent federal laws and regulations include 42 USC 5106a. ~~Information regarding child fatalities or near fatalities may be made public.~~ ~~(3-17-22)~~( )

01. Child Fatalities. In accordance with 42 USC 5106a(b)(2)(B)(x), the Department will disclose non-identifying summary information to the Statewide Child Fatality Review Team, established by the Governor's Task Force on Children at Risk, regarding child fatalities that were determined to be the result of abuse, neglect, or abandonment. (3-17-22)

02. Public Disclosure. The Department has the discretion to disclose child-specific information under this rule when the disclosure is not in conflict with the child's best interests and one (1) or more of the following applies: (3-17-22)

a. Identifying information related to child-specific abuse, neglect, or abandonment has been

previously published or broadcast through the media; (3-17-22)

b. All or part of the child-specific information has been publicly disclosed in a judicial proceeding; or (3-17-22)

c. The disclosure of information clarifies actions taken by the Department on a specific case. (3-17-22)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.06.01 – CHILD AND FAMILY SERVICES

DOCKET NO. 16-0601-2405 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202, Idaho Code, as well as Sections 16-1629, 16-1623, 16-2102, 16-2406, 16-2423, 16-2433, 39-1209, 39-1210, 39-1211, 39-5603, 39-7501, 56-204A, 56-803, 56-1003, 56-1004, 56-1004A, and 56-1007, Idaho Code.

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

In compliance with Executive Order Number 2020-01, Zero-Based Regulation a complete review and re-write of the rule was completed. The focus of the review and re-write was to eliminate outdated rules and streamline the rule chapter to be more clear. Rather than incorporating federal and state laws into the rule itself, references to those laws were used to ensure the public has the ability to review the source of those regulations directly. Content in the rule was reorganized to ensure topics were in the same place in the rule rather than being discussed in several different areas of the rule. Language was updated as well to be more clear and align with current practice. The rule was updated to ensure compliance with recent court rulings related to the child welfare program. Some of the larger changes to the rule were related to changes regarding the placement of individuals on the central registry to ensure due process, elimination of fees related to adoptions and adoption home studies, expanding the definition of family service worker, and removing the foster care reimbursement fees from the rule to be published on the department's website.

After further inspection of this rule chapter it was determined that the temporary and proposed rulemaking edits that were published in the June 5, 2024, Idaho Administrative Bulletin, Vol. 24-6 pages 29 through 36 were not incorporated into the ZBR chapter rewrite that was published in the September 4, 2024 Idaho Administrative Bulletin, Vol. 24-9 pages 348 through 414. As such, the Department is seeking to correct this error by vacating pending rule 16-0601-2401 and replacing it with the combined language of 16-1601-2401 and 16-0601-2402 into a new docket, 16-0601-2405.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the December 4th, 2024, Idaho Administrative Bulletin, Vol. 24-12, pages 24-89.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

Fees will not be increased as a result of this rulemaking.

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

There will not be a negative fiscal impact exceeding $10,000.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the pending rule, contact Jared Larsen at 208-334-5500.

DATED this 25th day of December, 2024.

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THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Sections 67-5221, Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 56-202, Idaho Code, as well as 16-1629, 16-1623, 16-2102, 16-2406, 16-2423, 16-2433, 39-1209, 39-1210, 39-1211, 39-5603, 39-7501, 56-204A, 56-803, 56-1003, 56-1004, 56-1004A, and 56-1007, Idaho Code.

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

VIRTUAL TELECONFERENCE Via WebEx

Wednesday, December 11, 2024
4:00 p.m.-5:00 p.m. (MT)

Join from the meeting link:
https://idhw.webex.com/idhw/j.php?MTID=mf627b57e4f0e011bafa57b6f98b732bc

Join by meeting number:
Meeting number (access code): 2821 038 7796
Meeting password: iZ2K7upJJd2 (49257875 when dialing from a phone or video system)

Join by phone:
+1-415-527-5035 United States Toll
+1-303-498-7536 United States Toll (Denver)

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 compliance with Executive Order Number 2020-01, Zero- Based Regulation a complete review and re-write of the rule was completed. The focus of the review and re-write was to eliminate outdated rules and streamline the rule chapter to be more clear. Rather than incorporating federal and state laws into the rule itself, references to those laws were used to ensure the public has the ability to review the source of those regulations directly. Content in the rule was reorganized to ensure topics were in the same place in the rule rather than being discussed in several

different areas of the rule. Language was updated as well to be more clear and align with current practice. The rule was updated to ensure compliance with recent court rulings related to the child welfare program. Some of the larger changes to the rule were related to changes regarding the placement of individuals on the central registry to ensure due process, elimination of fees related to adoptions and adoption home studies, expanding the definition of family service worker, and removing the foster care reimbursement fees from the rule to be published on the department's website.

After further inspection of this rule chapter it was determined that the temporary and proposed rulemaking edits that were published in the June 5, 2024, Idaho Administrative Bulletin, Vol. 24-6 pages 29 through 36 were not incorporated into the ZBR chapter rewrite that was published in the September 4, 2024 Idaho Administrative Bulletin, Vol. 24-9 pages 348 through 414. As such, the Department is seeking to correct this error by vacating pending rule 16-0601-2401 and replacing it with the combined language of 16-1601-2401 and 16-0601-2402 into a new docket, 16-0601-2405.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: Fees will not be increased as a result of this rule change.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state General Fund greater than ten thousand dollars ($10,000) during the fiscal year: There will not be a negative fiscal impact exceeding $10,000.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 3rd, 2024 Idaho Administrative Bulletin, Volume 24-4, pages 23 and 24.

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 Jared Larsen at 208-334-5500.

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 December 25th, 2024.

DATED this 21st day of November, 2024.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0601-2405

16.06.01 – CHILD AND FAMILY SERVICES

000. LEGAL AUTHORITY.
~~The Idaho Legislature has delegated to the Department, or the Board of Health and Welfare, or both jointly, the responsibility to establish and enforce such rules and methods of administration as may be necessary or proper to administer social services to people who are in need, under the following Sections:~~These rules are established to govern the statewide provision of services associated with child protection, foster care, and adoption under the following statutes: Sections 16-1601, 16-1629, 16-1623, 16-2001, 16-2102, 16-2406, 16-2423, and 16-2433, 39-1209 through 1211, 39-5603, 39-7501, 56-202(b), 56-204A, 56-204B, 56-803, 56-1003, 56-1004, 56-1004A, and 56-1007, Idaho Code. ~~(3-15-22)~~( )

001. ~~TITLE,~~ SCOPE~~, AND GOAL~~.

~~**01. Title**. These rules are titled IDAPA 16.06.01, "Child and Family Services." (3-15-22)~~

0~~2~~1. Scope. These rules are established to govern the statewide provision of: (3-15-22)

a. Services associated with child protection, alternate care, and adoption; and (3-15-22)

b. As resources are available, services aimed at preventing child abuse, neglect, and abandonment. (3-15-22)

~~**03. Goal**. The goal of all Child and Family Services programs is the safety, permanency, and well-being of children, as well as promoting the stability and security of Indian tribes and families. (3-15-22)~~

002. -- 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Criminal History and Background Check. All current Department employees, applicants, transfers, reinstated former employees, student interns, contract employees, Certified Adoption Professionals, volunteers, and others assigned to programs that involve direct contact with children or vulnerable adults as described in Section 39-5302, Idaho Code, must comply with the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." (3-15-22)

~~**02. Availability to Work or Provide Service**. Certain individuals are allowed to provide services after the self-declaration is completed as provided in Section 56-1004A, Idaho Code, except when they have disclosed a designated crime listed in IDAPA 16.05.06, "Criminal History and Background Checks." The criminal history check requirements applicable to each provider type are found in the rules that state the qualifications or certification of those providers. (3-15-22)~~

~~**03. Adoption**. An individual applying to the Department to be an adoptive parent or petitioning the court for the adoption of a child must comply with the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." (3-15-22)~~

010. DEFINITIONS AND ABBREVIATIONS A THROUGH E.
For the purposes of these rules, the following terms are used: (3-15-22)

~~**01. Adoption and Safe Families Act of 1997 (P.L. 105-89) (ASFA)**. Federal law whose purpose is to improve the safety of children, to promote adoption and other permanent homes for children who need them, and to support families. (3-15-22)~~

~~**02. Adoption Assistance**. Funds provided to adoptive parent(s) of a child who has special needs or who could not be adopted without financial or medical assistance. (3-15-22)~~

0~~3~~1. Adoption Services. Protective services through which a child is provided with a permanent home, under new legal parentage, including transfer of the mutual rights and responsibilities that prevail in the parent-child relationship. (3-15-22)

0~~4~~2. Alternate Care. Temporary living arrangements, when necessary for a child to leave their own home, through a variety of foster care, respite care, residential treatment, and institutional resources, under the protections established in ~~Public Law~~ P.L. 96-272, the federal "Adoption Assistance and Child Welfare Act of 1980" as amended by Public Law 105-89, the Adoption and Safe Families Act of 1997 (ASFA), ~~the Child Protective Act, Section 16-1601 et seq., Idaho Code~~ Title 16, Chapter 16, Idaho Code, and the Indian Child Welfare Act (ICWA), 25 U.S.C. Sections 1901-1963. ~~(3-15-22)~~( )

0~~5~~3. ~~Alternate Care~~ Child's Plan. A federally required component of the ~~Family Plan~~ family case plan

for a child in alternate care. The ~~alternate care~~ child's plan contains elements related to reasonable efforts, the family's plan, the child's alternate care provider, compelling reasons for not terminating parental rights, Indian status, education, ~~immunization,~~ medical, and other information important to the day-to-day care of the child. ~~(3-15-22)~~( )

0~~6~~4. **Board**. The Idaho State Board of Health and Welfare. (3-15-22)

0~~7~~5. **Case Management**. A change-oriented service to families that ensures and coordinates ~~the provision of family~~ ongoing assessment, family ~~service~~ case planning, treatment, ~~planning for~~ permanency, ~~protection~~ planning, child safety, advocacy, ~~review and reassessment,~~ documentation, and timely closure of a case. ~~(3-15-22)~~( )

~~**08. Certified Adoption Professional (formerly "qualified individual")**. An individual certified by the Department who meets the qualifications specified in Section 889 of these rules for completion of pre-placement adoption home studies, reports to the court under the Termination of Parent and Child Relationship and Adoption of Children Acts, and placement supervision reports.~~ ~~(3-15-22)~~

0~~9~~6. **Child and Family Services (CFS)**. Those programs and services provided to families and children, administered by the ~~D~~department in accordance with these rules. ~~(3-15-22)~~( )

~~**10. Child Protection**. All children under eighteen (18) who have been harmed or threatened with harm by a person responsible for their health or welfare through non-accidental physical or mental injury, sexual abuse (as defined by state law) or negligent treatment or maltreatment, including the failure to provide adequate food, clothing, or shelter must be served without regard to income.~~ ~~(3-15-22)~~

~~11~~07. **Child Protective Services**. Services provided in response to potential, alleged, or actual abuse, neglect, or abandonment of individuals under the age of eighteen (18) in accordance with the provisions ~~of Section 16-1601 et seq., Idaho Code, the "Child Protective Act."~~ Title 16, Chapter 16, Idaho Code. ~~(3-15-22)~~( )

~~12~~08. **Compact Administrator**. The individual designated to coordinate interstate transfers of persons requiring special services in accordance with the provisions of ~~Section 16-1901 et seq., Idaho Code, "Interstate Compact for Juveniles";~~ Title 16, Chapter 19, Idaho Code; ~~Section 16-2101 et seq., Idaho Code, "Interstate Compact on the Placement of Children";~~ Title 16, Chapter 21, Idaho Code; or ~~Section 39-7501 et seq., Idaho Code, "Interstate Compact on Adoption and Medical Assistance."~~ Title 39, Chapter 75, Idaho Code. ~~(3-15-22)~~( )

~~13~~09. **Daycare ~~for Children~~**. Care and supervision provided for compensation during part of a twenty-four (24) hour day, for a child or children not related by blood or marriage to the person or persons providing the care, in a place other than the child's or children's own home or homes. ~~(3-15-22)~~( )

1~~4~~0. **Department**. The Idaho Department of Health and Welfare. (3-15-22)

1~~5~~1. **Deprivation**. One of the factors used in determining Aid to Families with Dependent Children -- Foster Care (AFDC-FC) eligibility for children in foster care. Deprivation is a lack of, or interruption in, the maintenance, physical care, and parental guidance a child ordinarily receives from one (1) or both parents. A child is deprived by the continued absence of a parent, incapacity of a parent, death of a parent, unemployment or underemployment of the principal wage earner parent. (3-15-22)

1~~6~~2. **Director**. The Director of the Idaho Department of Health and Welfare or their designee. (3-15-22)

1~~7~~3. **Extended Family Member of an Indian Child**. As defined by the law~~,~~; or custom of ~~an~~ the Indian child's tribe or, in the absence of such law or custom, a person who has reached the age of eighteen (18) and who is ~~an~~ the Indian child's grandparent, aunt or uncle, brother or sister, brother-in-law or sister-in-law, niece or nephew, first or second cousin, or stepparent. ~~(3-15-22)~~( )

1~~8~~4. **Extended Foster Care**. A court order or voluntary case extending foster care placement services and authority for individuals between the ages of eighteen (18) and twenty-one (21) years to help such person achieve a successful transition to adulthood, ~~provided such person must have been~~ providing they were in the custody of the

department until ~~his~~ their eighteenth birthday and must meet the criteria set forth in 42 25 U.S.C. 675(8)(B)(iv). ~~(3-15-22)~~( )

011. DEFINITIONS AND ABBREVIATIONS F THROUGH K.
For the purposes of these rules, the following terms are used: (3-15-22)

01. Family. Parent(s), legal guardian(s), related individuals including birth or adoptive immediate family members, extended family members and significant other individuals, who are included in the family plan. (3-15-22)

02. Family Assessment. An ongoing process based on information gained through a series of meetings with a family to gain mutual ~~perception~~ understanding of strengths and resources that can support them in creating long-term solutions related to identified ~~service needs and~~ safety threats ~~to~~ and needs to support family integrity, unity, ~~or~~ and the ability to care for their ~~members~~ children. ~~(3-15-22)~~( )

03. Family Case Record. ~~Electronic and hard copy c~~ Compilation of all documentation relating to a family, including legal documents, identifying information, and evaluations. ~~(3-15-22)~~( )

04. ~~Family (~~Case~~)~~ Plan. ~~Also referred to as a family service plan. A written~~ document ~~that serves as the guide for provision of services. The plan,~~ developed with the family, ~~clearly~~ to guide the provision of services. The plan identifies who does what, when, how, and why. ~~The family plan~~ and incorporates ~~any special~~ specific plans ~~made~~ for ~~individual family members~~ case participants. If the family includes an Indian child, or child's tribe, tribal elders or leaders ~~should be~~ are consulted early in the plan development. ~~(3-15-22)~~( )

05. Family Services Worker. Case carrying personnel working in regional Child and Family Services Programs. (7-1-24)

~~**06. Federally Funded Guardianship Assistance for Relatives**. Benefits described in Subsection 702.04 and Section 703 of these rules provided to a relative guardian for the support of a child who is fourteen (14) years of age or older, who, without guardianship assistance, would remain in the legal custody of the Department of Health and Welfare.~~ ~~(3-15-22)~~

0~~7~~6. **Field Office**. A Department of Health and Welfare service delivery site. (3-15-22)

~~**08. Goal**. A statement of the long-term outcome or plan for the child and family.~~ ~~(3-15-22)~~

0~~9~~7. **Independent Living Services**. ~~Services p~~ Provided to eligible foster or former foster youth, ages fourteen (14) to twenty-three (23), designed to support a successful transition to adulthood. ~~(3-15-22)~~( )

~~10~~08. **Indian**. Any person who is a member of an Indian tribe or who is an Alaska Native and a member of a Regional Corporation as defined in 43 U.S.C. 1606. (3-15-22)

~~11~~09. **Indian Child**. Any unmarried person who is under the age of eighteen (18) ~~who~~ and is either: ~~(3-15-22)~~( )

a. A member of an Indian tribe; or (3-15-22)

b. Eligible for membership in an Indian tribe~~,~~ and ~~who~~ is the biological child of a member of an Indian tribe. ~~(3-15-22)~~( )

~~**12. Indian Child Welfare Act (ICWA)**. The Indian Child Welfare Act, 25 U.S.C. 1901, et seq.~~ ~~(3-15-22)~~

1~~3~~0. **Indian Child's Tribe**. (3-15-22)

a. The Indian tribe in which an Indian child is a member or eligible for membership, or (3-15-22)

b. In the case of an Indian child who is a member of or eligible for membership in more than one (1) tribe, the Indian tribe with which the Indian child has the more significant contacts. (3-15-22)

141. **Indian Tribe**. Any Indian Tribe, band, nation, or other organized group or community of Indians recognized as eligible for the services provided to Indians by the Secretary because of their status as Indians, including any Alaska Native village as defined in 43 U.S.C. 1602(c). (3-15-22)

~~**15. Intercountry Adoption Act of 2000 (P.L. 106-279)**. Federal law designed to protect the rights of, and prevent abuses against children, birth families, and adoptive parents involved in adoptions (or prospective adoptions) subject to the Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption, and to insure that such adoptions are in the children's best interests; and to improve the ability of the federal government to assist U.S. citizens seeking to adopt children from abroad and residents of other countries party to the Convention seeking to adopt children from the United States. (3-15-22)~~

~~**16. Interethnic Adoption Provisions of 1996 (IEP)**. IEP prohibits delaying or denying the placement of a child for adoption or foster care on race, color or national origin of the adoptive or foster parent(s), or the child involved. (3-15-22)~~

172. **Interstate Compact on the Placement of Children (ICPC)**. Interstate Compact on the Placement of Children (ICPC) in Title 16, Chapter 21, Idaho Code, ensures that the jurisdictional, administrative, and human rights obligations of interstate placement or transfers of children are protected. (3-15-22)

183. **Kin**. ~~Non-relatives~~Individuals who do not meet the definition of relative in Section 16-1602, Idaho Code, who have a significant, family-like relationship with a child. Kin may include extended family members, godparents, close family friends, clergy, teachers, and members of an ~~child's~~ Indian child's tribe, and foster parents who have a significant relationship with the child for at least six (6) months. ~~Also known as fictive kin.~~ ~~(3-15-22)~~( )

012. DEFINITIONS AND ABBREVIATIONS L THROUGH R.
For the purposes of these rules, the following terms are used: (3-15-22)

01. **Legal Guardianship**. A judicially-created relationship, in accordance with Title 15, Chapter 5, Part 2, Idaho Code, including one made by a tribal court, between a child and a relative or non-relative. (3-15-22)

~~**02. Licensed**. Facilities or programs are licensed in accordance with the provisions of IDAPA 16.06.02, "Child Care Licensing." (3-15-22)~~

~~**03. Licensing**. See IDAPA 16.06.02, "Child Care Licensing," Section 100. (3-15-22)~~

~~**04. Medicaid**. See "Title XIX." (3-15-22)~~

~~**05. Multiethnic Placement Act of 1994 (MEPA)**. MEPA prohibits states or public and private foster care and adoption agencies that receive federal funds from delaying or denying the placement of any child solely on the basis of race, color, or national origin. (3-15-22)~~

062. **Parent**. A person who, by birth or through adoption, is considered legally responsible for a child. The term "legal guardian" is not included in the definition of parent. (3-15-22)

073. **Permanency Planning**. ~~A primary function of family services initiated in all cases to identify~~ The identification of programs, services, and activities designed to establish permanent home and family relationships for children ~~within a reasonable amount of time~~. ~~(3-15-22)~~( )

~~**08. Personal Care Services (PCS)**. Services to eligible Medicaid recipients that involve personal and medically-oriented tasks dealing with the physical or functional impairments of the individual. (3-15-22)~~

~~**09. P.L. 96-272**. Public Law 96-272, the federal "Adoption Assistance and Child Welfare Act of 1980." (3-15-22)~~

~~10. P.L. 105-89~~. ~~Public Law 105-89, the federal "Adoptions and Safe Families Act of 1997," amends P.L. 96-272 and prohibits states from delaying or denying cross-jurisdictional adoptive placements with an approved family.~~ ~~(3-15-22)~~

~~11. Planning~~. ~~An orderly rational process that results in identification of goals and formulation of timely strategies to fulfill such goals, within resource constraints.~~ ~~(3-15-22)~~

~~12. Qualified Expert Witness–ICWA~~. ~~An individual who is an expert regarding tribal customs pertaining to family organization and child rearing practice, and is qualified to render an opinion as to whether continued custody of the child by the parent(s), or Indian custodian(s), is likely to result in serious emotional or physical damage to the child.~~ ~~(3-15-22)~~

~~13~~04. **Relative**. ~~Person related to a~~ A child's child's grandparent, great grandparent, aunt, great aunt, uncle, great uncle, brother-in-law, sister-in-law, first cousin, sibling and half sibling by blood, marriage, or adoption. ~~(3-15-22)~~( )

~~14~~05. **Relative Guardian**. A relative who is appointed a child's legal guardian in accordance with Title 15, Chapter 5, Part 2, Idaho Code, including a guardianship established by a tribal court. (3-15-22)

~~15~~06. **Reservation**. ~~A reservation is an area of land "reserved" by or for an Indian band, village, or tribe(s) to live on and use. Reservations were created by treaty, by congressional legislation, or by executive order. Since 1934, the Secretary of the Interior has had the responsibility of establishing new reservations or adding land to existing reservations~~ Indian country as defined in 18 U.S. Code Section 1151 and any lands, not covered under such section, title to which is held by the United States in trust for the benefit of any Indian tribe or individual or held by any Indian tribe or individual subject to a restriction by the United States against alienation. ~~(3-15-22)~~( )

~~16~~07. **Respite Care**. ~~Time-limited care provided to children. Respite care is utilized in circumstances that require s~~ Short term, temporary care of a child by a licensed or agency-approved caregiver different from their usual caregiver. ~~The duration of an episode of r~~ Respite care ranges from one (1) partial day up to fourteen (14) consecutive days. ~~(3-15-22)~~( )

08. Responsible Party. A department social worker, clinician, family services worker, or services provider who maintains responsibility and authority for case planning and case management. ( )

013. DEFINITIONS AND ABBREVIATIONS S THROUGH Z.
For the purposes of these rules, the following terms are used: (3-15-22)

~~01. SSI (Supplemental Security Income)~~. ~~Income maintenance grants for eligible persons who are aged, blind, or disabled. These grants are provided under Title VI of the Social Security Act and are administered by the Social Security Administration and local Social Security Offices.~~ ~~(3-15-22)~~

0~~2~~1. **Safety Assessment**. A process and standardized tool for contact between a family services worker and a family to objectively determine if safety threats, or immediate service needs exist that require further Child and Family Services response. (3-15-22)

0~~3~~2. **Safety Plan**. Plan developed by the ~~D~~department and a family that assures the immediate safety of a child ~~who has been determined to be conditionally safe or unsafe~~. ~~(3-15-22)~~( )

043. **Sibling**. One (1) of two (2) or more persons who shares the same biological or adoptive mother or father, or both. Siblings may be full-siblings or half-siblings. Siblings include those children who would be considered a sibling if not for the disruption in parental rights due to termination of parental rights or the death of a parent. (3-15-22)

~~05. State-Funded Guardianship Assistance~~. ~~Benefits described in Subsection 702.04 and Section 704 of these rules provided to a legal guardian for the support of a child who meets the eligibility criteria.~~ ~~(3-15-22)~~

~~06. TAFI. Temporary Assistance to Families in Idaho.~~ ~~(3-15-22)~~

~~07. Title IV-E. Title under the Social Security Act that provides funding for foster care maintenance and adoption assistance payments for certain eligible children.~~ ~~(3-15-22)~~

~~08. Title IV-E Foster Care. Child care provided in lieu of parental care in a foster home, children's agency, or institution eligible to receive Aid to Dependent Children under Title IV-E of the Social Security Act.~~ ~~(3-15-22)~~

~~09. Title XIX (Medicaid). Title under the Social Security Act that provides "Grants to States for Medical Assistance Programs."~~ ~~(3-15-22)~~

~~10. Title XXI. (Children's Health Insurance Program). Title under the Social Security Act that provides access to health care for uninsured children under the age of nineteen (19).~~ ~~(3-15-22)~~

~~11~~04. **Tribal Court**. A court with jurisdiction over child-custody proceedings ~~including~~ and which is either a Court of Indian Offenses, a court established and operated under the code or custom of an Indian tribe, or any other administrative body of a tribe vested with authority over child custody proceedings. ~~(3-15-22)~~( )

~~12. Unmarried Parents' Services. Services aimed at achieving or maintaining self-reliance or self-support for unmarried parents. These services include counseling for any unmarried parents who need such service in relation to their plans for their children and arranging for and paying for prenatal and confinement care for the well-being of the parent and infant. Services for unmarried parents are provided in accordance with Section 56-204A, Idaho Code.~~ ~~(3-15-22)~~

~~13~~05. **Voluntary Services Agreement**. A written and executed agreement between the ~~D~~department and parents or legal guardians regarding the ~~goal,~~ provision of voluntary foster care placement of a child and includes areas of concern, desired results, and task responsibility~~, including payment~~. ~~(3-15-22)~~( )

06. **Withholding of Medically Indicated Treatment**. Withholding of medically indicated treatment as defined by 42 U.S.C. 5106g(a)(5). ( )

014. -- 019. (RESERVED)

GENERAL REQUIREMENTS AND SERVICES
(Sections 020-239)

020. GENERAL REQUIREMENTS APPLICABLE TO ALL CHILD AND FAMILY SERVICES PROGRAMS.

~~01. Information, Referral and Screening. All residents of the state of Idaho, regardless of the duration of their residency or their income are entitled to receive, upon referral or request:~~ ~~(3-15-22)~~

~~a. Accurate and current information about services to children and families provided through the Department.~~ ~~(3-15-22)~~

~~b. Referral to other appropriate public or private services available in the community; and~~ ~~(3-15-22)~~

~~c. A screening to determine service needs and safety threats that can be addressed through Child and Family Services.~~ ~~(3-15-22)~~

0~~2~~1. **Initiating Child and Family Services**. Child and Family Services are initiated upon referral for services that the program is legally mandated to provide or after completion of a written ~~voluntary~~ request for services. Efforts will be made to identify any Indian children in the family and all possible tribes in which a child may be a member or eligible for membership. ~~(3-15-22)~~( )

a. A screening is conducted to determine service needs and safety threats that can be addressed

through Child and Family Services. ( )

b. Upon referral or application for services, the family services worker must inform the family that: ( )

i. They have the right to accept or reject services offered by the department, except those services imposed by law or by a court order; ( )

ii. Fees may be charged for certain services, and that the parent(s) has the financial responsibility for the child in care; ( )

iii. They have the right to pursue an administrative appeal of any decision of Child and Family Services relating to them, including any decision not to provide services or to discontinue services; the department's failure to act upon a referral or request for services within thirty (30) days; or a decision to remove a child from an alternate care placement unless court-ordered or court-authorized. ( )

032. Individual Authorized to Request Voluntary Services. Requests for voluntary services must be made by a ~~family member~~ parent or ~~by~~ an authorized representative~~, or by someone acting on behalf of an incompetent or incapacitated person~~. ~~(3-15-22)~~( )

~~**04. Record of Request for Services**. The date of referral or request for services will be documented in the records of the field office.~~ ~~(3-15-22)~~

~~**05. Information to Be Provided to Family**. Upon referral or application for services, the family services worker must inform the family that:~~ ~~(3-15-22)~~

~~**a.** They have the right to accept or reject services offered by the Department, except those services imposed by law or by a court order;~~ ~~(3-15-22)~~

~~**b.** Fees may be charged for certain services, and that the parent(s) has financial responsibility for the child in care;~~ ~~(3-15-22)~~

~~**c.** They have the right to pursue an administrative appeal of any decision of Child and Family Services relating to them, including any decision not to provide services or to discontinue planned services; the Department's failure to act upon a referral or request for services within thirty (30) days; or an decision to remove a child from an alternate care placement unless court-ordered or court-authorized.~~ ~~(3-15-22)~~

021. -- 029. (RESERVED)

030. CORE CHILD AND FAMILY SERVICES.
In addition to other services included in this chapter, the following ~~S~~state and federally mandated core services are provided ~~by or~~ to eligible youth and/or families through ~~regional~~ the Child and Family ~~offices include~~ Services Program: ~~(4-6-23)~~( )

~~**01. Crisis Services**. Crisis Services are an immediate response to ensure safety when a child is believed to be in imminent danger because of child abuse, neglect, or abandonment. Crisis services require immediate access to services always to assess safety and place in alternate care, if necessary, to ensure safety for the child.~~ ~~(4-6-23)~~

~~**02. Screening Services**. Initial contact with families and children to gather information to determine whether the child meets eligibility criteria to receive child protection or adoption services. When eligibility criteria is not met for Department mandated services, appropriate community referrals are made.~~ ~~(4-6-23)~~

031. Assessment and Safety/~~Service~~Case Planning Services. A family ~~A~~assessment ~~process~~ in which the safety threats to the child, and the family's concerns, strengths, and resources are identified ~~after which a written plan is developed by the worker, together with the family and other interested parties. Each plan must have a long-term goal that identifies behaviorally-specific and measurable desired results and has specific tasks that identify who,~~

~~how, and when the tasks will be completed~~. Assessment results inform the development and implementation of the case plan. ~~(4-6-23)~~( )

0~~4~~2. Prevention Services. Evidence-based services that support children and families and are designed to reduce the risk of child abuse, neglect, or abandonment. (4-6-23)

a. These services are provided in the Family First Prevention Services Act (Public Law 115-123) under the categories of mental health, substance use prevention and treatment, and in-home parent skill-based programs and services. Additional services can be implemented through community education, and partnerships with other community agencies such as schools and courts. (4-6-23)

b. The Department sets the maximum hourly or flat rates for Prevention Services covered by Title IV-E federal funding and are based on the cost for services. When services are provided by private providers, payment must be made according to a contract authorized by the Child and Family Services Program Manager, based on the cost for services to be provided. Current information about services and rates can be obtained from Child and Family Services website. (4-6-23)

~~**05. Court-Ordered Services**. These services primarily involve court-ordered investigations or assessments of situations where children are believed to be at risk due to child abuse, neglect, or abandonment.~~ ~~(3-15-22)~~

0~~6~~3. Alternate Care (Placement) Services. Temporary living arrangements outside of the family home for ~~children and youth~~ minors who ~~are victims of child abuse, neglect, or abandonment~~ are placed in the care or custody of the department under Title 16, Chapter 16, Idaho Code. The ~~D~~department arranges and finances, in full or in part, out-of-home placements. ~~Alternate care is initiated through either a court order or voluntarily through an out-of-home placement agreement. Payment will be made on behalf of a child placed in the licensed home of an individual or relative, a child care institution, a home licensed or approved by an Indian child's tribe, or in a state-licensed public child care institution accommodating no more than twenty-five (25) children. Payments may be made to individuals or to a child placement or child care agency.~~ ~~(4-6-23)~~( )

~~**07. Community Support Services**. Services provided to a child and family in a community-based setting designed to increase the strengths and abilities of the child and family and to preserve the family whenever possible. Services include respite care and family preservation.~~ ~~(3-15-22)~~

0~~8~~4. Interstate Compact on Out-of-State Placements. Where necessary to encourage all possible positive contacts between a child in alternate care with ~~family~~ relatives, kin, and~~, including~~ extended family, placement with ~~family members or others who are~~ families outside the state of Idaho will be considered. ~~On very rare occasion t~~The ~~D~~department may contract with a residential facility out-of-state if it best serves the needs of the child~~, and is at a comparable cost to facilities within Idaho. When out-of-state placement is considered in the permanency planning for a child, such p~~ Placement will be coordinated with the respective interstate compact administrator according to the provisions of ~~Section 16-2101, et seq., Idaho Code, the "Interstate Compact on the Placement of Children." Placements must follow all state and federal laws~~ Title 16, Chapter 21, Idaho Code. ~~(4-6-23)~~( )

0~~9~~5. Independent Living. Services, including assessment and planning, provided to eligible youth and young adults to promote self-reliance and successful transition to adulthood. ~~(3-15-22)~~( )

a. Eligibility - Current ~~Foster Youth. To be eligible for independent living services, the youth must~~ foster youth or young adults will: ~~(4-6-23)~~( )

i. Be fourteen (14) to twenty-one (21) years of age; (3-15-22)

ii. Currently be under ~~D~~department or tribal care and placement authority established by a court order or voluntary agreement with the youth's family, or be under a voluntary agreement for continued care if the youth is between eighteen (18) and twenty-one (21) years of age; and ~~(3-15-22)~~( )

b. Eligibility - ~~Former Foster Youth. To be eligible for independent living services, the youth must~~ Youth or young adults formally in foster care will: ~~(4-6-23)~~( )

i. Be ~~a former foster youth who is currently under twenty-three~~ (23) years of age; and ~~(3-15-22)~~( )

ii. Have been under ~~D~~department or tribal care and placement authority established by a court order or voluntary agreement with the youth's family, or under a voluntary agreement for continued care after the youth has reached eighteen (18) years of age; and ~~(3-15-22)~~( )

iii. Have been placed in foster care or similar eligible setting for a minimum of ninety (90) days total after reaching sixteen (16) years of age or have aged out of foster care; or (3-15-22)

iv. Be eighteen (18) to twenty-three (23) years of age, provide verification of meeting the Independent Living eligibility criteria in another state, and currently be a resident of Idaho. (3-15-22)

c. Eligibility Limit. Once established as in Subsection 030.09.b. in this rule, a youth's eligibility is maintained up to their twenty-third birthday, regardless of whether they continue to be the responsibility of the Department, tribe, or be in foster care. (3-15-22)

~~10~~06. Adoption Services. ~~Department s~~ Services designed to promote and support the permanency of children ~~with special needs~~ in foster care through adoption. This involves the legal and permanent transfer of parental rights and responsibilities to the family assessed as the most suitable to meet the needs of the individual child. ~~Adoption services seek to build the community's capacity to deliver adoptive services.~~ ~~(4-6-23)~~( )

~~**11. Administrative Services**. Regulatory activities and services that assist the Department in meeting the goals of safety, permanency, health and well-being for children and families include:~~ ~~(4-6-23)~~

~~**a.** Child care licensing; (3-15-22)~~

~~**b.** Daycare licensing; (3-15-22)~~

~~**c.** Community development; and (3-15-22)~~

~~**d.** Contract development and monitoring. (3-15-22)~~

031. -- 049. (RESERVED)

050. PROTECTIONS AND SAFEGUARDS FOR CHILDREN AND FAMILIES.
~~The federal and state laws that are the basis for these rules include a number of mandatory protections and safeguards intended to ensure timely permanency for children and to protect the rights of children, their families, and their tribes.~~ ~~(3-15-22)~~

01. Reasonable Efforts. Services offered or provided to a family intended to prevent or eliminate the need for removal of the child from the family, to reunify a child with their family, and to finalize a permanent plan. The following efforts must be made and specifically documented by the Department in reports to the court. The court will make the determination of whether or not the Department's efforts were reasonable. (3-15-22)

a. Efforts to prevent or eliminate the need for a child to be removed from their home; (3-15-22)

b. Efforts to return a child home are not required due to a judicial determination of aggravated circumstances; and (3-15-22)

c. Efforts to finalize a permanent plan, so that each child in the Department's care will have a family with whom the child can have a safe and permanent home. (3-15-22)

02. Active Efforts. ~~The e~~ Efforts beyond reasonable efforts required under ICWA to provide remedial services and rehabilitative programs designed to prevent the breakup of an Indian family, or to reunify an Indian family. Active efforts must include contacts and work with an Indian child's tribe. ~~(3-15-22)~~( )

03. ~~ICWA Placement Preferences~~Compliance with the Indian Child Welfare Act of 1978. ~~(3-15-22)~~( )

~~**a.** When the Indian child's permanency goal is reunification, the preferences are described in Section 402 of these rules. (3-15-22)~~

~~**b.** When the Indian child's permanency goal is adoption or guardianship, the preferences are described in Subsection 800.01 of these rules. (3-15-22)~~

~~**c.** When the placement preferences are not followed, the court must determine that good cause exists for not following the preferences. (3-15-22)~~

~~**04. Least Restrictive Setting**. Efforts will be made to ensure that any child in the Department's care resides in the least restrictive, most family-like setting possible. Placement will be made in the least restrictive setting and in close proximity to the parent(s) or if not, written justification that the placement is in the best interest of the child. (3-15-22)~~

0~~5~~4. **Legal Requirements for Indian Children**. When there is reason to believe that a child is an Indian child, notice of the pending proceeding must be sent according to the notice provisions specified in Section 051 of these rules. Notice must also include notice of the tribe's right to intervene; their right to twenty (20) days additional time to prepare for the proceeding; the right to appointment of counsel if the parent(s) or Indian custodian(s) is indigent; and the right to examine all documents filed with the court upon which placement may be based. (3-15-22)

0~~6~~5. **Visitation for Child's Parent(s) or Legal Guardian(s)**. ~~Visitation arrangements must be provided to the child's parent(s) or legal guardian(s) unless visitation is contrary to the child's safety.~~ The department should determine the scope, duration, and manner of visitation that best promotes the best interest of the child and ensures that visitation does not impair the physical or mental health of a child. In-person visitation arrangements between a child and a parent who has been substantiated at a Level One or Two by the department for one of the following: sexual abuse, sexual exploitation, or physical abuse will not be granted unless it is in the best interest of the child and the child's physical and/or mental health will not be impaired. If in-person visitation is granted, it will only occur under the following conditions: ~~(3-15-22)~~( )

a. Approved by a program manager, after consultation with the child's guardian ad litem, where applicable, who concludes that in-person visitation is in the best interest of the child and that the child's physical and/or mental health will not be impaired; ( )

b. Under conditions set forth by the program manager. Conditions of supervised visitation will include the following: ( )

i. The parent will not be left alone with the child for any reason, including restroom breaks; ( )

ii. For sexual abuse and exploitation cases, the parent will not allow the child to sit on his or her lap; ( )

iii. The parent will not be allowed to engage in secret conversations or other communication that cannot be monitored in real time; ( )

c. The best interest decision and visit conditions are documented and explained in writing. ( )

~~**07. Notification of Change in Placement**. Written notification must be made within seven (7) days of a change of placement of the foster child if a child is relocated to another foster care setting. Notification must be sent to the child's parent(s) or legal guardian(s). When the child is an Indian child, written notification must also be sent to the child's Indian custodian(s), if applicable, and to the child's tribe. (3-15-22)~~

0~~8~~6. **Notification of Change in Visitation**. ~~Written n~~ Notification to the child's parent(s) or legal guardian(s) if there is to be a change in their visitation schedule with their child or ward in foster care.

~~(3-15-22)~~( )

~~09. Notification of Right to Participate and Appeal.~~ ~~Written notification to the child's parent(s) or legal guardian(s) must be made regarding their right to discuss any changes and the opportunity to appeal if they disagree with changes in placement or visitation.~~ ~~(3-15-22)~~

~~10~~07. **Qualified Expert Witness~~-(QEW) under~~ ICWA**. The testimony of an expert witness is required at the hearing in which an Indian child is placed in state custody, typically the adjudicatory, and at the hearing for termination of parental rights. A QEW must be qualified to testify regarding whether the child's continued custody by the parent or Indian custodian is likely to result in serious emotional or physical damage to the child and should be qualified to testify as to the prevailing social and cultural standards of the Indian child's Tribe. The department, the court, or any party may request the assistance of the Indian child's Tribe or the Bureau of Indian Affairs office serving the Indian child's Tribe in locating persons qualified to serve as expert witnesses. A ~~person who is most likely to be a qualified expert witness~~ QEW ~~in the placement of an Indian child~~ in order of preference is: ~~(3-15-22)~~( )

a. A member of the Indian child's ~~t~~Tribe ~~who is recognized by the tribal community as knowledgeable in tribal customs pertaining to family organization and child rearing practices~~; ~~(3-15-22)~~( )

b. ~~An individual who is not a tribal member who has substantial experience in the delivery of child and family services to Indians and extensive knowledge of prevailing social and cultural standards and child rearing practices within the Indian child's tribe; or~~A member of the Tribe of the Indian child's parent; ~~(3-15-22)~~( )

c. ~~A professional person who has substantial education and experience in a pertinent specialty area and substantial knowledge of prevailing social and cultural standards and child rearing practices within the Indian community.~~A descendant of the Indian child's Tribe; ~~(3-15-22)~~( )

d. A member of a tribe recognized as sharing the same ethnicity, language, territory, traditions, or customs as the child's tribe; ( )

e. A member of any federally recognized tribe; ( )

f. An individual not meeting the definitions in (a) through (e) who is designated by the child's Tribe as qualified to testify to the prevailing social and cultural standards of the Indian child's Tribe. ( )

g. The family services worker regularly assigned to the Indian child may not serve as a QEW in proceedings concerning the child. ( )

~~11~~08. **Compliance with Requirements of the Multiethnic Placement Act of 1994 (MEPA) as Amended by the Interethnic ~~Adoption Provisions~~ Placement (IEPA) of 1996**. ~~(3-15-22)~~( )

~~a. The Department prohibits entities that are involved in foster care or adoption placements and that receive federal financial assistance under Title IV-E, Title IV-B, or any other federal program from delaying or denying a child's foster care or adoptive placement on the basis of the child's or the prospective foster or adoptive parent's race, color, or national origin.~~ ~~(3-15-22)~~

~~b. The Department prohibits entities that are involved in foster care or adoption placements and that receive federal financial assistance under Title IV-E, Title IV-B, or any other federal program, from denying to any individual the opportunity to become a foster or adoptive parent on the basis of the prospective foster or adoptive parent's or the child's race, color, or national origin;~~ ~~(3-15-22)~~

~~c. To remain eligible for federal assistance for their child welfare programs, the Department must diligently recruit foster and adoptive parents who reflect the racial and ethnic diversity of the children in the state who need foster and adoptive homes;~~ ~~(3-15-22)~~

~~d. A child's race, color, or national origin cannot be routinely considered as a relevant factor in assessing the child's best interests;~~ ~~(3-15-22)~~

~~c. Failure to comply with MEPA/IEP's prohibitions against discrimination is a violation of Title VI of the Civil Rights Act of 1964; and~~ (3-15-22)

~~f~~a. Nothing in MEPA/IEP is to be construed to affect the application of the Indian Child Welfare Act of 1978. (3-15-22)

~~12~~09. **Family Decision-Making and Plan Development**. (3-15-22)

a. A ~~family~~ case plan will be completed within thirty (30) days of the date the case was opened. ~~(3-15-22)~~( )

b. Families will be given ample opportunity to participate in the identification of areas of concern, their strengths, and developing service goals and tasks. The family plan and any changes to it must be signed and dated by the family. If the family refuses to sign the plan, the reason for their refusal will be documented on the plan. (3-15-22)

c. Plans are to be reviewed with the family no less frequently than once every three (3) months. When there are major changes to the plan including a change in the long term goal, the family plan must be renegotiated by the ~~D~~department and the family as well as signed by the family. A new plan must be negotiated at least annually. ~~(3-15-22)~~( )

1~~3~~0. **Compelling Reasons**. Reasons why the parental rights of a parent of a child in the ~~D~~department's care and custody should not be terminated when the child has been in the custody of the ~~D~~department for fifteen (15) out of the most recent twenty-two (22) months. ~~(3-15-22)~~( )

a. These reasons must be documented in the Alternate Care Plan, in a report to the court, and the court must make a determination if the reasons are sufficiently compelling. (3-15-22)

b. A compelling reason must be documented when a child's plan for permanency is not adoption, guardianship, or return home. (3-15-22)

c. When compelling reasons are not appropriate, the petition for termination of parental rights must be filed by the end of the child's fifteenth month in foster care. (3-15-22)

1~~4~~1. ~~**ASFA Placement**~~ **Permanency Preferences**. The following ~~placement~~ preferences will be considered in the order listed below when recommending and making permanency decisions: ~~(3-15-22)~~( )

a. Return home if safe to do so; (3-15-22)

b. Adoption or legal guardianship by a relative or kin; (3-15-22)

c. Adoption or legal guardianship by non-relative; (3-15-22)

d. Another planned permanent living arrangement such as long-term foster care. (3-15-22)

051. NOTICE REQUIREMENTS FOR ICWA.

01. Notice of Pending Proceedings -- Who is Notified. When there is reason to believe that a child is an Indian child, the initial and any subsequent Notice of Pending Proceedings must be sent to the Indian child's parent(s), custodian(s), and tribe. Notices of Pending Proceedings must be sent to the ICWA Designated Agent for the child's tribe via Registered Mail, Return Receipt Requested. All Notices of Pending Proceedings must be received by the child's parent(s), Indian custodian(s) and tribe at least 10 (ten) days before the proceeding is scheduled to occur. Returned receipts are to be kept in the child's file and made available for review by the court. (3-15-22)

02. Rights Under a Notice of Pending Proceedings. Notices of Pending Proceedings must also include notice of the tribe's right to intervene; their right to twenty (20) additional days to prepare for the proceedings; the right to appointment of counsel if the parent(s) or Indian custodian(s) are indigent; and the right to

examine all documents filed with the court upon which placement may be based. (3-15-22)

03. Notice of Pending Proceedings--When Identity or Location of Parent(s), Indian Custodian(s), or Tribe is Unknown. If the identity or location of the parent(s) or Indian custodian(s) or the tribe is unknown, the Notice of Pending Proceedings must be sent to the Secretary of the Interior by certified mail with a return receipt requested at the following address: Department of the Interior, Bureau of Indian Services, Division of Human Services, Code 450, Mail Stop, 1849 C Street N.W., Washington, D.C. 20240. (3-15-22)

052. -- 059. (RESERVED)

060. FAMILY CASE RECORDS.

01. Electronic and Physical Files. The ~~D~~department will maintain an electronic file and a physical file containing information on each family receiving services. The physical file will contain non-electronic documentation such as originals or original copies of all court orders, birth certificates, social security cards, and assessment information that is original outside the ~~D~~department. ~~(3-15-22)~~( )

02. Storage of Records. All physical family case records must be stored in a secure file storage area, away from public access and retained not less than five (5) years after the case is closed, after which they may be destroyed. (3-15-22)

a. Exception for Adoption Records. Complete family case records involving adoptive placements must be forwarded to the ~~D~~department's central adoption unit for permanent storage. ~~(3-15-22)~~( )

b. Exception for Case Records Involving an Indian Child. A case record involving an Indian child must be available at any time at the request of an Indian child's tribe or the Secretary of the Interior. (3-15-22)

~~**061. -- 239. (RESERVED)**~~

~~**REVIEWS AND HEARINGS**~~
~~**(Sections 240-399)**~~

~~**240. SIX-MONTH REVIEWS FOR CHILDREN IN ALTERNATE CARE PLACEMENT.**~~
~~When a judicial review does not occur at the end of a six (6) month period for any child in alternate care placement, the Department will conduct a case review to assure compliance with all applicable state and federal laws, and to ensure the plan focuses on the goals of safety, permanency and well-being of the child.~~ ~~(3-15-22)~~

~~**01. Notice of Six-Month Review**. The parent(s) or legal guardian(s), foster parent(s) of a child, and any preadoptive parent(s) or relative(s) providing care for the child, are to be provided with notice of their right to be heard in the six-month review. In the case of an Indian child, the child's tribe and any Indian custodian must also be provided with notice. This must not be construed to require that any foster parent, preadoptive parent, or relative providing care for the child be made a party to the review solely on the basis of the receipt of such notice. Participants have the right to be represented by the individual of their choice.~~ ~~(3-15-22)~~

~~**02. Procedure in the Six-Month Review**. The parties who received notice will be given the opportunity to participate in the case review.~~ ~~(3-15-22)~~

~~**03. Members of Six-Month Review Panel**. The six-month review panel must include a Department employee who is not in the direct line of supervision in the delivery of services to the child or parent(s) or legal guardian(s) being reviewed. The review panel may include agency staff, staff of other agencies, officers of the court, members of Indian tribes, and citizens qualified by experience, professional background, or training. Members of the panel will be chosen by and receive instructions from the Department's Child and Family Services Program Manager or their designee, to enable them to understand the review process and their roles as participants.~~ ~~(3-15-22)~~

~~**04. Considerations in Six-Month Review**. Whether conducted by the court in a review hearing or a Department review panel, under State law, Federal law and regulation, each of the following must be addressed in a six-month review:~~ ~~(3-15-22)~~

~~a. Determine the extent of compliance with the family services plan; (3-15-22)~~

~~b. Determine the extent of progress made toward alleviating or mitigating the causes necessitating the placement; (3-15-22)~~

~~c. Review compliance with the Indian Child Welfare Act, when applicable; (3-15-22)~~

~~d. Determine the safety of the child, the continuing need for and appropriateness of the child's placement; and (3-15-22)~~

~~e. Project a date by which the child may be returned and safely maintained at home or placed for adoption, legal guardianship, or other permanent placement. (3-15-22)~~

~~05. Recommendations and Conclusions of Six Month Review Panel. Following the six month review, written conclusions and recommendations will be provided to all participants, subject to Department safeguards for confidentiality. The document containing the written conclusions and recommendations must also include appeal rights. (3-15-22)~~

~~241~~061. -- 399. (RESERVED)

ALTERNATE (OUT-OF-HOME) CARE
(Sections 400-424)

400. AUTHORITY FOR ALTERNATE CARE SERVICES.
Upon approval of the regional Child and Family Services Program Manager or their designee, the ~~D~~department may provide or purchase alternative care under the following conditions: ~~(3-15-22)~~( )

01. Department Custody. When the child is in the legal custody or guardianship of the ~~D~~department; or ~~(3-15-22)~~( )

02. Voluntary Placement. ~~Upon a~~ Agreement with the parent(s) or legal guardian(s) ~~or young adult under extended foster care when~~ after the parent(s) or legal guardian(s) request assistance from the agency due to circumstances that interfere with their ~~provision of proper care~~ ability to meet the needs of or they are no longer able to maintain a child in their home and ~~they can benefit from social work and treatment services~~ it is in the best interest of the child for an out of home placement with case planning services to address the family situation. Young adults who exited foster care at age 18, who are not yet 21, may also enter a voluntary placement under extended foster care. ~~(3-15-22)~~( )

a. A ~~service~~ case plan and an out-of-home placement agreement must be developed between the Department and the family. The ~~service~~ case plan will identify areas of concern, goals, desired results, time frames, tasks and task responsibilities. The out-of-home placement agreement will include the terms for reimbursement of costs with any necessary justification for deviation from Child Support guidelines. ~~(3-15-22)~~( )

b. A voluntary agreement for out-of-home placement entered into between the ~~D~~department and the parent(s) or legal guardian(s) of a minor child that specifies the legal obligations of all parties and may be revoked at any time by the child's parent(s) or legal guardian(s) and the child must be returned to the parent or legal guardian ~~upon their request~~ unless a court determines that the return of the child would be contrary to the child's best interest. ~~(3-15-22)~~( )

c. A contract between the ~~D~~department and the service provider, if applicable, must also be in effect. ~~(3-15-22)~~( )

d. ~~Voluntary out-of-home placements exceeding one hundred eighty (180) days without a judicial determination that it is in the best interests of the child to continue their current placement cannot be reimbursed by Title IV-E funds~~When seeking federal funding the department will comply with the Social Security Act section 472. ~~(3-15-22)~~( )

e. Indian child. Where any parent or Indian custodian voluntarily consents to a foster care placement, such consent shall not be valid unless executed in writing and recorded before a judge of a court of competent jurisdiction and accompanied by the presiding judge's certificate that the terms and consequences of the consent were fully explained in detail and were fully understood by the parent or Indian custodian. The court shall also certify that either the parent or Indian custodian fully understood the explanation in English or that it was interpreted into a language that the parent or Indian custodian fully understood. Any consent given prior to, or within ten days after, birth of the Indian child shall not be valid. Any parent or Indian custodian may withdraw consent to a foster care placement under State law at any time and, upon such withdrawal, the child shall be returned to the parent or Indian custodian unless a court determines that the return of the child would be contrary to the child's best interest. ( )

401. CONSIDERATIONS FOR PLACEMENT IN ALTERNATE CARE.
The ~~D~~department will make ~~meaningful reasonable attempts,~~ timely and ongoing efforts to identify and notify, both verbally and in writing~~, to inform in priority order,~~ individuals identified below of the potential imminent placement and the requirements for consideration as a placement resource. The ~~D~~department ~~will place children in a safe and trusted environment~~ will comply with 16-1629(11), Idaho Code, to make reasonable efforts to place the child in the least restrictive environment to the child consistent with the best interest and special needs of the child~~ren as required by P.L.96-272, Section 475(5). Ideally, placement priority will be given in the following order: (a) Immediate family; (b) Extended family members; (c) Non-family members with a significant established relationship with the child; (d) other licensed foster parent(s). Upon immediate contact with persons in categories a) through d) above, and after preliminary screening, within seventy-two (72) hours of decision to place, Departmental staff will make reasonable attempts to inform immediate family members of the way to become a placement resource. Alternate care placement will in all cases include consideration of~~ and follow placement priority: ~~(3-15-22)~~( )

01. Family Assessment. ~~The family assessment conducted in accordance with the provisions of the CFS Practice Standards~~ Relatives and non-relatives must comply with IDAPA 16.06.02 as a condition of licensed placement. ~~(3-15-22)~~( )

~~**02. Ability of Providers**. The ability of potential alternate care providers to address and be sensitive to the unique and individual needs of the child and ability to comply and support the plan for the child and their family. (3-15-22)~~

~~**03. Family Involvement**. The involvement of the family in planning and selecting the placement. The Department will use a family unity meeting concept making reasonable efforts to gather immediate and extended family members and other significant supporters to identify family strengths relevant to creating a safe environment for the child. This process will be fully reported to the court along with resulting plans and commitments. (3-15-22)~~

402. INVOLUNTARY PLACEMENT OF INDIAN CHILDREN.

01. Involuntary. ~~p~~Placement of an Indian child in foster care must be based upon clear and convincing evidence, including information from a qualified expert witness~~es, that the continued custody of the child by the parent(s) or Indian custodian(s) is likely to result in serious emotional or physical damage to the child. In the absence of good cause to the contrary, a preference must be given to placement with:~~ that active efforts were made to prevent the Indian child's placement or are preventing reunification. ~~(3-15-22)~~( )

02. Notice. Notice to the child's Tribe will be made as stated in Subsection 05.01 of these rules. ( )

03. Accepted. An Indian child accepted for foster care or proadoptive placement shall be placed in the least restrictive setting which most approximates a family and in which his special needs, if any, may be met. The child shall also be placed within reasonable proximity to his or her home, taking into account any special needs of the child. ( )

04. Placement. In any foster care or preadoptive placement of an Indian child where the child's Tribe has not established a different order of preference, preference must be given, in descending order, as listed below, to the placement of the child with: ( )

~~01~~**a.** Extended Family. A member of the Indian child's extended family; (3-15-22)

~~02~~**b.** Foster Home Approved by Tribe. A foster home licensed ~~or~~ approved, as specified by the Indian child's tribe; ~~(3-15-22)~~( )

~~03~~**c.** Licensed Indian Foster Home. An Indian foster home licensed or approved by an authorized non-Indian licensing authority; or (3-15-22)

~~04~~**d.** Indian Institution. An institution for children approved by an Indian tribe or operated by an Indian organization ~~that~~ which has a program suitable to meet the child's needs. ~~(3-15-22)~~( )

403. DATE A CHILD ENTERED FOSTER CARE.
A child is considered to have entered foster care on the date the child is actually removed from their home. All foster care benefits and eligibility determinations must be based on this date. ~~All periodic reviews, permanency hearings, and time frames for termination of parental rights must be based on the date the child entered foster care~~ However for the purpose of funding the department will follow requirements included in the Social Security Act Section 475. ~~(3-15-22)~~( )

404. FOSTER CARE GOAL.
It is the goal of the Department that not more than twenty-five percent (25%) of foster youth will be in foster care longer than twenty-four (24) months. The Department will monitor this goal annually. (3-15-22)

405. ALTERNATE CARE CASE MANAGEMENT.
Case management must continue while the child is in alternate care and must ensure the following: (3-15-22)

01. Preparation ~~for~~ Provided to the Placement. Preparing a child for placement in alternate care is the joint responsibility of the child's family, the child (when appropriate), the family services worker, and the alternate care provider. ~~(3-15-22)~~( )

02. Information for Alternate Care Provider. The Department and the family have informed the alternate care provider of their roles and responsibilities in meeting the needs of the child including: (3-15-22)

a. Any medical, health and dental needs of the child including the names and address of the child's health and educational providers, a record of the child's immunizations, the child's current medications, the child's known medical problems, and any other pertinent health information concerning the child; (3-15-22)

b. The name of the child's doctor; (3-15-22)

c. The child's current functioning and behaviors; (3-15-22)

d. A copy of the child's portion of the ~~service~~ case plan including any visitation arrangements; ~~(3-15-22)~~( )

e. The case history of the child, including the reason the child came into foster care, the child's legal status, and the permanency goal for the child; (3-15-22)

f. A history of the child's previous placements and reasons for placement changes, excluding information that identifies or reveals the location of any previous alternate care providers without their consent; (3-15-22)

g. The child's cultural and racial identity; (3-15-22)

h. Any educational, developmental, or special needs of the child; (3-15-22)

i. The child's interest and talents; (3-15-22)

j. The child's attachment to current caretakers; (3-15-22)

k. The individualized and unique needs of the child; (3-15-22)

l. Procedures to follow in case of emergency; and (3-15-22)

m. Any additional information, that may be required by the terms of the contract with the alternate care provider. (3-15-22)

03. Consent for Medical Care. ~~Parent(s) or legal guardian(s) have signed a Departmental form of consent for medical care and keep the family services worker advised of where they can be reached in case of an emergency. Any refusal to give medical consent must be documented in the family case record~~ Whenever possible the parent(s) or legal guardian(s) should sign for medical, dental, or mental health appointments. The department will follow Section 16-1602(29), Idaho Code, when parent(s) or legal guardian(s) are unavailable and Section 16-1627, Idaho Code, when authorization for emergency medical treatment is needed. ~~(3-15-22)~~( )

~~**04. Financial Arrangements**. The family services worker must assure that the alternate care provider understands the financial and payment arrangements and that necessary Department forms are completed and submitted.~~ ~~(3-15-22)~~

0~~5~~4. Contact with Child. The family, the family services worker, and the alternate care provider ~~have~~ will establish~~ed~~ a schedule for frequent and regular visits with the child by the family and by the family services worker or designee. ~~(3-15-22)~~( )

a. Face-to-face contact with a child by the assigned family services worker must occur at least monthly or more frequently depending on the needs of the child or the provider, or both, and the stability of the placement. Face-to-face contact may be made in settings other than where the child resides as long as contact between the assigned family services worker and the child occurs where the child resides a minimum of once every sixty (60) days. (7-1-24)

b. The ~~D~~department will ~~have strategies in place to detect~~ assess for possible abuse, neglect, or abandonment of children in alternate care. ~~(3-15-22)~~( )

c. Frequent and regular contact between the child and parents and other family members will be encouraged and facilitated unless it is specifically determined not to be in the best interest of the child. Such contact will be face-to-face if possible, with this contact augmented by telephone calls, written correspondence, pictures, and the use of video and other technology as may be relevant and available. (3-15-22)

0~~6~~5. Discharge Planning. Planning for discharge from alternate care are developed with all concerned parties. Discharge planning will be initiated at the time of placement and completed prior to the child's return home or to the community. (3-15-22)

0~~7~~6. Transition Planning. Planning for discharge from alternate care into a permanent placement are developed with all concerned parties. Discharge planning will be initiated at the time of placement and completed prior to the child's return home or to the community. (3-15-22)

0~~8~~7. Financial and Support Services. As part of the discharge planning, Departmental resources are coordinated to expedite access to Department financial and medical assistance and community support services. (3-15-22)

406. -- 421. (RESERVED)

422. ALTERNATE CARE PLANNING.
The elements of alternate care planning for the family and the child are mandated by the provisions of ~~Title IV-E,~~ Sections 471(a)(16), 475(1), and 475(5)(A) and (D) of the Social Security Act and Section 16-1621, Idaho Code. ~~(3-15-22)~~( )

~~**01. Alternate Care Plan Required**. Each child receiving alternate care under the supervision of the state must have a standardized written alternate care plan.~~ ~~(3-15-22)~~

~~**a.** The purpose of the alternate care plan is to facilitate the safe return of the child to their own home as expeditiously as possible or to make other permanent arrangements for the child if such return is not feasible. (3-15-22)~~

~~**b.** The alternate care plan must be included as part of the family service plan. (3-15-22)~~

~~**02. Written Alternate Care Plan**. The Department must complete a written alternate care plan within thirty (30) days after a child has been placed in alternate care and at least every six (6) months thereafter. A copy of the alternate care plan will be provided to the child's parent, legal guardian, foster parent, Indian custodian, tribe, and to the child if they are over twelve (12) years of age. (3-15-22)~~

423. -- 424. (RESERVED)

ELIGIBILITY AND FUNDING INFORMATION
(Sections 425-441)

425. TITLE IV-E ELIGIBILITY.
The state will claim Title IV-E funding for ~~a foster child who meets the following criteria:~~ foster care placement costs as allowed within the Social Security Act, sections 421, 422, 423, 424, 428, 471, 472, 473, 474, and section 475 (Effective February 9, 2018). Claims for Title IV-E maintenance may begin as early as the first day of placement in the month in which all initial Title IV-E eligibility factors are met. ~~(3-15-22)~~( )

~~**01. Physical or Constructive Removal of the Child**. The child was physically or constructively removed from the home: (3-15-22)~~

~~**a.** Under a voluntary placement agreement; or (3-15-22)~~

~~**b.** As the result of a judicial determination that: (3-15-22)~~

~~i. Remaining in the home would be contrary to the child's welfare; or (3-15-22)~~

~~ii. Placement in foster care would be in the best interest of the child. (3-15-22)~~

~~**c.** The determination that a situation is contrary to the child's welfare must be made in the first court ruling that sanctions, even temporarily, the removal of a child from the home. (3-15-22)~~

~~**02. Child's Residence**. The child has been living in the home of a parent or other relative specified at 45 CFR 233.90(c)(1)(v) either in the month of, or within six (6) months prior to the month: (3-15-22)~~

~~**a.** Removal court proceedings were initiated; or (3-15-22)~~

~~**b.** The voluntary placement agreement was signed. (3-15-22)~~

~~**03. AFDC Eligibility**. The child was AFDC (Aid to Families with Dependent Children) eligible in the removal home during the month of the initiation of court proceedings that initiated the removal or the month the voluntary placement agreement is signed. AFDC eligibility is based upon the standards found in the State's IV-A Plan on July 16, 1996. (3-15-22)~~

~~**04. "Removal From" and "Living With" Requirements**. The "removal from" (01. of this rule) and "living with" (Subsection 425.02. of this rule) requirements must be satisfied by the same specified relative who meets AFDC eligibility (Subsection 425.03. of this rule). (3-15-22)~~

~~**05. Judicial Determination**. A judicial determination was obtained regarding reasonable efforts to prevent a child's removal from the home no later than sixty (60) days from the child's foster care entry date. When there is a judicial determination of "aggravated circumstances," the court order must state that no reasonable efforts to reunify the family are required. (3-15-22)~~

~~**06. Agency with Placement Care and Responsibility**. The IV-E agency, or another public agency or Tribe that has a plan approved under 42 U.S.C. 671 in accordance with 42 U.S.C. 679c with which the Title IV-E agency has a written agreement in effect, has placement and care responsibility.~~ ~~(3-15-22)~~

~~**07. Child in Foster Care or Childcare Institution**. The child is in a fully licensed or approved foster family home, or childcare institution, or supervised independent living situation for young adults in extended foster care.~~ ~~(3-15-22)~~

~~**08. Compliance with Safety Requirements**. Compliance with the safety requirements was documented for the prospective foster family home or childcare institution.~~ ~~(3-15-22)~~

~~**09. Child's Age**. The child is under the age of eighteen (18), or up to age twenty-one (21) if they meet the criteria under 42 U.S.C. 675(8)(B)(iv).~~ ~~(3-15-22)~~

~~**10. Child's Citizenship Status**. The child is a US citizen or qualified immigrant under Sections 403, 431, and 432 of the Personal Responsibility Work Opportunity Reconciliation Act (P.L. 104-193.~~ ~~(3-15-22)~~

426. – 427. (RESERVED)

~~**427. DETERMINATION OF ELIGIBILITY FOR TITLE IV-E.**~~
~~The family services workers must submit an application to the Child Welfare Funding Team to evaluate for Title IV-E eligibility.~~ ~~(3-15-22)~~

428. CUSTODY AND PLACEMENT.

01. Interstate Placements. In interstate placements, a child may be placed with an approved unlicensed relative when delaying the placement would be harmful to the child's well-being. In those cases, a subsequent request for foster care licensure will be made through the Interstate Compact on the Placement of Children. ~~However, in these instances, a child is ineligible for Title IV-E until the placement is licensed.~~
~~(3-15-22)~~( )

02. Intrastate Placements That Become Interstate Placements. If a foster care placement that was initially intrastate becomes an interstate placement because the family with whom the child is placed relocates to another state, a request for foster care licensure will be made through the Interstate Compact on the Placement of Children immediately upon the decision to move the child. ~~If the state to which the family has moved accepts the family's Idaho foster care license as effective, the placement is considered licensed until a determination is made that the family is in compliance with the licensing and other applicable laws of the state to which the family has moved.~~
~~(3-15-22)~~( )

429. ~~EFFECTIVE DATE.~~(RESERVED)
~~Claims for Title IV-E maintenance may begin as early as the first day of placement in the month in which all initial Title IV-E eligibility factors are met. A child cannot receive SSI and Title IV-E foster maintenance payments during the same time period.~~ ~~(3-15-22)~~

430. ONGOING ELIGIBILITY.
To continue eligibility for Title IV-E, ~~a child must meet the following conditions:~~ ~~(3-15-22)~~

~~**01. Child's Age**. The child is under the age of eighteen (18), or up to age twenty-one (21) if they meet the criteria under 42 U.S.C. 675(8)(B)(iv).~~ ~~(3-15-22)~~

~~**02. Department Custody**. The child remains in the Department's custody through either a current court order or a voluntary placement agreement that has not been in effect more than one hundred and eighty (180) days.~~ ~~(3-15-22)~~

~~**03. Child's Residence**. The child continues to live in a fully licensed or approved foster family home, or childcare institution, or on a court-ordered home visit.~~ ~~(3-15-22)~~

~~**04. Redetermination**. A redetermination is used for a child who: (3-15-22)~~

~~**a.** Left foster care; (3-15-22)~~

~~**b.** Was placed in a Title IV-E ineligible living situation such as: unlicensed placement, a hospital, or a detention center; (3-15-22)~~

~~**c.** Exceeded one hundred eighty (180) days in a voluntary placement agreement in which there was no judicial determination of "best interests." The child's Title IV-E eligibility ceases on the 181st day; and (3-15-22)~~

~~**d.** Is on a home visit that exceeds the time specified in the court order signed by the Judge without a new judicial determination granting an extension. (3-15-22)~~

~~**05. Annual Redetermination**.~~ the department will complete an ~~A~~annual redetermination ~~is required~~ to assure that the court has determined that the ~~D~~department has made reasonable efforts to finalize a permanency plan for the child within twelve (12) months of the date the child is considered to have entered foster care and at least once every twelve (12) months thereafter while the child is in foster care. ~~(3-15-22)~~( )

431. (RESERVED)

432. ~~TITLE XIX FOSTER CHILD~~MEDICAID ELIGIBILITY FOR CHILD IN FOSTER CARE.
For Title XIX Medicaid eligibility for a foster child, please refer to IDAPA 16.03.01, ~~"Eligibility for Health Care Assistance for Families and Children," Section 536~~. ~~(3-15-22)~~( )

433. INCOME, BENEFITS AND SAVINGS OF CHILDREN IN FOSTER CARE.
~~On behalf of the child and with the assistance of CWFT staff, family services workers are required to identify and apply for income or benefits from (one (1) or) every available source including Social Security, tribal benefits, or estates of deceased parents. The address of the payee must be DHW FACS CWFT, 450 West State Street, P. O. Box 83720 Boise, ID 83720-0036~~FACS will apply for income or benefits including social security, tribal benefits, or estates of deceased parents. The payee will be DHW-FACS-CWFT. ~~(3-15-22)~~( )

434. FORWARDING OF BENEFITS.
Child Support Services will be notified when a child goes on a trial home visit and be provided the name and address of the responsible party to discontinue accrual of child support owed to the state. ( )

~~**01. Home Visit**. If the Department is receiving benefits and the child is returned to the home of the parent(s) or legal guardian(s) or relatives for a trial visit, Child Support Services must be notified by a family services worker giving the name and address of the person in order to discontinue accrual of child support owed to the State. (3-15-22)~~

0~~2~~1. **Return to Foster Care**. If the child returns to foster care, the Department's Child Support Unit must be notified immediately of the correct payee. (3-15-22)

435. (RESERVED)

436. PARENTAL FINANCIAL SUPPORT FOR CHILDREN IN ALTERNATE CARE.
~~In accordance with Section 56-203B, Idaho Code, parents are responsible for costs associated with the care of their child in alternate care~~When a child enters care if there is a child support order already in effect for that child, the child support funds will be redirected to the department to contribute to the cost of the child's care. If there is no child support order already in effect, a new child support case will not automatically be opened. The department may initiate a child support case for a child in care, in its discretion, if the department concludes that doing so is in the best interest of the child. This provision does not limit the authority of the department to initiate or otherwise litigate child support on other grounds. ~~(3-15-22)~~( )

~~**01. Notice of Parental Responsibility**. The Department will provide the parents(s) with written notification of their responsibility to contribute toward the cost of their child's support, treatment, and care, including~~

~~clothing, medical, incidental, and educational costs.~~ ~~(3-15-22)~~

~~**02. Financial Arrangements with Parent(s).** Parent(s) are responsible to reimburse the Department for the costs of alternate care when their child is placed in alternate care in accordance with a court order or voluntary placement agreement.~~ ~~(3-15-22)~~

~~**a.** The amount of support is based on the parents' income, the costs of care for the child, and any unique circumstances affecting the parents' ability to pay.~~ ~~(3-15-22)~~

~~**b.** Every parent is expected to contribute to the cost of their child's care, but no parent will be asked to pay more than the actual cost of care, including clothing, medical, incidental and educational costs. The cost of room and board must be paid by the parent(s) to the Department, and the Department will in turn reimburse the alternate care providers.~~ ~~(3-15-22)~~

437. ACCOUNTING AND REPORTING.
The Department's Division of Family and Community Services, Child Welfare Funding Team must account for the receipt of funds and develop reports showing how much money has been received and how it has been utilized. (3-15-22)

438. SUPPORT AGREEMENT FOR VOLUNTARY PLACEMENTS.
If the placement is voluntary, the parent(s) must sign an agreement that specifies the amount of support to be paid, when it is to be paid to the payee, and the address to which it is to be paid. (3-15-22)

439. ~~SUPPORT IN COURT-ORDERED PLACEMENT.~~(RESERVED)
~~In the case of a court-ordered placement, if no support agreement has been reached with the parent(s) prior to the custody or commitment hearing, the Department's report to the Court will indicate the necessity to hold a support hearing.~~ ~~(3-15-22)~~

440. INSURANCE COVERAGE.
The parent(s) or legal guardian(s) must inform the Department of all insurance policies covering the child, including names of carriers, and policy or subscriber numbers. If medical, health, and dental insurance coverage are available for the child, the parent(s) must acquire and maintain such insurance. (3-15-22)

441. REFERRAL TO CHILD SUPPORT SERVICES.
The Department will refer the parent(s) to the Bureau of Child Support Services for support payment arrangements. (3-15-22)

01. Assignment of Child Support. The Department through the Bureau of Child Support Services will secure assignment of any support due to the child while in alternate care. Social Security and Supplemental Security Income benefits are specifically aimed at meeting the child's needs and therefore will follow the child in placement and the Department must request to be named payee for all funds for placements extending over thirty (30) days. (3-15-22)

02. Collection of Child Support. The Department must take action to collect any child support ordered in a divorce or custody decree. ~~(3-15-22)~~( )

MEDICAL AND DENTAL FOR CHILDREN IN OUT-OF-HOME CARE
(Sections 442-479)

442. MEDICAID FOR CHILDREN IN ALTERNATE CARE.
Every child placed in alternate care will receive a medical card each month. (3-15-22)

443. EPSDT SCREENING.
Children in alternate care will receive the Early Periodic Screening, Diagnosis and Treatment (EPSDT) services allowable under Medicaid. Those children already receiving Medicaid at the time of placement will be screened within thirty (30) days after placement. Children not receiving Medicaid at the time of placement will receive a screening within thirty (30) days from the date Medicaid eligibility is established. (3-15-22)

444. MEDICAL EMERGENCIES.
In case of serious illness, the alternate care provider must notify the child's doctor and the Department immediately. The parent(s) or legal guardian(s) or the court in an emergency, or the Department if it is the guardian of the child, have the authority to consent to major medical care or hospitalization. (3-15-22)

445. DENTAL CARE.
Each child age three (3) who is placed in alternate care must receive a dental examination as soon as possible after placement, but not later than ninety (90) days, and thereafter according to a schedule prescribed by the dentist. (3-15-22)

01. Costs Paid by Medicaid. If dental care not included in the state medical assistance program is recommended, a request for payment must be submitted to the state Medicaid dental ~~consultant~~ contractor. ~~(3-15-22)~~( )

02. Emergencies. For children in shelter care, emergency dental services will be provided for and paid for by the Department, if there are no other financial resources available. (3-15-22)

446. COSTS OF PRESCRIPTION DRUGS.
The Department will purchase prescribed drugs, at the Medicaid rate, for a child in alternate care through participating pharmacists, in excess of the Medicaid monthly maximum. (3-15-22)

447. MEDICAL EXAMINATION UPON ENTERING ALTERNATE CARE.
Within thirty (30) days of entering alternate care, each child will receive a medical examination to assess the child's health status, and thereafter according to a schedule prescribed by the child's physician or other health care professional. (3-15-22)

448. -- 450. (RESERVED)

451. DRIVERS' TRAINING, DRIVERS' LICENSES, AND PERMITS FOR CHILDREN IN ALTERNATE CARE.
No Department employee or foster parent is allowed to sign for any foster child's driver's license or permit without written authorization from the Child and Family Services Program Manager. Any Department employee or foster parent signing for a foster child's driver's license or permit without the approval of the Child and Family Services Program Manager assumes full personal responsibility and liability for any driving related damages that may be assessed against the child. Those damages will not be covered by the Department's insurance. (3-15-22)

01. Payments by Department. Subject to existing appropriations, the Department may make payments for driver's training, driver's license, and permits for a child in the Department's legal custody when driver's training or obtaining a driver's license or permit is part of the child's Independent Living Plan. In addition, subject to existing appropriations, the Department may reimburse a foster parent, licensed by the Department, for the cost of procuring owner's or operator's insurance listing a child residing in their home as a named insured with respect to the operation of a motor vehicle subject to the limits exclusive of interest and costs with respect to each motor vehicle as provided in Section 49-117, Idaho Code. (3-15-22)

02. Payment by Parent(s) or Legal Guardian(s). The parent(s) or legal guardian(s) of children in foster care may authorize drivers' training, provide payment and sign for drivers' licenses and permits. (3-15-22)

452. -- 479. (RESERVED)

LICENSURE AND REIMBURSEMENT OF ALTERNATE CARE PROVIDERS
(Sections 480-549)

480. ALTERNATE CARE LICENSURE.
All private homes and facilities providing care for children under these rules must be licensed in accordance with IDAPA 16.06.02, "~~Child~~Foster Care Licensing," unless foster care placement of an Indian child is made with a foster home licensed or approved by the Indian child's tribe, or an institution for children approved by an Indian tribe or

operated by an Indian organization. ~~(3-15-22)~~( )

481. FACILITIES OPERATED BY THE STATE.
Facilities operated by the State and providing care for children under these rules must meet the standards for ~~child care licensure~~ Children's Residential Care Facilities in IDAPA 16.04.18. ~~(3-15-22)~~( )

~~482. PAYMENT FOR SHELTER CARE.~~
~~Payment for placement of children requiring temporary, emergency alternate care is twenty dollars ($20) per day for children from birth through age seventeen (17), for a maximum of thirty (30) days of shelter care for each uninterrupted placement.~~ ~~(3-15-22)~~

48~~3~~2. PAYMENT TO FAMILY ALTERNATE CARE PROVIDERS.
~~Monthly payments for care provided by family alternate care providers are:~~The rates for alternate care providers are proposed by Child and Family Services to the Joint Finance and Appropriations Committee (JFAC) when the annual review of reimbursements rates indicates that the amount is not sufficient to support foster parents in meeting the needs of children and young adults in extended foster care. Current rates as approved by JFAC are posted on the Child and Family Services website and will include the following: ( )

~~**Family Alternate Care Payments – Table 483**~~

~~Ages~~	~~0-5~~	~~6-12~~	~~13-17~~	~~18-20~~
~~Monthly Room and Board~~	~~$632~~	~~$702~~	~~$759~~	~~$876~~

~~(4-6-23)~~

~~**01. Gifts**. An additional thirty dollars ($30) for Christmas gifts and twenty dollars ($20) for birthday gifts will be paid in the appropriate months.~~ ~~(3-15-22)~~

~~**02. Clothing**. Costs for clothing will be paid, based upon the Department's determination of each child's needs. All clothing purchased for a child in alternate care becomes the property of the child.~~ ~~(3-15-22)~~

~~**03. School Fees**. School fees due upon enrollment will be paid directly to the school or to the alternate care providers, based upon the Department's determination of the child's needs.~~ ~~(3-15-22)~~

01. Shelter Care. Reimbursement rate for placement of children requiring emergency alternate care for a maximum of thirty (30) days. ( )

02. Room and Board. Reimbursement rates for placement of children in relative or non-relative foster care by age. ( )

03. Additional Reimbursement. Based upon an ongoing assessment of the child's circumstances that necessitate special rates as well as the foster parent's ability, activities, and involvement in addressing those special needs. ( )

04. Gifts. Additional payments to support gifts for children in foster care at Christmas and the child's birthday. ( )

05. Crisis Level of Need. The director or designee may approve enhanced rates for foster parents when there are insufficient foster homes available to meet the needs of children needing placement including sibling groups. ( )

483. REIMBURSEMENT IN THE HOME OF A RELATIVE.
Relatives licensed as a foster family must be afforded the opportunity to receive foster care reimbursement for any child(ren) placed in their home through the Department. A relative foster family may choose not to accept a foster care reimbursement and apply for a TAFI grant or provide for the child's care using their own financial resources. ( )

~~**484. ADDITIONAL PAYMENTS TO FAMILY ALTERNATE CARE PROVIDERS.**~~
~~For those children who require additional care above room, board, shelter, daily supervision, school supplies, personal incidentals, the Department may pay the family alternate care provider an additional amount to the amount paid under Section 483 of these rules. This family alternate care rate is based upon a ongoing assessment of the child's circumstances that necessitate special rates as well as the care provider's ability, activities, and involvement in addressing those special needs. Additional payment will be made as follows:~~ ~~(3-15-22)~~

~~**01. Lowest Level of Need**. Ninety dollars ($90) per month for a child requiring a mild degree of care for documented conditions including:~~ ~~(3-15-22)~~

~~**a.** Chronic medical problems;~~ ~~(3-15-22)~~

~~**b.** Frequent, time-consuming transportation needs;~~ ~~(3-15-22)~~

~~**c.** Behaviors requiring extra supervision and control; and~~ ~~(3-15-22)~~

~~**d.** Need for preparation for independent living.~~ ~~(3-15-22)~~

~~**02. Moderate Level of Need**. One hundred fifty dollars ($150) per month for a child requiring a moderate degree of care for documented conditions including:~~ ~~(3-15-22)~~

~~**a.** Ongoing major medical problems;~~ ~~(3-15-22)~~

~~**b.** Behaviors that require immediate action or control; and~~ ~~(3-15-22)~~

~~**c.** Alcohol or other substance use disorder.~~ ~~(3-15-22)~~

~~**03. Highest Level of Need**. Two hundred forty dollars ($240) per month for a child requiring an extraordinary degree of care for documented conditions including:~~ ~~(3-15-22)~~

~~**a.** Severe emotional or behavioral disturbance;~~ ~~(3-15-22)~~

~~**b.** Severe developmental disability; and~~ ~~(3-15-22)~~

~~**c.** Severe physical disability such as quadriplegia.~~ ~~(3-15-22)~~

~~**04. Reportable Income**. Additional payments for more than ten (10) qualified children received during any calendar year must be reported as income to the Internal Revenue Service.~~ ~~(3-15-22)~~

484. ADDITIONAL FINANCIAL SUPPORT TO FAMILY ALTERNATE CARE PROVIDERS.

01. Clothing. Costs for clothing will be paid, based upon the Department's determination of each child's needs. All clothing purchased for a child in alternate care becomes the property of the child. ( )

02. School Fees. School fees due upon enrollment will be paid directly to the school or to the alternate care providers, based upon the Department's determination of the child's needs. ( )

485. TREATMENT FOSTER CARE.
A family home setting in which treatment foster parents provide twenty-four (24) hour room and board as well as therapeutic services and a high level of supervision. Services provided in treatment foster care are at a more intense level than provided in foster care and at a lower level than provided in residential care. Services may include the following: participation in the development and implementation of the child's treatment plan, behavior modification, community supports, crisis intervention, documentation of services and the child's behavior, participation as a member of a multi-disciplinary team, and transportation. Placement into a treatment foster home for children in the custody of the ~~D~~department under the purview of the Child Protective Act, is based on the documented needs of the child, the inability of less restrictive settings to meet the child's needs, and the clinical ~~judgement~~judgment of the ~~D~~department. ~~(3-15-22)~~( )

01. Qualifications. Prior to being considered for designation and reimbursement as a treatment foster parent, each prospective treatment foster parent must accomplish the following: (3-15-22)

a. Meet all foster family licensure requirements as set forth in IDAPA 16.06.02, "~~Child~~Foster Care Licensing"; ~~(3-15-22)~~( )

b. Complete ~~D~~department-approved treatment foster care initial training; and ~~(3-15-22)~~( )

c. Provide a minimum of two (2) references in addition to those provided to be licensed to provide foster care. The additional references must be from individuals who have worked with the prospective treatment foster parent. The additional references must verify that the prospective treatment foster parent has: (3-15-22)

i. Training related to, or experience working with, children or youth with mental illness or behavior disorders; and (3-15-22)

ii. Demonstrated cooperation and a positive working relationship with families and providers of child welfare or mental health services. (3-15-22)

02. Continuing Education. Following designation as a treatment foster home, each treatment foster home parent must complete fourteen (14) hours of additional training per year as specified in an agreement developed between the treatment foster parents and the ~~D~~department. ~~(3-15-22)~~( )

03. Availability. At least one (1) treatment foster parent, in each treatment family home, must be available twenty-four (24) hours a day, seven (7) days a week to respond to the needs of the foster child. (3-15-22)

04. Payment. The ~~D~~department will pay treatment foster parents up to one thousand eight hundred ($1,800) dollars per month, per child, which includes the monthly payment rate ~~specified in Sections 483 and 484 of these rules~~ posted on the Child and Family Services website. The payment will be made to treatment foster parents in accordance with a contract with the Department. ~~The purpose of the contract is to make clear that the treatment foster parents must fulfill the requirements for treatment foster parents under the child's treatment plan referenced in Subsection 485.06 of this rule.~~ ~~(3-15-22)~~( )

05. Payment to Contractors. The ~~D~~department may also provide treatment foster care through a contract with an agency that is a private provider of treatment foster care. The ~~D~~department will specify the rate of payment in the contract with the agency. ~~(3-15-22)~~( )

06. Treatment Plan. The treatment foster parent(s) must implement the portions of the ~~D~~department or Children's Agency-approved treatment plan for which they are designated as responsible, for each child in their care. ~~This plan is incorporated as part of the family services plan identified in Section 011.05 of these rules.~~ ~~(3-15-22)~~( )

486. ~~GROUP FOSTER~~ OTHER ALTERNATIVE CARE.

~~Group f~~Foster care ~~is~~ for children who generally require more structured services and activities ~~and discipline~~ than found in a family setting. ~~Examples are intermediate residential treatment, short-term group care, and emancipation homes.~~ ~~(3-15-22)~~( )

01. Referral ~~— Group Foster Care~~. Any referral of a child to a ~~group foster care facility~~ other alternative care-setting where the ~~D~~department ~~would be making~~ will make full or partial payment must ~~be~~ have prior ~~authorized~~ authorization by the Child and Family Services Program Manager or designee. ~~(3-15-22)~~( )

02. Placement. ~~Placement is based on~~ Determined by the documented ~~service~~ mental, medical or behavioral health needs of each child and the ability of ~~the group care~~ other alternate care provider to meet those needs. ~~(3-15-22)~~( )

03. Payment ~~— Group Foster Care~~. Payment will be in accordance with the contract authorized by the regional director or division administrator, based on the needs of the children being placed and the services to be

provided. ~~(3-15-22)~~( )

~~**487. RESIDENTIAL CARE FACILITIES.**~~
~~Placement into a residential care facility for children with a severe emotional or behavioral problems is based on the documented needs of the child and the inability of less restrictive settings to meet the child's needs. (3-15-22)~~

~~**01. Referral**. Any referral of a child to a residential care facility where the Department would be making full or partial payment must be prior authorized by the Child Services and Family Program Manager or designee. (3-15-22)~~

~~**02. Payment**. When care is purchased from private providers, payment must be made in accordance with a contract authorized by the Child Services and Family Program Manager, based on the needs of each child being placed and the services to be provided. When care is provided in facilities operated by the Department, payment will be arranged in cooperation with Department fiscal officers. (3-15-22)~~

~~**488. -- 491. (RESERVED)**~~

~~**492. REIMBURSEMENT IN THE HOME OF A RELATIVE.**~~
~~Relatives licensed as a foster family must be afforded the opportunity to receive foster care reimbursement for any child(ren) placed in their home through the Department. A relative foster family may choose not to accept a foster care reimbursement and apply for a TAFI grant or provide for the child's care using their own financial resources. (3-15-22)~~

4~~93~~87. -- 549. (RESERVED)

CHILD PROTECTION SERVICES
(Sections 550-639)

~~**550. CHILD PROTECTION SERVICES.**~~
~~Sections 56-204A, 56-204B, 16-1601, 16-1629 and 16-2001, Idaho Code, make the Department an official child protection agency of state government dealing with situations of reported child abuse, neglect, or abandonment. A respectful, non-judgmental approach should be the policy for assessments, especially during the initial contact with the family. Training in communication would include multicultural and diversity issues and interest-based conflict resolution. (3-15-22)~~

~~**551. REPORTING ABUSE, NEGLECT, OR ABANDONMENT.**~~
~~Professionals and other persons identified in Section 16-1605, Idaho Code, have a responsibility to report abuse, neglect, or abandonment and are provided protection for reporters. (3-15-22)~~

~~**01. Ministers**. Duly ordained ministers of religion are exempt from reporting child abuse, neglect, or abandonment if: (3-15-22)~~

~~**a.** The church qualifies as tax-exempt under 26. U.S.C. 501(c)(3); (3-15-22)~~

~~**b.** The confession or confidential communication was made directly to the duly ordained minister of religion; and (3-15-22)~~

~~**c.** The confession was made in the manner and context that places the duly ordained minister of religion specifically and strictly under a level of confidentiality that is considered inviolate by canon law or church doctrine. (3-15-22)~~

~~**02. Health and Welfare Employees**. All Department of Health and Welfare personnel are responsible for recognizing and immediately reporting to Child and Family Services or to law enforcement any concern regarding abuse, neglect, or abandonment of a child or children. Failure to report as required by Section 16-1605, Idaho Code, is a misdemeanor. (3-15-22)~~

550 -- 551. (RESERVED)

552. REPORTING SYSTEM.
~~Each region of t~~The ~~D~~department maintains a system for receiving and responding to reports or complaints on a twenty four (24) hour per day, seven (7) day per week basis statewide~~ throughout the entire region. The region will advertise the system to the public throughout the region and ensure the accurate recording of as many facts as possible at the time of the report~~. ~~(3-15-22)~~( )

553. ASSIGNING REPORTS FOR SAFETY ASSESSMENT.

01. Child Reports. The Department ~~must~~ will assign all reports of possible abuse, neglect, or abandonment of children for safety assessment, unless ~~the field office has knowledge or information that discredits the report beyond a reasonable doubt~~ there is insufficient information to indicate assignment is necessary. ~~(3-15-22)~~( )

02. Infant Reports. To ensure the protection of infants in health care facilities throughout the state and who have been in continuously hospitalized since birth, who were born extremely prematurely, or who have a long-term disability, the department will assign reports of instances of withholding of medically indicated treatment from disabled infants with life-threatening conditions in accordance with the department's response priorities. ( )

554. RESPONSE PRIORITIES.
The Department ~~must~~ will use the following ~~statewide standards~~ priorities for responding to allegations of abuse, neglect, or abandonment~~, using the determination of risk to the child as the primary criterion~~. ~~Any~~ If a variance is necessary from these response ~~standards must~~ priorities, it will be documented in the family's case file with a description of action taken, and ~~must~~ will be reviewed and signed by the Child and Family Services Supervisor. ~~(3-15-22)~~( )

01. Priority I. The ~~D~~department ~~must~~ will respond immediately if a child is in immediate danger involving a life-threatening or emergency situation and for cases of sexual abuse when a child may have contact with the alleged perpetrator~~. Emergency situations include sexual abuse when a child may have contact with the alleged perpetrator and circumstances indicate a need for immediate response.~~ Law enforcement ~~must~~ will be notified and requested to ~~respond or to accompany a family services worker~~ assist. Every attempt ~~should~~ will be made to coordinate the ~~D~~department's assessment with law enforcement's investigation. The child ~~must~~ will be seen by a ~~Department~~ family services worker, law enforcement, and medical personnel if applicable, immediately unless written regional protocol agreements direct otherwise. All allegations of physical abuse of a child through the age of six (6) or with profound developmental disabilities ~~should~~ will be considered ~~under~~ Priority I unless there is reason to believe that the child is not in immediate danger. ~~(3-15-22)~~( )

02. Priority II. A child is not in immediate danger but allegations of abuse, ~~including physical or sexual abuse, or serious physical or medical~~ or neglect are clearly defined in the referral~~. Law enforcement must be notified within twenty-four (24) hours~~. The child ~~must~~ will be seen by the family services worker within forty-eight hours (48) of the ~~D~~department's receipt of the referral. Law enforcement must be notified within twenty-four (24) hours of receipt of all Priority II referrals ~~that involve concerns of abuse, neglect, or abandonment~~. ~~(3-15-22)~~( )

03. Priority III. A child may be in a vulnerable situation because of services needs which, if left unmet, may result in harm, or a child is without parental care for safety, health and well-being~~. The child and parent(s) or legal guardian(s) will be interviewed for substantiation of the facts, and to assure that there is no abuse, neglect, or abandonment by parent(s) or legal guardian(s).~~ A family services worker must respond within three (3) calendar days and the child ~~must~~ will be seen by the worker within five (5) calendar days of the ~~D~~department's receipt of the referral. ~~(3-15-22)~~( )

04. Notification of the Person Who Made the Referral. The ~~D~~department ~~must~~ must notify the person who made the child protection referral of the receipt of the referral within five (5) days, unless notification is declined. ~~(3-15-22)~~( )

05. Disclosure of Information to Professionals. The Department has the discretion to disclose, on a need-to-know basis, minimally necessary information to individuals who are professionally involved in the ongoing care of the child who is the subject of a report of abuse, neglect, or abandonment. This includes information that the

professional ~~will~~ needs to know in order to fulfill their role in maintaining the child's safety and well-being. This provision applies to: ~~(3-15-22)~~( )

a. Physicians, residents on a hospital staff, interns, and nurses; (3-15-22)

b. School teachers, school staff, and day care personnel; and (3-15-22)

c. Mental health professionals, including psychologists, counselors, marriage and family therapists, and social workers. (3-15-22)

555. SUPERVISORY REVIEW - CERTAIN PRIORITY I AND II CASES.
In all Priority I and II cases where the alleged victim of abuse, neglect, or abandonment is ~~through the age of~~ six (6) years old or younger, review by a supervisor~~y~~ or team of all case documentation and ~~other~~ facts will be conducted within forty-eight (48) hours of initiation of the safety assessment. Such review will be documented in the file with the signature of the supervisor or team leader, time and date, whether additional safety-related issues will be pursued and by whom, and any planning for initiation of services. ~~(3-15-22)~~( )

556. REPORTS INVOLVING INDIAN CHILDREN.
Possible abuse, neglect, or abandonment of a child who is known or believed to be Indian will be reported to appropriate tribal authorities immediately. If the reported incident occurs off a reservation, the ~~D~~department will perform the investigation. The ~~D~~department will also investigate incidents reported on a reservation if requested to do so by appropriate authorities of the tribe. A record of any response will be maintained in the case record and written documentation will be provided to the appropriate tribal authorities. ~~(3-15-22)~~( )

557. REPORTS INVOLVING MILITARY FAMILIES.
~~Reports of possible child abuse, neglect, or abandonment involving a military family must be reported in accordance with the provisions of any agreement with the appropriate military family advocacy representative, in accordance with the provisions of Section 811 of Public Law 99-145. Child abuse, neglect, or abandonment of a child on a military reservation falls under federal jurisdiction~~The department will comply with notice requirements pertaining to child abuse or neglect in which the person having care of the child is a member of the armed forces (or the spouse of the member) as required by 10 USC 1787. ~~(3-15-22)~~( )

558. ~~COMMUNITY RESOURCES.~~(RESERVED)
~~The Department will provide information and referral to community resources or may offer preventative services to the family. Information and referral services enable individuals to gain access to human services through providing accurate, current information on community and Department resources.~~ ~~(3-15-22)~~

559. CHILD PROTECTION SAFETY AND COMPREHENSIVE ASSESSMENTS.
The ~~D~~department's safety and comprehensive assessments ~~must~~ will be conducted in a standardized format and utilize statewide assessment and multi-disciplinary team protocols. ~~The assessment must include contact with the child(ren) involved and the immediate family and a records check for history with respect to child protection issues.~~ ~~(3-15-22)~~( )

01. Assessment of a Child. The family services worker ~~must make~~ will complete an assessment of every child of concern. When the child is interviewed as part of a safety and comprehensive assessment, the interview of a child concerning a child protection report ~~must~~ will be conducted: ~~(3-15-22)~~( )

a. In a manner that protects all children involved from undergoing any unnecessary traumatic experience~~, including multiple interviews~~; ~~(3-15-22)~~( )

b. By a professional with specialized training in using techniques that consider the natural communication modes and developmental stages of children; and (3-15-22)

c. In a neutral, non-threatening environment, ~~such as a specially equipped interview room,~~ if available. ~~(3-15-22)~~( )

02. Assessment of the Family. The family services worker conducting the interview ~~must~~ will:

~~(3-15-22)~~( )

a. Immediately notify the parent(s) or legal guardian(s) of the purpose and nature of the assessment. (3-15-22)

b. Provide at the initial contact the name and work phone numbers of the family services worker and their supervisor to ensure the family has a contact for questions and concerns that may arise following the visit; (3-15-22)

c. Inquire if the family is Indian, or has Indian heritage, for the purposes of ICWA; (3-15-22)

d. Interview siblings who are identified as being at risk; and (3-15-22)

e. Not divulge the name of the person making the report of child abuse or neglect. (3-15-22)

03. Collateral Interviews. Any assessment of an abuse or neglect report ~~must~~ will include at ~~least~~ minimum one (1) collateral interview with a person who is familiar with the circumstances of the child(ren) ~~or children~~ involved. Collateral interviews will be conducted with discretion and preferably with the parent(s)' or legal guardian(s)' permission. ~~(3-15-22)~~( )

04. Completion of a Comprehensive Assessment. A Safety Assessment will be completed on each referral assigned for assessment of abuse or neglect, or both. When safety threats are identified in the safety assessment and the case remains open for services~~, a comprehensive assessment must be completed~~. ~~(3-15-22)~~( )

~~**05. Role of Law Enforcement**. Section 16-1617, Idaho Code, specifies that the Department may enlist the cooperation of peace officers for phases of the safety assessment for which they have the expertise and responsibility and consistent with the relevant multidisciplinary team protocol. Such areas include:~~ ~~(3-15-22)~~

~~**a.** Interviewing the alleged perpetrator;~~ ~~(3-15-22)~~

~~**b.** Removing the alleged perpetrator from the child's home in accordance with Section 16-1608(b), Idaho Code, the "Domestic Violence Act"; and~~ ~~(3-15-22)~~

~~**c.** Taking a child into custody in accordance with Section 16-1608, Idaho Code, where a child is endangered and prompt removal from their surroundings is necessary to prevent serious physical or mental injury.~~ ~~(3-15-22)~~

0~~6~~5. **Notification of the Person Who Made the Referral**. The ~~D~~department must notify the person who made the child protection referral when the safety assessment has been completed. ~~(3-15-22)~~( )

560. DISPOSITION OF CHILD PROTECTION REPORTS.
Within five (5) days following completion of safety assessments, the ~~D~~department will determine whether the reports are substantiated or unsubstantiated. All persons who are ~~the subject of a child protection safety assessment~~ identified as a caretaker will be notified of the disposition of the assessment as it pertains to them. ~~(3-15-22)~~( )

01. Substantiated. Child abuse, neglect, or abandonment reports are substantiated by one (1) or more of the following: (3-15-22)

a. Witnessed by a family services worker, as defined in Section 011 of these rules; (3-15-22)

b. A court determines, in an adjudicatory hearing, that a child comes within the jurisdiction of ~~the Child Protective Act,~~ Title 16, Chapter 16, Idaho Code; ~~(3-15-22)~~( )

c. A confession by the alleged offender; ~~(3-15-22)~~( )

d. Corroborated by physical or medical evidence; or (3-15-22)

e. Established by evidence that it is more likely than not that abuse, neglect, or abandonment occurred. (3-15-22)

02. Unsubstantiated. Child abuse, neglect, or abandonment reports are unsubstantiated when they are not found to be substantiated under Subsection 560.01 of this rule~~. For intradepartmental statistical purposes, the Department will indicate whether the unsubstantiated disposition of the safety assessment was~~ due to:
~~(3-15-22)~~( )

a. Insufficient evidence; or (3-15-22)

b. An erroneous report. (3-15-22)

561. CHILD PROTECTION CENTRAL REGISTRY.
~~The Adam Walsh Child Protection and Safety Act of 2006,~~In compliance with P.L. 109-248, July 27, 2006,~~ 120 Stat. 587, has directed the states to establish a central registry for the purpose of sharing information about persons who have substantiated reports of abuse, neglect, or abandonment against children. T~~ the Child Protection Central Registry was established under the authority of Section 16-1629(3), Idaho Code.~~ The primary purpose of the Child Protection Central Registry is to aid the Department in protecting children and vulnerable adults from individuals who have previously abused, neglected, or abandoned children. The Child Protection Central Registry maintained by the Department is separate and apart from the central registry for convicted sexual offenders maintained by the Idaho State Police under Title 18, Chapter 83, Idaho Code.~~ The Child Protection Central Registry provisions in this chapter of rules apply to safety assessments conducted by the ~~D~~department after October 1, 2007. ~~(3-15-22)~~( )

562. CONFIDENTIALITY OF THE CHILD PROTECTION CENTRAL REGISTRY AND REQUESTS TO CHECK THE REGISTRY.

01. Confidentiality of Child Protection Central Registry. The names on the Child Protection Central Registry are confidential and may only be released with the written consent of the individual on whom a criminal history and background check is being conducted, unless otherwise required by federal or state law. No information is released regarding the severity or type of child abuse, neglect, or abandonment. (3-15-22)

02. Child Protection Central Registry Check Fee. The fee for requesting a name-based check of the Child Protection Central Registry is twenty ($20) dollars. The request must be accompanied with a signed written consent by the individual whose name is being checked. (3-15-22)

563. LEVELS OF RISK ON THE CHILD PROTECTION CENTRAL REGISTRY.
When an incident of abuse, neglect, or abandonment has been substantiated, a level of risk is assigned to the incident. ~~The level of risk is determined by the severity and type of the abuse, neglect, or abandonment and the potential risk of future harm to a child. The highest level of risk is designated as Level One and the lowest level of risk is Level Three.~~
~~(3-15-22)~~( )

01. Child Protection Level One. ~~An individual with a Level One designation has been determined to pose a high to severe risk to children.~~ Names of individuals for whom an incident of abuse, neglect, or abandonment has been substantiated for any of the following will remain permanently on the Child Protection Central Registry at Level One. ~~(3-15-22)~~( )

a. Sexual Abuse as defined in Sections 16-1602(1)(b)~~ and~~ or 18-1506, Idaho Code; ~~(3-15-22)~~( )

b. Sexual Exploitation as defined in Sections 18-1507~~ and~~ or 18-1507A, Idaho Code; ~~(3-15-22)~~( )

c. ~~Physical a~~Abuse as described in Section 16-1602(1)(a), Idaho Code, that causes life-threatening, disabling, or disfiguring injury or damage; ~~(3-15-22)~~( )

d. Neglect as described in Section 16-1602(31), Idaho Code, that results in life-threatening, disabling, or disfiguring injury or damage; (3-15-22)

e. Abandonment as described in Section 16-1602(2), Idaho Code, that results in life-threatening,

disabling, or disfiguring injury or damage; (3-15-22)

f. Death of a child as a result of abuse, neglect, or abandonment; ~~(3-15-22)~~( )

g. Torture of a child as described in Section 18-4001, Idaho Code; (3-15-22)

h. Aggravated Circumstances as described in Section 16-1602(6), Idaho Code; or (3-15-22)

i. Occurrence of two (2) or more separate, substantiated incidents of abuse, neglect, or abandonment, ~~each of which falls under the circumstances~~ listed under Subsection 563.02 of this rule. ~~(3-15-22)~~( )

02. Child Protection Level Two. An individual with a Level Two designation ~~has been determined to pose a medium to high risk to children and~~ will remain on the Child Protection Central Registry for a minimum of ten (10) years. After the end of the ten-year (10) period, an individual may petition the ~~D~~department to request their name be removed from the Child Protection Central Registry in accordance with Section 566 of these rules. Names of individuals for whom an incident of abuse, neglect, or abandonment has been substantiated for any of the following will be given the designation of Level Two. ~~(3-15-22)~~( )

a. Prenatal use of any controlled substance as defined under Section 37-2701(e), Idaho Code, except as prescribed by a medical professional; (3-15-22)

b. Administering or knowingly allowing a child to absorb or ingest one (1) or more controlled substances as defined under Section 37-2701(e), Idaho Code, except in the amount prescribed for the child by a medical professional; (3-15-22)

c. Child exposed to: (3-15-22)

i. Drug paraphernalia, as defined in Section 37-2701(~~n~~o), Idaho Code; ~~(3-15-22)~~( )

ii. Manufacture of controlled substances, as defined under Section 37-2701(e), Idaho Code, and Section 37-2701(~~s~~t), Idaho Code; or ~~(3-15-22)~~( )

iii. Chemical components used in the manufacture of controlled substances, as defined under Section 37-2701(e), Idaho Code. (3-15-22)

~~**d.** Failure to thrive caused by abuse, neglect, or abandonment, as established by medical evidence; (3-15-22)~~

ed. ~~Physical a~~Abuse as described in Section 16-1602(1)(a), Idaho Code, that results in neither disabling nor disfiguring injury or damage, but requires medical treatment as recommended by a medical provider; ( )

e. ~~a~~Abandonment as described in Section 16-1602(2), Idaho Code, that results in neither disabling nor disfiguring injury or damage, but requires medical treatment as recommended by a medical provider: ( )

f. ~~or n~~Neglect as described in Section 16-1602(31), Idaho Code, that results in neither disabling nor disfiguring injury or damage, but ~~may require medical or other treatment~~ requires medical treatment as recommended by a medical professional; ~~(3-15-22)~~( )

~~f~~g. The restraint or confinement of a child that poses a substantial risk of causing life-threatening, disabling, or disfiguring injury or damage; (3-15-22)

gh. Medical neglect as described in Section 16-1602(31), Idaho Code, that poses a substantial risk of resulting in life-threatening, disabling, or disfiguring injury or damage; (3-15-22)

~~h~~i. Malnutrition as established by medical evidence; or (3-15-22)

~~i~~j. Occurrence of two (2) or more separate, substantiated incidents of abuse, neglect, or abandonment,

~~each of which falls under the circumstances~~ listed under Subsection 563.03 of this rule. ~~(3-15-22)~~( )

03. Child Protection Level Three. An individual with a Level Three designation ~~has been determined to pose a mild to medium risk of harm to the health, safety, or well-being of a child. The name of that individual~~ will remain on the Child Protection Central Registry for a minimum of five (5) years. After the end of the five-year (5) period, an individual may petition the ~~D~~department to request their name be removed from the Child Protection Central Registry in accordance with Section 566 of these rules. Names of individuals for whom an incident of abuse, neglect, or abandonment has been substantiated for any of the following are given the designation of Level Three. ~~(3-15-22)~~( )

a. Lack of supervision; (3-15-22)

b. Failure to protect from abuse, neglect, or abandonment as described in Section 16-1602, Idaho Code; (3-15-22)

c. Failure to discharge parental responsibilities described under Section 16-1602(31)(b), Idaho Code; ~~or~~ ~~(3-15-22)~~( )

d. ~~Physical a~~Abuse as described in Section 16-1602(1)(a), Idaho Code, that causes minor injuries or damage that does not require medical treatment; ( )

e. ~~or n~~Neglect as described in Section 16-1602(31), Idaho Code, that causes minor injuries or damage that does not require medical treatment. ~~(3-15-22)~~( )

564. NOTIFICATION OF A SUBSTANTIATED INCIDENT OF ABUSE, NEGLECT, OR ABANDONMENT, AND RELATED ADMINISTRATIVE REVIEW AND CONTESTED CASE APPEAL RIGHTS.

01. Notification of Substantiated Incident. Prior to placement on the Child Protection Central Registry, the ~~D~~department will notify by certified mail, return receipt requested, each individual for whom an incident of abuse, neglect, or abandonment has been substantiated. The individual has twenty-eight (28) days from the date on the notification to file a request for an administrative review ~~under the requirements in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings."~~ Failure to request a review will result in the individual's name being entered on the Child Protection Central Registry without further right for appeal. The ~~D~~department's written notice will state: ~~(3-15-22)~~( )

a. The risk level assigned to the incident; (3-15-22)

b. The basis for the ~~D~~department's decision; ~~(3-15-22)~~( )

c. The individual's right to request an administrative review by the ~~D~~department's Family and Community Services (FACS) Division Administrator of the ~~D~~department's decision; and ~~(3-15-22)~~( )

d. The ~~D~~department's contact information. ~~(3-15-22)~~( )

~~**02. Administrative Review Not Requested**. If the individual does not request an administrative review by the FACS Division Administrator within twenty-eight (28) days from the date on the notification, their name will automatically be entered on the Child Protection Central Registry without further notice or right for appeal.~~ ~~(3-15-22)~~

0~~3~~2. Administrative Review Requested. If the individual requests an administrative review by the FACS Division Administrator within twenty-eight (28) days from the date on the notification, the appeal process will begin. The individual will receive redacted documents regarding the incident that is being appealed. The individual will have fourteen (14) days to submit additional documentation. At the end of the fourteen-day period, the incident will be reviewed by the FACS Division Administrator and a decision will be rendered to either affirm, reverse, or modify, the decision to substantiate the incident of abuse, neglect, or abandonment. The Department will notify the individual of the FACS Division Administrator's decision by mail. If the administrative review affirms or modifies

the decision to substantiate, failure to timely request a contested case appeal will result in the individual's name being entered on the Child Protection Central Registry without further right for appeal. ~~(3-15-22)~~( )

0~~4~~3. **Reversal of Decision to Substantiate**. When the FACS Division Administrator completes the administrative review and reverses the decision to substantiate the incident of abuse, neglect, or abandonment, ~~and determines that the incident is not substantiated,~~ then no further action is required by the individual. The individual's name will not be placed on the Child Protection Central Registry. ~~(3-15-22)~~( )

0~~5~~4. **Contested Case Appeal**. When the FACS Division Administrator completes the administrative review and affirms the decision to substantiate the incident of abuse, neglect, or abandonment, the individual will be notified by mail that ~~their name has been placed on the Child Protection Central Registry and~~ the individual has twenty-eight (28) days to continue the appeal process and will be informed of: ~~(3-15-22)~~( )

a. The basis for the ~~D~~department's decision; ~~(3-15-22)~~( )

b. The procedures for filing a contested case appeal ~~under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings," Section 101~~; ~~(3-15-22)~~( )

c. The procedures for filing a petition for removal from the Child Protection Central Registry after the applicable minimum time has passed under Section 566 of these rules; ~~and~~ ~~(3-15-22)~~( )

d. The ~~D~~department's contact information~~.~~; and ~~(3-15-22)~~( )

e. That failure to respond at any point in the appeal process will end the appeal process and the individual's name will automatically be entered on the Child Protection Central Registry without further notice or right to appeal. ( )

05. Child Protection Central Registry. Following a decision by the hearing officer to affirm the decision to substantiate, an individual's name will be placed on the Child Protection Central Registry. ( )

565. ~~PETITION FOR REMOVAL OF AN INDIVIDUAL'S NAME ON THE CHILD PROTECTION CENTRAL REGISTRY PRIOR TO OCTOBER 1, 2007.~~ (RESERVED)

~~After January 1, 2008, an individual whose name was placed on the Child Protection Central Registry prior to October 1, 2007, may file a petition to have their name removed from the registry in accordance with Subsection 566.01 of these rules. The petitioner will be assigned a child protection risk level in accordance with criteria under Section 563 of these rules and the case will be reviewed to determine if it meets the requirements for removal.~~ ~~(3-15-22)~~

566. PETITION FOR REMOVAL OF AN INDIVIDUAL'S NAME FROM THE CHILD PROTECTION CENTRAL REGISTRY.

Any individual whose name is on the Child Protection Central Registry and whose required minimum time on the registry has elapsed, may petition the Department to remove their name from the Registry. If not previously assigned a risk level, the petitioner will be assigned a child protection risk level in accordance with the criteria under Section 563 of these rules. An individual whose name appears with a Level One designation on the Child Protection Central Registry is not eligible to petition for removal. ~~(3-15-22)~~( )

01. Petition for Removal From the Child Protection Central Registry. Any individual whose name appears on the Child Protection Central Registry with a designation of either Level Two or Level Three, may petition to have their name removed from the Child Protection Central Registry after the minimum period of time has elapsed for the applicable level. The petition must include a written statement from the petitioner to the ~~D~~department's FACS Division Administrator requesting that the petitioner's name be removed from the Child Protection Central Registry. ~~(3-15-22)~~( )

02. Criteria for Granting Petition for Removal From the Child Protection Central Registry. The petition for removal from the Child Protection Central Registry will be granted if: (3-15-22)

a. There are no additional substantiated reports on the Child Protection Central Registry or that of

other states in which the petitioner has resided since the last substantiated report of abuse, neglect, or abandonment in Idaho; and (3-15-22)

b. There are no convictions, adjudications, or withheld judgments for any of the crimes listed under Subsection 566.03 of this rule: (3-15-22)

i. On Idaho's central repository of criminal history records as established and maintained by the Idaho State Police under Title 67, Chapter 30, Idaho Code; or (3-15-22)

ii. On the criminal history repository of other states in which the petitioner has resided since the last substantiated report of abuse, neglect, or abandonment in Idaho. (3-15-22)

03. Criminal History Checks. It is the responsibility of the petitioner to request, pay for, and obtain the criminal history checks and submit them to the ~~D~~department. ~~(3-15-22)~~( )

~~**a.** The Department will not remove a petitioner from the Child Protection Central Registry if a criminal history check reveals any of the following, within five (5) years of the receipt of the petition:~~ ~~(3-15-22)~~

~~i. Physical Assault;~~ ~~(3-15-22)~~

~~ii. Battery; or~~ ~~(3-15-22)~~

~~iii. A drug related offense.~~ ~~(3-15-22)~~

~~**b.** The Department will not remove a petitioner from the Child Protection Central Registry if a criminal history check reveals any of the following:~~ ~~(3-15-22)~~

~~i. Child abuse or neglect;~~ ~~(3-15-22)~~

~~ii. Spousal abuse;~~ ~~(3-15-22)~~

~~iii. A crime against children, including child pornography; or~~ ~~(3-15-22)~~

~~iv. A crime involving violence, including rape, sexual assault, or homicide, but not including other physical assault or battery.~~ ~~(3-15-22)~~

a. The department will not remove a petitioner from the Child Protection Central Registry when the petitioner's criminal history and background check reveals a conviction for a disqualifying crime under IDAPA 16.05.06, "Criminal History & Background Checks", Section 210, except the department may remove a petitioner from the Child Protection Central Registry where the conviction arose from the same events for which the person was placed on the registry. ( )

04. Granting or Denying Removal From the Child Protection Central Registry. The ~~D~~department will issue a letter granting or denying removal of the petitioner's name from the Child Protection Central Registry within twenty-eight (28) days of receipt of the petition. ~~(3-15-22)~~( )

05. Appeal of a Denial of Removal From the Child Protection Central Registry. The individual may appeal the denial of removal of their name from the Child Protection Central Registry ~~under IDAPA 16.05.03, "Contested Cases Proceedings and Declaratory Ruling," Section 101~~. ~~(3-15-22)~~( )

567. "SAFE HAVEN" EXEMPTION FOR PARENTS OF CERTAIN ABANDONED INFANTS.
No disposition will be made on the parent(s) and no information will be entered into the Child Protection Central Registry when a parent(s) relinquishes their infant within the first thirty (30) days of life to a "Safe Haven" according to Title 39, Chapter 82, Idaho Code~~, Idaho Safe Haven Act~~. ~~(3-15-22)~~( )

568. COURT-ORDERED CHILD PROTECTION SAFETY ASSESSMENT.
When, in any divorce proceeding or upon request for modification of a divorce decree, an allegation of child abuse or

child sexual abuse is made, implicating either party, the court may order that an investigation/safety assessment be conducted by the ~~D~~department. Court orders for preliminary child protective safety assessment and for any subsequent assessment the court may deem necessary will be served on the ~~D~~department supervisor for child protection services in the field office in which the court has geographical jurisdiction. The child protection supervisor must immediately initiate the safety assessment and consult with the court promptly if there are any obstacles preventing its completion. Immediately upon completing the report, the ~~D~~department must make a written report to the court. ~~(3-15-22)~~( )

569. PETITION UNDER THE CHILD PROTECTIVE ACT.
If any incident of child abuse, neglect, or abandonment is substantiated through a safety ~~or comprehensive~~ assessment, ~~or both,~~ or during the provision of services, and cannot be resolved through informal processes or voluntary agreement that is adequate for protection of the child, the ~~D~~department will request the prosecuting attorney to file a Child Protective Act petition. ~~(3-15-22)~~( )

570. ~~COOPERATION WITH LAW ENFORCEMENT.~~(RESERVED)
~~The Department will cooperate with law enforcement personnel in their handling of criminal investigations and the filing of criminal proceedings.~~ ~~(3-15-22)~~

571. CHILD CUSTODY INVESTIGATIONS FOR THE DISTRICT COURT.
Where no other community resources are available and when ordered by the district courts, the ~~D~~department will, for a fee of thirty-five dollars ($35) per hour, conduct safety ~~and comprehensive~~ assessments ~~and provide social information to assist the court in child custody actions,~~ that will provide information to assist the court ~~to determine the most therapeutic placement for the child~~. ~~(3-15-22)~~( )

01. Requests From Private Attorney. If a parent's attorney requests a safety ~~or comprehensive~~ assessment, ~~or both,~~ and a report of findings regarding the fitness of a parent, the attorney must be advised that such service is provided on behalf of a child but not on behalf of a litigant, and that any such assessment and report would be provided to the court pursuant to a court order. ~~(3-15-22)~~( )

02. Conduct of the Assessment. In conducting the assessment, the family services worker must explain to the family the purpose for which the information is being obtained. If the judge intends to treat the report as evidence, the family must be informed that any information they provide will be brought out at the court hearing. If the family refuses to give information to the family services worker, the ~~D~~department has no authority to require cooperation. However, the judge may issue an order directing the family to provide information to the family services worker for the purpose of making a report to the court. ~~(3-15-22)~~( )

03. Report to Court. The family services worker will provide a report only to the Magistrate judge who ordered the assessment, and must use the ~~D~~department's ~~format for the assessment of need~~ standardized format. The report must describe what was observed about the home conditions and the care of the child(ren). ~~(3-15-22)~~( )

04. Department Clients. If the family is or has been a client of the Department, disclosure of information must comply with IDAPA 16.05.01, "Use and Disclosure of ~~D~~department Records." ~~(3-15-22)~~( )

572. -- 699. (RESERVED)

ADOPTION SERVICES
(Sections 700-710)

700. ADOPTION SERVICES POLICY.
Where reasonable efforts to reunite or preserve a family are unsuccessful, or where relinquishment is requested by the parent(s), the ~~D~~department will consider whether termination of parental rights is in the best interests of the child. The ~~D~~department must make every effort to place any child legally free for adoption in an appropriate adoptive home. Each child will be placed with an adoptive family who can support the racial, ethnic or cultural identity of the child, and is able to cope with any forms of discrimination the child may experience. ~~(3-15-22)~~( )

701. SERVICES TO BE PROVIDED IN ADOPTIONS.

In addition to the ~~core~~ services provided under these rules, the ~~D~~department ~~must assure provision of~~ provides the following: ~~(3-15-22)~~( )

~~**01. Response to Inquiries**. Written or personal inquiries from prospective adoptive families must be answered within two (2) weeks.~~ ~~(3-15-22)~~

0~~2~~1. **Pre-Placement Child/Family Assessment**. An assessment of the child's ~~family of origin~~ history, needs as an individual and as part of a family~~, and completion of a life story book for each child preparing for adoptive placement~~. ~~(3-15-22)~~( )

~~**03. Compliance with Multi-Ethnic Placement Act and Interethnic Adoption Provisions**. Selection of the most appropriate adoptive family consistent with the Multi-Ethnic Placement Act and Interethnic Adoption Provisions, if the child is not an Indian.~~ ~~(3-15-22)~~

~~**04. (Pre-Placement) Home Study**. An adoptive home study to ensure selection of an appropriate adoptive home.~~ ~~(3-15-22)~~

0~~5~~2. **Preparation for Placement**. ~~Preparation of the child by an assigned family services worker who will assist~~ Assistance to the child in addressing ~~anticipated~~ grief and loss due to separation from their parents and ~~assisting the child~~ with the transition ~~into~~ to an adoptive ~~home~~ placement. ~~(7-1-24)~~( )

0~~6~~3. **Technical Assistance**. Assistance in completing the legal adoption, including compliance with the Indian Child Welfare Act. (3-15-22)

~~**07. Adoption Assistance**. A determination of eligibility for adoption assistance must be made for each child placed for adoption through the Department prior to the finalization of their adoption. Eligibility for adoption assistance is determined solely on the child's need. No means test may be applied to the adoptive family's income or resources. Once eligibility is established, the Division will negotiate a written agreement with the adoptive family. The agreement must be fully executed by all parties prior to the finalization of the adoption in order to be valid.~~ ~~(3-15-22)~~

~~**08. Period of Support Supervision**. Once a child is placed with an adoptive family, a period of support and supervision by the Department lasting at least six (6) months must be completed prior to the finalization of the adoption. If the child has been a foster child placed with the family for a period of at least six (6) months, the family may submit a written request to the Department's Child and Family Services Program Manager to reduce the supervisory period to a minimum of three (3) months.~~ ~~(3-15-22)~~

0~~9~~4. **Post Adoption Services**. ~~Services after an adoption is final~~ Post adoption services are provided within available resources. Children with negotiated adoption assistance agreements~~, whether~~ from ~~Idaho or from another~~ any state, are eligible for any services available to Idaho children. International adoptees residing in Idaho are also eligible for any services available to Idaho children under the Inter-Country Adoption of 2000 (P.L.106-279). Children with ~~either~~ IV-E or state adoption assistance agreements are eligible for Medicaid in Idaho. A referral from an Interstate Compact on Adoption and Medical Assistance member state ~~will~~ serves as ~~a~~ formal application for services in Idaho. Applications for Medicaid are made through the Department in accordance with IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children." ~~(3-15-22)~~( )

~~**702. CONDITIONS FOR GUARDIANSHIP ASSISTANCE.**~~
~~The following conditions must be met for a child to be eligible for federally-funded or state-funded guardianship assistance.~~ ~~(3-15-22)~~

~~**01. Assessment of Suitability**. The Department or its contractor will determine the suitability of an individual to become a legal guardian for a specific child or sibling group through a guardianship study.~~ ~~(3-15-22)~~

~~**02. Eligibility for Guardianship Assistance**. The Department will determine eligibility for guardianship assistance for each child placed in the legal custody of the Department prior to the finalization of the guardianship. The child will first be considered for eligibility for a federally-funded subsidy. Should the child be found ineligible for a federally-funded subsidy, the child will then be considered for a state-funded subsidy.~~(3-15-22)

~~**03. Guardianship and Foster Care Licensure**. To receive guardianship assistance, a potential legal guardian must apply for and receive a foster care license. (3-15-22)~~

~~**04. Guardianship Assistance Agreements and Payments**. The Department and the prospective legal guardian must enter into a written agreement prior to the finalization of the guardianship. Benefits may include both a monthly cash payment and Medicaid benefits. The cash payment may not exceed the published foster care rate a child would receive if living in family foster care in Idaho. Eligibility for guardianship assistance is based on the child's needs. No means test may be applied to the prospective legal guardian family's income or resources in a determination of eligibility. The Department will provide the prospective legal guardian with a copy of the agreement. All Guardianship Assistance Agreements must contain the following: (3-15-22)~~

~~**a.** The amount and manner in which the guardianship assistance payment will be provided to the prospective legal guardian; (3-15-22)~~

~~**b.** The manner in which the payment may be adjusted periodically in consultation with the legal guardian, based on the circumstances of the legal guardian and the needs of the child; (3-15-22)~~

~~**c.** Any additional services and assistance for which the child and legal guardian will be eligible under the agreement; (3-15-22)~~

~~**d.** The procedure by which the legal guardian may apply for additional services; (3-15-22)~~

~~**e.** A statement that the agreement will remain in effect without regard to the state of residency of the legal guardian; (3-15-22)~~

~~**f.** The procedure by which the Department will make a mandatory annual evaluation of the need for continued assistance and the amount of the assistance; and (3-15-22)~~

~~**g.** Guardianship assistance payments are prospective only. There will be no retroactive benefits or payments. (3-15-22)~~

~~**h.** In Title IV-E Relative Guardianship Assistance Agreements, the prospective relative guardian may identify a successor legal guardian to be appointed guardianship of the child due to the death or incapacitation of the relative legal guardian. (3-15-22)~~

~~**05. Termination of Guardianship Assistance**. Federally-funded or state-funded guardianship assistance benefits and cash payments are automatically terminated when: (3-15-22)~~

~~**a.** A court terminates the legal guardianship or removes the legal guardian; (3-15-22)~~

~~**b.** The child no longer resides in the home of the legal guardian, and the legal guardian no longer provides financial support for the child; (3-15-22)~~

~~**c.** The child has reached the age of eighteen (18) years if the guardianship was finalized prior to the child's sixteenth (16) birthday or twenty-one (21) years if finalized after the child's sixteenth (16) birthday, regardless of the child's educational status or physical or developmental delays; or (3-15-22)~~

~~**d.** The child marries, dies, or enters the military. (3-15-22)~~

~~**e.** Title IV-E relative guardianship assistance benefits do not end upon the death or incapacitation of the relative legal guardian if the relative legal guardian identified a successor legal guardian in the child's Title IV-E Relative Guardianship Assistance Agreement and the successor legal guardian assumes legal responsibility for the child. (3-15-22)~~

~~**06. Administrative Review for Guardianship Assistance**. The prospective legal guardian has twenty-eight (28) days from the date of the Department's notification of the guardianship assistance determination, to~~

request an administrative review. The determination will be reviewed by the FACS Division Administrator, and a decision will be rendered to either affirm, reverse, or modify, the decision. The Department will notify the individual, by mail, of the FACS Division Administrator's decision, of their right to appeal, and procedures for filing an appeal according to requirements in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." (3-15-22)

703. FEDERALLY FUNDED GUARDIANSHIP ASSISTANCE ELIGIBILITY, REQUIREMENTS, AND BENEFITS.
In addition to Section 702 of these rules, the following requirements and benefits are applicable to a federally funded guardianship assistance for an eligible child and a relative guardian. (3-15-22)

01. Eligibility. A child is eligible for a federally funded guardianship if the Department determines the child meets the following: (3-15-22)

a. Is fourteen (14) years of age, or older, sometime during the consecutive six (6) month residence with the prospective relative legal guardian as specified in Subsection 703.01.e. of this rule; (3-15-22)

b. Has been removed from their home under a voluntary placement agreement, or as a result of a judicial determination that continuation in the home would be contrary to the welfare of the child; (3-15-22)

c. Being returned home or adopted are not appropriate permanency options for the child; (3-15-22)

d. Has been eligible for Title IV-E foster care maintenance payments during at least six (6) consecutive months during which the child resided in the home of the prospective relative legal guardian who was licensed or approved as meeting the licensure requirements as a foster family home. While it is not required that Title IV-E foster care maintenance payments have been paid on behalf of the child during the six-month timeframe, it is required the child meet all Title IV-E foster care maintenance payment eligibility criteria in the home of the fully licensed or approved relative foster parent for a consecutive six- (6) month period to be eligible for Title IV-E guardianship assistance payment with that prospective relative legal guardian; (3-15-22)

e. Has been consulted regarding the legal guardianship arrangement; and (3-15-22)

f. Has demonstrated a strong attachment to the prospective relative legal guardian, and the relative legal guardian has a strong commitment to caring permanently for the child. (3-15-22)

g. When a successor legal guardian has been named in the child's most recent Title IV-E Relative Guardianship Assistance Agreement, the child remains eligible for guardianship assistance benefits upon the death or incapacitation of the relative legal guardian with any cash assistance paid to the successor legal guardian. (3-15-22)

02. Siblings of an Eligible Child. (3-15-22)

a. The Department may make guardianship assistance payments in accordance with a guardianship assistance agreement on behalf of each sibling of an eligible child, under the age of twenty-one (21), who is placed with the same relative under the same legal guardianship arrangement if the Department and the relative legal guardian agree that the placement is appropriate. (3-15-22)

b. Nonrecurring expenses associated with obtaining legal guardianship of the eligible child's siblings are available to the extent the total cost does not exceed two thousand dollars ($2,000). (3-15-22)

c. The agency is not required to place siblings with the relative legal guardian of the child at the same time with the eligible child for the siblings to qualify for a cash payment. (3-15-22)

d. A sibling of the eligible child does not have to meet the eligibility criteria for the relative legal guardian to receive a guardianship assistance payment or for the relative legal guardian to receive nonrecurring expenses. (3-15-22)

03. Medicaid. A child who is eligible for federally funded relative guardianship assistance is eligible for Title XIX Medicaid in the state where the child resides. (3-15-22)

04. Case Plan Requirements. A child who is eligible for federally funded relative guardianship assistance must have a case plan that includes: (3-15-22)

a. How the child meets the eligibility requirements; (3-15-22)

b. Steps the agency has taken to determine that return to the home or adoption is not appropriate; (3-15-22)

c. The efforts the agency has made to discuss adoption with the child's relative foster parent and the reason why adoption is not an option; (3-15-22)

d. The efforts the agency has made to discuss the legal guardianship and the guardianship assistance with the child's parent or parents, or the reason the efforts were not made; (3-15-22)

e. The reason why a permanent placement with a prospective relative legal guardian and receipt of a guardianship assistance payment is in the child's best interests; and (3-15-22)

f. If the child is not placed with siblings, a statement as to why the child is separated from their siblings. (3-15-22)

05. Criminal History and Background Checks. To be eligible for a federally-funded guardianship assistance payment, all prospective legal guardians and other adult members of the household must receive a criminal history and background check clearance, according to the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." As a licensed foster parent, if the prospective relative legal guardian has already received a clearance, another check is not necessary. (3-15-22)

06. Nonrecurring Expenses. The Department will reimburse the cost, up to two thousand dollars ($2,000), of nonrecurring expenses associated with obtaining a federally funded legal guardianship for an eligible child. (3-15-22)

704. STATE FUNDED GUARDIANSHIP ASSISTANCE ELIGIBILITY, REQUIREMENT, AND BENEFITS.

In addition to Section 702 of these rules, the following requirements and benefits are applicable to a state-funded guardianship assistance for an eligible child and their legal guardian. (3-15-22)

01. Eligibility for State-Funded Guardianship Assistance. A child is eligible for a state-funded guardianship assistance if the Department determines the child meets the following: (3-15-22)

a. Assistance is based on the child's identified needs; (3-15-22)

b. The child's parents have had their parental rights legally terminated; and (3-15-22)

c. There is documentation of unsuccessful efforts to place the child for adoption. (3-15-22)

02. Limitations on State-Funded Guardianship Assistance. State-funded guardianship assistance is subject to state appropriations and availability of state general funds. (3-15-22)

03. Medicaid Benefits Under State-Funded Guardianship Assistance. State-funded guardianship assistance may include Medicaid benefits for the child(ren) receiving payment. These Medicaid benefits may only be used in Idaho. If the legal guardian moves to another state, they will be required to apply for Medicaid for the child(ren) in the new state of residency. (3-15-22)

04. Nonrecurring Expenses. In cases where state-funded guardianship assistance is being considered, if the potential legal guardian is not able to afford the attorney and court costs to obtain legal guardianship of a child in the legal custody of the Department of Health and Welfare, financial assistance may be available from the Department. Financial assistance for legal fees may be provided regardless of the legal guardian's state of residence.

~~(3-15-22)~~

70~~5~~2. -- 709. (RESERVED)

710. FAMILY HISTORY.
If the ~~family case plan~~ child's permanency goal is termination of parental rights and adoption ~~is considered a part of the total planning for the child~~, the following information will be obtained and placed in the child's permanent adoption record: ~~(3-15-22)~~( )

01. Informational Forms. ~~Informational b~~ Background forms regarding the birth mother, birth father, and ~~the~~ child including demographic, medical, social, and genetic information. ~~(3-15-22)~~( )

02. Hospital Records. ~~Hospital~~ Child's birth records ~~on child~~. ~~(3-15-22)~~( )

03. Evaluations/Assessments. ~~Evaluations/Assessments previously~~ Any evaluations and assessments completed on child. ~~(3-15-22)~~( )

04. Current Picture. Current picture of child. (3-15-22)

05. Narrative Social History. ~~Child and family's narrative s~~ Social history that addresses: ~~(3-15-22)~~( )

a. Family dynamics and history; (3-15-22)

b. Child's current functioning and behaviors; (3-15-22)

c. Interests, talents, abilities, strengths; (3-15-22)

d. Child's cultural and racial identity needs. ~~The ability to meet the cultural and racial needs of the child does not necessitate a family have the same culture or race as the child;~~ ~~(3-15-22)~~( )

e. Child's ~~L~~life story, including placement moves~~,~~ and reasons~~, key people~~; ~~(3-15-22)~~( )

f. Child's attachments to current caretakers, siblings and other significant ~~others; i.e., special friends, teachers, etc.~~ connections; ~~(3-15-22)~~( )

g. Medical, developmental and educational needs; (3-15-22)

h. Child's ~~history,~~ past experiences, and ~~previous~~ trauma; ~~(3-15-22)~~( )

i. ~~Membership~~Indian child's ancestry including membership or eligibility for membership in, and social and cultural ~~contacts with~~ connections to the parent's tribe~~, if any~~, including names and addresses of extended family; ~~(3-15-22)~~( )

~~**j.** Indian child's Indian ancestry;~~ ~~(3-15-22)~~

~~**k**~~**j.** Individualized recommendations regarding each child's need for permanency; and (3-15-22)

~~**l**~~**k.** Reasons for requesting termination of parental rights. (3-15-22)

TERMINATION OF PARENT-CHILD RELATIONSHIP
(Sections 711-749)

~~**711. DECISION AND APPROVAL PROCESS FOR TERMINATION OF PARENT AND CHILD RELATIONSHIP (TPR).**~~
~~Any recommendation to the Child and Family Services Program Manager regarding the termination of parental rights will be based on the outcome of a team decision-making process and must receive written approval by the program~~

~~manager before a petition may be filed.~~ ~~(3-15-22)~~

71~~2~~1. -- 713. (RESERVED)

714. VOLUNTARY TERMINATION.
~~The Department becomes involved in voluntary terminations when a parent(s) requests the Department to place their special needs child or children for adoption and when voluntary termination is a goal in the family case plan.~~ Parent(s) requesting placement of a ~~potentially healthy unborn or healthy~~ newborn child ~~should be~~ are referred to ~~the~~ Idaho's licensed private adoption agencies ~~in Idaho~~. Parent(s) requesting placement of a newborn Indian child are referred to tribal social services agencies. ~~(3-15-22)~~( )

~~**715. VOLUNTARY CONSENT.**~~
~~In obtaining a parent's consent to terminate their parental rights through the Department, a Consent to Terminate Parental Rights and Waiver of Rights to Hearing must be signed before the Magistrate Judge. Once a parent's consent has been given before the court, a corresponding petition under the Termination of Parent and Child Relationship Act will be filed by legal counsel representing the Department.~~ ~~(3-15-22)~~

~~**716. VOLUNTARY TERMINATION OF PARENTAL RIGHTS TO AN INDIAN CHILD.**~~
~~Consent to voluntary termination of parental rights by the parent(s) or Indian custodian(s) of an Indian child is not valid unless executed in writing and recorded before a court of competent jurisdiction, which may be a tribal court. The written consent must be accompanied by the presiding judge's certificate that:~~ ~~(3-15-22)~~

~~**01. Explanation of Consent**. The terms and consequences of the consent were fully explained in detail and were fully understood by the parent(s) or Indian custodian(s); and~~ ~~(3-15-22)~~

~~**02. Interpretation If Necessary**. The parent(s) or Indian custodian(s) fully understood the explanation in English or it was interpreted into a language the parent(s) or Indian custodian(s) understood.~~ ~~(3-15-22)~~

~~**717. FILING OF PETITION FOR VOLUNTARY TERMINATION.**~~
~~The petition for a voluntary termination of parental rights may be filed by an authorized agency, by the guardian(s) of the person or the legal custodian of the child or the person standing in loco parentis to the child, or by any other person having a legitimate interest in the matter.~~ ~~(3-15-22)~~

~~**718. REPORT TO COURT -- VOLUNTARY TERMINATION.**~~
~~If a voluntary consent to termination has been signed by the parent(s) before the Magistrate Court, an investigation or Report to the Court under the Termination Act is at the court's discretion. If the petition has been filed by the Department of Health and Welfare, Division of Family and Community Services, a report is required to accompany the petition, under Section 16-2008(2), Idaho Code.~~ ~~(3-15-22)~~

715. -- 718. (RESERVED)

719. INVESTIGATION.
An investigation ~~of the allegations in the petition~~ and ~~a~~ report ~~recommending disposition of the petition~~ under the Termination of Parent and Child Relationship Act may be completed by an authorized agency, certified adoption professional or the department. ~~will be completed and submitted to the court within thirty (30) days, unless an extension of time is granted by the court. The purpose of this investigation is to verify the allegations through all available sources, including the petitioner, parent(s) and possibly the extended family of the child. The Report to the Court under the Termination of Parent and Child Relationship Act, is to serve as an aid to the court in determining a disposition that complies with the Indian Child Welfare Act where applicable, or that will be in the best interest of the child. If a petition is filed by a party other than the Department, the court may order such an investigation by the Department. The law also allows completion of an investigation by an authorized agency or a certified adoption professional, prior to adjudication and disposition. If the Department is the petitioner, the report will accompany the petition. Reports submitted under the Termination of Parent and Child Relationship Act based on a parent's voluntary consent~~ In addition to the factors set forth in Section 16-2008(2), Idaho Code, completed reports will include:
~~(3-15-22)~~( )

01. Description of Investigation. The ~~circumstances of~~ allegations contained in the petition ~~and the~~

~~facts determined from the investigation; and~~ ~~(3-15-22)~~( )

02. **The Process of the Assessment and Investigation**: ( )

0~~2~~3. **Child-Related Factors**. ~~Child related factors,~~ The child's circumstances, including: ~~(3-15-22)~~( )

a. ~~Child's c~~Current functioning and behaviors; ~~(3-15-22)~~( )

b. Medical, educational and developmental needs ~~of the child~~; ~~(3-15-22)~~( )

c. ~~Child's h~~History and past experiences; ~~(3-15-22)~~( )

d. ~~Child's i~~Identity needs; ~~(3-15-22)~~( )

e. ~~Child's i~~Interests and talents; ~~(3-15-22)~~( )

f. ~~Child's a~~Attachments to current caretakers and any absent parent; ~~(3-15-22)~~( )

g. ~~Child's c~~Current living situation; ~~(3-15-22)~~( )

04. **Documentation**. Documentation of compliance with the Indian Child Welfare Act, including identification of whether the child or parent is Indian and if so: ( )

~~h~~a. ~~Indian child's membership or eligibility for membership in tribe(s)~~Notification of the pending proceedings to the parent(s) or Indian custodian(s) and the Indian child's tribe, or the Secretary of the Interior if their identity or location is unknown; ~~(3-15-22)~~( )

~~i~~b. ~~Indian child's contacts with tribe(s)~~Notification of the right of the parent(s) or Indian custodian(s) and the Indian child's tribe to intervene in the proceeding and their right to be granted up to twenty (20) additional days to prepare for the proceeding; ~~(3-15-22)~~( )

c. Evidence, including identity and qualifications of expert witnesses, that continued custody of the child by the parent(s) or Indian custodian(s) is likely to result in serious emotional or physical damage to the child; ( )

~~j~~05. **Circumstances**. The ~~present~~ circumstances~~, history, condition and desire~~ of the parent(s) whose rights are being terminated ~~regarding plans for the child;~~ including: ~~(3-15-22)~~( )

a. Present circumstances, history, and condition; ( )

b. Desires regarding plans for the child; ( )

c. Reasonable efforts made by the petitioner(s) to locate an absent parent(s) and provisions of notification to an unmarried father of the paternity registration requirement under Section 16-1513, Idaho Code; ( )

d. Contact with the parent(s) of a minor parent, unless lack of contact is explained; and ( )

e. The advertisement of any parent with a disability of their right to provide information regarding the manner in which the use of adaptive equipment or supportive services will enable the parent to carry out the responsibilities of parenting the child; ( )

~~k~~06. **Facts**. ~~Such o~~Other facts ~~as~~ which may be pertinent to the parent and child relationship and this particular case; i.e., compliance with Interstate Compact Placement on Children; and ~~(3-15-22)~~( )

~~l~~07. **Recommendation**. A recommendation and reasons as to whether or not the termination of the

parent and child relationship should be granted. ~~(3-15-22)~~( )

~~**720. FILING OF A PETITION FOR INVOLUNTARY TERMINATION OF PARENT AND CHILD RELATIONSHIP.**~~

~~Unless there are compelling reasons it would not be in the interest of the child, the Department is required to file a Petition to Terminate the Parent and Child Relationship within sixty (60) days of a judicial determination that one (1) or more of the following has occurred:~~ ~~(3-15-22)~~

~~**01. Abandonment**. An infant has been abandoned;~~ ~~(3-15-22)~~

~~**02. Reasonable Efforts to Reunify the Family Are Not Required**. That reasonable efforts, as defined in Section 16-1610(2)(i)(iii), Idaho Code, are not required because the court determines the parent(s) has subjected a child or children to aggravated circumstances.~~ ~~(3-15-22)~~

~~**721. REPORT TO THE COURT -- INVOLUNTARY TERMINATION.**~~

~~If a petition for an involuntary termination of parental rights has been brought before the Magistrate Court, an investigation or report to the court under the Termination Act is required. If the petition has been filed by the Department, a report is required under Section 16-2008(2), Idaho Code. Reports submitted under the Termination Act based on an involuntary termination of parental rights must include:~~ ~~(3-15-22)~~

~~**01. Allegations**. The allegations contained in the petition.~~ ~~(3-15-22)~~

~~**02. Investigation**. The process of the assessment and investigation.~~ ~~(3-15-22)~~

~~**03. Family Circumstances**. The present condition of the child and parent(s), especially the circumstances of the parent(s) whose rights are being terminated and contact with the parent(s) of a minor parent, unless lack of contact is explained.~~ ~~(3-15-22)~~

~~**04. Medical Information**. The information forms regarding the child, birth mother, and birth father will be submitted with the Report to the Court. Reasonably known or available medical and genetic information regarding both birth parents and source of such information, as well as reasonably known or available providers of medical care and services to the birth parents.~~ ~~(3-15-22)~~

~~**05. Efforts to Maintain Family**. Other facts that pertain to the parent and child relationship including what reasonable efforts have been made to keep the child with the family, or what active efforts to prevent the breakup of the Indian family have been made.~~ ~~(3-15-22)~~

~~**06. Absent Parent**. Reasonable efforts made by the petitioner to locate an absent parent(s) and provision of notification to an unmarried father of the paternity registry requirement under Section 16-1513, Idaho Code.~~ ~~(3-15-22)~~

~~**07. Planning**. Proposed plans for the child consistent with:~~ ~~(3-15-22)~~

~~**a.** The Indian Child Welfare Act, including potential for placement with the Indian child's extended family, other members of the Indian child's tribe, or other Indian families; and~~ ~~(3-15-22)~~

~~**b.** The Adoption and Safe Families Act of 1997, which prohibits states from delaying or denying cross-jurisdictional adoptive placements with an approved family, and requires individualized documentation regarding the child's needs in permanent placement.~~ ~~(3-15-22)~~

~~**08. Compliance with the Indian Child Welfare Act**. Documentation of compliance with the Indian Child Welfare Act, including identification of whether the child is Indian and if so:~~ ~~(3-15-22)~~

~~**a.** Notification of the pending proceedings to the parent(s) or Indian custodian(s) and the Indian child's tribe, or to the Secretary of the Interior if their identity or location is unknown according to Section 051 of these rules;~~ ~~(3-15-22)~~

~~**b.** Notification of the right of the parent(s) or Indian custodian(s), and the Indian child's tribe, to intervene in the proceeding and their right to be granted up to twenty (20) additional days to prepare for the proceeding;~~ ~~(3-15-22)~~

~~**c.** Notification that if the court determines indigency, the parent(s) or Indian custodian(s) have the right to court-appointed counsel;~~ ~~(3-15-22)~~

~~**d.** Evidence, including identity and qualifications of expert witnesses, that continued custody of the child by the parent(s) or Indian custodian(s) is likely to result in serious emotional or physical damage to the child;~~ ~~(3-15-22)~~

~~**09. Termination of Parent-Child Relationship.**~~ ~~(3-15-22)~~

~~**a.** A recommendation and the reasons whether or not termination of the parent and child relationship is in the best interest of the child; and~~ ~~(3-15-22)~~

~~**b.** Upon the court's written decision to terminate parental rights, two certified copies of the "Findings of Fact, Conclusions of Law and Decree" are to be placed in the child's permanent record.~~ ~~(3-15-22)~~

72~~2~~0. -- 749. (RESERVED)

BECOMING AN ADOPTIVE PARENT
(Sections 750-850)

750. APPLICATION TO BE ADOPTIVE PARENT(S).
~~Each field office is responsible for compiling the names and addresses of adoptive applicant(s), along with the dates of inquiry and membership in an Indian tribe, if any. A database or register must be maintained in order to assure the orderly completion of home studies~~An applicant must participate in the process and tasks to complete an adoptive home study. ~~(3-15-22)~~( )

01. Initial Application. Each adoptive applicant must: (3-15-22)

a. Cooperate with and allow the ~~D~~department, or certified adoption professional, to determine compliance with these rules to conduct an adoption home study; ~~(3-15-22)~~( )

b. Inform the ~~D~~department, or certified adoption professional, if the applicant has previously applied to become a foster or adoptive parent, is currently licensed as a foster parent, or has been involved in the care and supervision of children or adults; ~~(3-15-22)~~( )

c. Provide a medical statement for each applicant, signed by a qualified medical professional, within the twelve (12) months period prior to application for adoption, indicating the applicant is in such physical and mental health so as to not adversely affect either the health or quality of care of the adopted child; (3-15-22)

d. Provide the name of, and a signed release to obtain the following information about, each member of the household: (3-15-22)

i. Admission to, or release from, a facility, hospital, or institution for the treatment of an emotional, intellectual, or substance abuse issue; (3-15-22)

ii. Outpatient counseling, treatment, or therapy for an emotional, intellectual, or substance abuse issue. (3-15-22)

e. Provide three (3) satisfactory references, one (1) of which may be from a person related to the applicant. Each applicant must provide additional references upon the request of the ~~D~~department or certified adoption professional; ~~(3-15-22)~~( )

f. All applicants for adoption and other adult members of the household must comply with the

provisions in IDAPA 16.05.06, "Criminal History and Background Checks" and IDAPA 16.06.02, "~~Child~~Foster Care Licensing," Section ~~404~~202. ~~(3-15-22)~~( )

02. Psychological Evaluation. An evaluation by a psychologist or a psychiatrist can be required ~~by the family services worker or certified adoption professional~~ when an applicant has received or is currently receiving treatment for psychological problems or mental illness or when the family services worker, or certified adoption professional, in consultation with their supervisor, determines that there appear to be emotional problems in the family that merit further evaluation. ~~(3-15-22)~~( )

03. Orientation of Potential Applicants. Initial meetings with individual families or groups of applicants, ~~or with individual families,~~ must be scheduled promptly ~~by the Department or the certified adoption professional, whichever received the inquiry and initial application from the family. These initial meetings must be used~~ to explain policies and procedures regarding adoptive placement, the kinds of children available, and the nature of the home study. ~~(3-15-22)~~( )

04. Denial of Application. Following an initial interview, an applicant who does not appear to meet the ~~Department's~~ requirements at the time of initial application may be denied a full home study. The family will be advised why they were ineligible for a full home study and notice provided to the applicant of their right to appeal this decision. Upon resolution of the factors leading to the denial, the applicant may again file an application and receive a home study. ~~(3-15-22)~~( )

05. Application for Subsequent Adoptions. Following the finalization of an adoption, a family may apply to be considered for another placement. (3-15-22)

a. ~~Adoptive p~~Parents who have ~~experienced a successful~~ finalized an adoption and wish to reapply must complete an adoption application and financial statement, complete a ~~Criminal History and~~ Background Check, and submit medical reports and three (3) personal references. One (1) reference may be from a person related to the applicant. When requested by the ~~D~~department or certified adoption professional, an applicant must provide additional references. ~~(3-15-22)~~( )

b. The prospective adoptive family will assist in amending the original adoption study to include information concerning the acceptance and adjustment of the child previously placed in the home and their request for another placement. (3-15-22)

c. Prospective adoptive parent(s) applying for subsequent adoption with an agency with whom they have maintained a foster care license since their previous adoption may have the requirement for a new ~~Criminal History and~~ Background Check, medical reports and personal references waived by the agency. ~~(3-15-22)~~( )

751. -- 761. (RESERVED)

762. COMPLETING THE ADOPTION HOME STUDY.
~~Upon application by a potential adoptive family, the family services worker or certified adoption professional will conduct the pre-placement adoptive home study and issue a recommendation.~~ The initial home study ~~must be~~ is completed prior to placement of any child for adoption in that home. (3-15-22)

01. Interviews. Family assessment interviews as well as individual interviews ~~must be~~ are held with the prospective adoptive parent(s). ~~(3-15-22)~~( )

02. Content. Adoption home studies for foster care, special needs, independent, relative, and step-parent adoptions must include an assessment of the following: (3-15-22)

a. Names, including maiden or other names used by the applicant(s); (3-15-22)

b. Legal verification that the person(s) adopting is at least fifteen (15) years older than the child, or twenty-five (25) years of age or older, except in cases where the adopting person is a spouse of the child's parent, must be accomplished by viewing: ~~(3-15-22)~~( )

i. ~~Viewing a~~A certified copy of the birth certificate filed with the Bureau of Vital Statistics; or (3-15-22)

ii. ~~Viewing o~~One (1) of the following documents for which a birth certificate was presumably required prior to its issuance~~, such as~~: armed services or other governmental identification, including a valid Idaho driver's license, passport, visa, alien identification cards, or naturalization papers. ~~(3-15-22)~~( )

iii. If verifying documentation is not available, the report must indicate the date and place of birth and reason for lack of verification. (3-15-22)

c. Verification ~~that~~ the family has resided and maintained a dwelling within the State of Idaho for at least six (6) consecutive months prior to the filing of the petition; ~~(3-15-22)~~( )

d. Adequacy of the family's house, property, and neighborhood for the purpose of providing adoptive care as determined by on-site observations; (3-15-22)

e. Educational background of the applicant(s); (3-15-22)

f. A statement of employment, family income, and financial resources, including access to health and life insurance and the family's management of these resources; (3-15-22)

g. Current and historical mental illness, drug or alcohol abuse, and medical conditions and how they may impact the adoptive parent(s) ability to care for an adopted child; (3-15-22)

h. Previous criminal convictions and history of child abuse and neglect; (3-15-22)

i. Family history, including childhood experience and the applicant(s) parents' methods of discipline and problem-solving; (3-15-22)

j. Verification of marriages and divorces; (3-15-22)

~~**k.** Decision-making, communication, and roles within the marital relationship, if applicable; (3-15-22)~~

~~**l**~~**k.** ~~The n~~Names, ages, and addresses of all biological and adopted children currently residing inside or outside the home. Information regarding the current adjustment and special needs of the applicant(s) children; ~~(3-15-22)~~( )

~~**m**~~**l.** The religious and cultural practices of the family, including their interest and ability to ~~nurture and validate~~ parent and support a child's ~~particular~~ knowledge of and involvement in that child's cultural, racial, ethnic, and religious~~, and ethnic~~ background different than their own; ~~(3-15-22)~~( )

~~**n**~~**m.** For an Indian child, the study will ~~also~~ determine the prevailing social and cultural standards of the Indian community in which the parent(s) or extended family resides or maintains social and cultural ties~~.~~:; ~~(3-15-22)~~( )

~~**o**~~**n.** Individual and family functioning including inter-relationships with each member of the household and the family's ability to help a child integrate into the family; (3-15-22)

~~**p**~~**o.** Activities, interests, and hobbies; (3-15-22)

~~**q**~~**p.** Child care and parenting skills, including historical and current methods of discipline used in the home; (3-15-22)

~~**r**~~**q.** Reasons for applying for adoption; (3-15-22)

~~**s**~~**r.** ~~The family's p~~Prior and current experiences with adoption, understanding of adoption, and ability

to form relationships and bond with a specific child or general description of children; ~~(3-15-22)~~( )

~~t~~**s.** ~~The a~~Attitudes toward adoption by immediate and extended members of the family and other persons who reside in the home; (3-15-22)

~~u~~**t.** Specifications of the child preferred by the family that include the number of children, age, gender, race, ethnic background, social, emotional, and educational characteristics. The family's ability to accept the behavior and personality of a specific child (if known) or general description of children and their ability to meet the child's particular educational, developmental, and psychological needs; (3-15-22)

~~v~~**u.** Emotional stability and maturity in dealing with the needs, challenges, and related issues associated with the placement of a child into the applicant(s) home; (3-15-22)

~~w~~**v.** ~~The family's a~~Attitude about an adopted child's birth family including: ~~(3-15-22)~~( )

i. ~~Their a~~Ability to accept a child's background and help the child cope with their past; and ~~(3-15-22)~~( )

ii. ~~Their w~~Willingness to work with the child's family or tribe; ~~(3-15-22)~~( )

~~x~~**w.** Training needs of the applicant(s); and (3-15-22)

~~y~~**x.** A recommendation regarding the family's ability to provide adoptive care to a specific child (if known) or general description of children. (3-15-22)

763. PRE-ADOPTIVE PARENT RESPONSIBILITIES.
The pre-adoptive parent is responsible to keep the department, agency or ~~C~~certified ~~A~~adoption ~~P~~professional that completed the home study informed of any changes in the family's circumstances, or of any subsequent decision against adoption. ~~(3-15-22)~~( )

764. ~~ADOPTIVE~~ADOPTION HOME STUDY.
An adoption home study is valid for the purposes of new adoptive placement for a period of one (1) year following the date of completion. Upon completion of an adoptive placement agreement, an adoption home study remains valid for a period of two (2) years from the date of completion for the purpose of finalizing the adoption of the child(ren) for whom the adoptive placement agreement was written. (3-15-22)

765. -- 769. (RESERVED)

770. CLOSURE OF ~~ADOPTIVE~~ ADOPTION HOME STUDIES.
Upon pre-adoptive placement of a child or children in the home ~~of a pre-adoptive parent~~, the ~~parent's~~ adoption home study closes for the placement of an additional child or children for the purpose of adoption until a home study update is completed. ~~(3-15-22)~~( )

771. ADOPTION HOME STUDY UPDATE.
An ~~adoptive~~ adoption home study must be updated on an annual basis to remain valid for new adoptive placements. ~~A current home study is defined as a home study completed within the previous twelve (12) months.~~ Adoption ~~H~~home study updates must include the following: ~~(3-15-22)~~( )

01. Initial Adoption Home Study and Subsequent Home Study Updates. All ~~C~~changes to the ~~I~~information ~~C~~contained in the ~~I~~initial Adoption Home Study and any ~~S~~subsequent Adoption Home Study Updates. ~~(3-15-22)~~( )

02. Family Functioning and Inter-Relationships. ~~All~~ Information on any ~~C~~changes in ~~F~~family Functioning and ~~I~~inter- ~~R~~relationships. ~~(3-15-22)~~( )

03. Circumstances Adversely Impacting Child Placed for Adoption. ~~Any~~ Information ~~R~~regarding ~~C~~circumstances ~~W~~within the ~~F~~family that may ~~A~~adversely ~~I~~impact a ~~C~~child ~~P~~placed for ~~A~~adoption. ~~(3-15-22)~~( )

04. A Home Study Update Completed for the Purpose of Adoptive Placement of an Additional Child or Children in the Home. A home study update completed for the purpose of adoptive placement of an additional child or children in the home where a child or children are already placed for adoption and that adoption has not yet finalized must include agreement for the placement of the additional child or children by the individual or agency responsible for the placement of the initial child or children, and the individual or agency responsible for the additional child or children. (3-15-22)

772. -- 789. (RESERVED)

790. FOSTER PARENT ADOPTIONS.
The procedure and requirements are the same for all adoptive applicants. ~~This includes foster parents who want to be considered as adoptive parents for a child who has a plan of adoption.~~ Licensed foster parents with a current home study recommending them for both foster care and adoption do not need an adoption specific home study to adopt a child matching the characteristics of a child or children for whom they are approved or recommended for placement. They are eligible to be considered for adoption as part of the home study process completed to provide foster care. These requirements include compliance with the Indian Child Welfare Act, the Multi-Ethnic Placement Act of 1994 and the Interethnic Adoption Provisions of 1996. ~~(3-15-22)~~( )

791. -- ~~799~~832. (RESERVED)

~~800. PLACEMENT OF THE CHILD.~~
~~Adoptive placement of a child in the custody or guardianship of the Department will be determined as follows:~~ ~~(3-15-22)~~

~~01. Factors to be Considered in Determining Suitability of Adoptive Placements~~. ~~(3-15-22)~~

~~**a.** For an Indian child, absent good cause to the contrary, the following preferences for placement under the Indian Child Welfare Act must be followed:~~ ~~(3-15-22)~~

~~i. Extended family;~~ ~~(3-15-22)~~

~~ii. Other members of the child's tribe; or~~ ~~(3-15-22)~~

~~iii. Other Indian families.~~ ~~(3-15-22)~~

~~**b.** The primary factor in the review of a prospective adoptive family's eligibility is the ability to protect and promote the best interests of a child to be placed in their home.~~ ~~(3-15-22)~~

~~**c.** The Department will not delay or deny the placement of a child with an approved family that is located outside of the jurisdiction responsible for the care and planning for the child.~~ ~~(3-15-22)~~

~~**02. Selection of Adoptive Placement**. The adoptive placement of a child in the custody or legal guardianship of the Department will be selected using a committee process of no less than three (3) individuals and be approved by a field program manager as described by the practice standards of the Department.~~ ~~(3-15-22)~~

~~**03. Disclosure**. The field office must provide full confidential background information and discuss the child's history fully with the prospective adoptive parent(s) prior to the placement. The disclosure of background information must be confirmed at the time of placement by a written statement from the family services worker to the prospective adoptive family, which they will be asked to acknowledge and sign. A copy of this statement must be provided to the adoptive family and one (1) copy will be kept in the child's permanent record.~~ ~~(3-15-22)~~

~~801. -- 829. (RESERVED)~~

~~830. ADOPTION APPLICATION FEE.~~
~~The adoption application fee covers the costs of processing the adoption application and does not guarantee that the applicant family will receive a child for adoption. The application fee is non-refundable. Money collected through the~~

~~Department's adoption program may be utilized to pay state adoption assistance payments for children with special needs and pay the service fees, recruitment costs, and placement fees for private agencies serving children who have special needs.~~ ~~(3-15-22)~~

~~831. HOME STUDY, SUPERVISORY REPORTS, AND REPORTS OF THE COURT FEES.~~
~~A family who cares for a child, or children, with special needs who is in the custody of the Department is not required to pay the costs of the Department adoption services identified in Section 832 of these rules for the adoption of that child, or children. A relative or kin family being considered by the Department for adoption of a child from foster care who is their relative or kin, is not required to pay the costs referenced in Section 832 of these rules. If a family who did not pay the fee uses that home study to pursue adoption of a child not in the Department's custody, the family must pay the Department for the full cost of the study and any other applicable fees identified in Section 832 of these rules.~~ ~~(3-15-22)~~

~~832. FEE SCHEDULE - ADOPTIONS THROUGH DEPARTMENT.~~

~~TABLE 832~~	
~~Service~~	~~Fee~~
~~General Information/Adoption Inquiries~~	~~No Charge~~
~~Health and Welfare Application:~~ ~~Couple~~ ~~Single Parent~~	 ~~$50~~ ~~$25~~
~~Second Placement or Reapplication~~	~~$25~~
~~Pre-placement Home Study - Payment due at time of study or per agreement~~	~~$450~~
~~Report to Court under the Adoption Act~~	~~$150~~
~~Second Placement~~	~~$150~~
~~Placement Supervision Fee - Charged at the time of placement~~	~~$300~~
~~Closed Adoption Home Study/Court Report Retrieval Fee~~	~~$50~~
~~Report to the Court Under the Termination Act~~	~~$40 per hour~~

~~(3-15-22)~~

833. PLACEMENT SUPERVISION -- TRANSFER FROM OUT OF STATE PRIVATE AGENCY.
When a prospective adoptive parent(s) moves to Idaho, with a child who has been placed with them by a private agency in their former state of residency, ~~the sending state agency must arrange through the Interstate Compact on the Placement of Children,~~ supervision services are provided through one of Idaho's private, licensed adoption agencies, or a certified adoption professional. ~~(3-15-22)~~( )

834. -- ~~849.~~ ~~(RESERVED)~~

~~850. INDEPENDENT, RELATIVE AND STEPPARENT ADOPTIONS.~~
~~Independent adoptive placements are handled under Section 16-1506, Idaho Code.~~ ~~(3-15-22)~~

~~851. --~~859. (RESERVED)

THE ADOPTIVE PLACEMENT
(Sections 860-888)

860. PLACEMENT OF THE CHILD.
The adoptive placement of a child in the custody or legal guardianship of the department will be selected using a

committee process of no less than three (3) individuals and be approved by a regional program manager. ( )

01. Factors Considered in Determining Adoptive Placements. ( )

a. For an Indian child, Indian Child Welfare Act (1978) placement preferences must be followed: ( )

i. A member of the child's extended family; ( )

ii. Other members of the Indian child's tribe; ( )

iii. Other Indian families. ( )

b. The primary factor in determining adoptive placement is the prospective family's ability to protect and promote the best interests of the child to be placed in their home. ( )

c. The ability to meet the cultural and racial needs of the child does not necessitate the family have the same culture or race of the child. ( )

02. Disclosure. Full background information and the child's history must be discussed with the prospective adoptive parent(s) prior to pre-adoptive placement. The disclosure of background information is confirmed at the time of placement by a written acknowledgment signed by the family services worker and prospective adoptive family. A copy of this statement must be provided to the adoptive family and one (1) copy is kept in the child's permanent record. ( )

860~~0~~1. PROCEDURES FOLLOWING ~~THE~~ ADOPTIVE PLACEMENT.
~~Following the adoptive placement, a~~A period of support and supervision ~~by the Department~~ lasting at least six (6) months must be completed following the adoptive placement prior to the finalization of the adoption. In situations where a foster family has a significant relationship with a child and the child has been placed in their home for at least the last six (6) months, the supervisory period may be reduced to a minimum of three (3) months. ~~The family services worker will make s~~ Scheduled visits to the home will be made at least monthly during this period to assist the child and the family in their adjustment ~~to each other and will update the child's permanent record by means of monthly progress reports. When completion of the adoption is recommended by the field office and approved by the Permanency Program Specialist, the Department will request the prospective adoptive parent(s) contact their attorney. The regional family services worker will provide the attorney with the necessary documentation to file the petition for adoption~~. ~~(3-15-22)~~( )

861~~1~~2. PROGRESS REPORTS.
~~Progress r~~Reports documenting the progress of the child's placement will be prepared at least every thirty (30) days. ~~regularly and will be based on~~ Reports include the family services worker's or certified adoption professional's findings based on their observation of each child and prospective adoptive parent(s) with an emphasis on~~.~~: ~~(3-15-22)~~( )

01. Initial and Subsequent Reports. ~~Progress reports must be made at intervals not to exceed thirty (30) days. These reports will include the family services worker's or certified adoption professional's observation of each child and the prospective adopting parent(s), with emphasis on:~~ ~~(3-15-22)~~( )

a. Special needs~~, special~~ and/or circumstances~~, or both,~~ of each child ~~at time of placement~~; ~~(3-15-22)~~( )

b. Services planned or provided to each child and the family ~~during the report period~~; ~~(3-15-22)~~( )

~~**c. Services to be provided to each child and the family;** (3-15-22)~~

~~**d**~~**c.** General appearance and adjustment of each child during the report period ~~(may include eating, sleep patterns, responsiveness, bonding)~~; ~~(3-15-22)~~( )

~~e~~d. Adjustment of each child to ~~all of the following that apply:~~ school~~,~~ and/or daycare~~, and day treatment program~~; ~~(3-15-22)~~( )

~~f~~e. Health and developmental progress, and medical practitioner information for each child; (3-15-22)

~~g~~f. ~~Whether each child has been accepted~~Acceptance of each child for coverage on the family's medical insurance, when coverage begins, and whether there will be any limitations, exclusions, or both; ~~(3-15-22)~~( )

~~h~~g. ~~Family's~~Each family member's adjustment to adoptive placement; ~~(3-15-22)~~( )

~~i~~h. Adoption assistance negotiation; (3-15-22)

~~j~~i. Changes in family situation or circumstances; and ~~(3-15-22)~~( )

~~k~~j. Areas of concern during the report period as addressed by each child and the adoptive parent(s); and (3-15-22)

~~l. The date of the next required six (6) month review or twelve (12) month permanency hearing.~~ ~~(3-15-22)~~

~~02. Monthly Foster Care Payments -- Pre-Adoptive Placement. To receive Title IV-E monthly foster care payments during the period pending completion of adoption, the prospective adoptive parent(s) must have a foster care license.~~ ~~(3-15-22)~~

~~862. PETITION TO ADOPT UNDER THE ADOPTION OF CHILDREN ACT.~~

~~01. Filing a Petition. When the family and the child who was placed for adoption in that home are ready to finalize the adoption, the family's attorney files a petition to adopt with the court. A copy of that petition is served upon the director of the Department. Upon receipt of a copy of the petition to adopt, the family services worker, licensed children's adoption agency worker or certified adoption professional verifies the allegations set forth in the petition and make a thorough investigation of the matter and report the findings in writing to the court within thirty (30) days.~~ ~~(3-15-22)~~

~~02. Registration and Acknowledgment. Upon receipt of the petition to adopt, the field office registers the petition and acknowledge receipt to the court and to the petitioner(s) or private adoption agency. If the licensed adoption agency or certified adoption professional who completed the pre-placement home study is not identified, the information should be obtained from the petitioner(s)' attorney. The register will indicate the date the petition was received, the date the study is due in court, the date the completed study was sent to the court, whether an Indian child is involved, and other pertinent data.~~ ~~(3-15-22)~~

863. INVESTIGATION OF PETITION TO ADOPT AND REPORT TO THE COURT.

~~According to Section 16-1506, Idaho Code, an~~Written reports of investigation regarding ~~the~~ allegations stated in ~~the~~ petitions ~~and subsequent written report of findings must be filed with the court unless the investigation is waived by order of the court. The~~ filed under Section 16-1506, Idaho Code, are filed at the same time as the prospective adoptive family's ~~pre-placement~~ adoption home study ~~will be filed at the same time as the written report of investigation. If the family services worker,~~ The investigation and report may be completed by the department, licensed ~~child placing~~ adoption agency ~~staff~~, or certified adoption professional ~~is unable to complete the study within thirty (30) days, an extension of time must be requested in writing of the court, stating the reasons for the request.~~ supervising the adoptive placement. Caution is exercised discussing identifying information to avoid revealing information in the petition while attempting to secure the necessary facts for the report. If ~~the worker has~~ there is reason to believe ~~that~~ the child may be an Indian child and the child's tribe or the Secretary of the Interior has not received written Notice of Pending Proceedings, the worker must inform the court, ~~and~~ the ~~petitioner's~~ attorney for the petitioner(s) and the independent agency of the need to comply with the Indian Child Welfare Act. ~~This adoption~~ The report to the court must address the following: ~~(3-15-22)~~( )

01. Legal Availability of the Child. ~~It is the responsibility of the petitioners, through their attorney, to present documentary evidence to the court so the judge can examine it and be satisfied that the identity, birthdate, and parentage of the child are as represented in the petition.~~ The family services worker or certified adoption professional will interview the family and any other person(s) having knowledge in the matter, review all documentary evidence presented by the petitioner(s), and record the information and source of the information, noting any discrepancies. Such documentary evidence must include the following: ~~(3-15-22)~~( )

a. ~~The b~~Birth certificate of the child; ~~(3-15-22)~~( )

b. ~~The c~~Consent(s) of the child's parent(s) to terminate their parental rights, termination decrees for any parent(s) whose parental rights have been terminated involuntarily by the court, and documentation of marriage and divorce; ~~(3-15-22)~~( )

c. Termination decrees for any parent(s) whose parental rights have been terminated involuntarily by the court; ( )

d. Documentation of marriage and divorce; ( )

~~e~~c. If the child is an Indian child, a copy of the Notice of Pending Proceedings for Termination of Parental Rights, and the return receipts showing that the notice was received by the Indian child's parent(s) or Indian custodian(s), and the child's tribe; (3-15-22)

~~d~~f. Consent to adoption has been secured for all persons from whom it is required, including a legal guardian(s), to make the child legally available for adoption; (3-15-22)

~~e~~g. ~~The d~~Death certificate of a deceased parent; ~~(3-15-22)~~( )

~~f~~h. Verification from the Bureau of Vital Statistics of the registry of any putative father; and (3-15-22)

~~g~~i. The Interstate Compact on the Placement of Children Form 100-A, for a child born outside of the state of Idaho, to determine if required state authorizations have been given, or if the Compact does not apply. (3-15-22)

02. Needs of the Child. ~~The report to the court must address the needs of the child,~~ History of the child and the child's birth family including ~~but~~: ~~(3-15-22)~~( )

~~a.~~ ~~The history of the child and the child's birth family;~~ ~~(3-15-22)~~

~~b~~a. ~~The family history for a child who has been previously adopted, should include i~~Information about the child's previous adoptive family and the circumstances of the disruption if the child was previously adopted; ~~(3-15-22)~~( )

~~e~~b. ~~A d~~Detailed description of the circumstances that brought about the placement with the prospective adoptive family; ~~(3-15-22)~~( )

~~d~~c. ~~The state of Idaho~~ Social, ~~M~~medical, and ~~G~~genetic ~~H~~history forms must be completed, made available to the prospective adoptive family, and submitted to the court, showing reasonably known or available medical and genetic information regarding both birth parents and the child, as well as reasonably known or available providers of medical care and services to birth parents and child; and ~~(3-15-22)~~( )

~~e~~d. The appropriateness of the prospective adoptive family for the particular child or children who are the subject of the petition including any alleged relative or stepparent relationship between the child and the prospective adoptive parent(s) specifying any documentary evidence of that relationship. ~~(3-15-22)~~( )

~~03. Degree of Relationship of the Child to Petitioners~~. ~~In those cases where the court has ordered an investigation of petitions to adopt by relatives or step parents, the study must record such alleged relationship and~~

~~specify the documentary evidence the petitioners have of that relationship.~~ ~~(3-15-22)~~

0~~4~~3. Evaluation and Recommendation. ~~The family services worker or certified adoption professional must provide a~~ A brief summary of data presented in prior sections and the ~~pre-placement~~ adoption home study, supporting the recommendation regarding the adoption. ~~(3-15-22)~~( )

~~**05. Medical Information**. A copy of medical and genetic information compiled in the investigation must be made available to the prospective adoptive family by the family services worker or certified adoption professional prior to the final order of adoption.~~ ~~(3-15-22)~~

~~**06. Confidentiality of Information**. The family services worker must exercise caution in discussing identifying information and avoid revealing that information in the petition while attempting to secure the necessary facts for the study.~~ ~~(3-15-22)~~

~~**07. Financial Accounting**. A financial accounting must be approved by the court of any financial assistance given to the birth parent(s) that exceeds five hundred dollars ($500), in accordance with Section 18-1511, Idaho Code.~~ ~~(3-15-22)~~

864. -- 869. (RESERVED)

870. REMOVAL OF A CHILD FROM A PROSPECTIVE ADOPTIVE HOME.
~~Despite careful assessment of the child and the family prior to placement, circumstances may arise that make it necessary to remove the child from the prospective adoptive home prior to adoption. The child may manifest problems the family is unable to accept or to handle constructively; or changed circumstances may develop that make it inadvisable for the placement to continue.~~ The final decision to remove a child from a prospective adoptive home will be made by the Department as the legal guardian of the child. ~~(3-15-22)~~( )

~~**871. TEMPORARY REPLACEMENT AFTER DISRUPTION.**~~
~~When a disruption occurs and it becomes necessary to remove a child from a prospective adoptive home, the field office where the child has been placed is responsible for finding a temporary arrangement for the child until another permanent placement can be arranged. In the case of the adoption of an Indian child, the consent of the parent(s) may be withdrawn for any reason at any time prior to the entry of a final decree of adoption, and the child returned to the parent(s).~~ ~~(3-15-22)~~

87~~2~~1. -- 880. (RESERVED)

881. CLOSURE OF CASE.
~~The family services worker must request from the adopting parent(s)' attorney, a~~A certified copy of the final order of adoption~~,~~ and a copy of the ~~family service worker's~~ executed consent to adoption ~~taken at the time of the adoption finalization. These documents~~ are necessary to close the adoption file and initiate the child's adoption assistance benefits. ~~(3-15-22)~~( )

882. RECORDS OF PLACEMENT.
Upon finalization of the adoption, the complete record from the local field office, regarding the child and family will be ~~requested by the State Adoption Program Specialist for permanent storage~~ permanently stored. ~~Records of adoption involving Indian children must be forwarded by the State Adoption Program Specialist to the Secretary of the Interior.~~ ~~(3-15-22)~~( )

883. ~~POST LEGAL ADOPTION SERVICES.~~(RESERVED)
~~Upon finalization of the adoption, the Department can offer post legal adoption services upon request, including case management services, referrals for counseling or other supportive services.~~ ~~(3-15-22)~~

884. OPENING SEALED ADOPTION RECORDS ~~OF ADOPTIONS~~.
In addition to the exceptions noted in Section 16-1511, Idaho Code, ~~a~~ sealed adoption proceedings may be opened in the following circumstances according to the Indian Child Welfare Act: ~~(3-15-22)~~( )

01. Motion of an Indian Individual. Upon motion of an Indian individual who has reached the age of

eighteen (18) and was the subject of an adoption, the court must provide tribal affiliation, if any, of the individual's biological parent(s) and other information necessary to protect any rights flowing from the individual's tribal relationship. (3-15-22)

02. Request From the Secretary of the Interior or the Indian Child's Tribe. Upon request of the Secretary of the Interior or the Indian child's tribe, evidence of efforts to comply with the Indian Child Welfare Act must be made available to the parties requesting such information. (3-15-22)

885. -- 888. (RESERVED)

CERTIFIED ADOPTION PROFESSIONAL
(Sections 889-899)

889. CERTIFIED ADOPTION PROFESSIONAL REQUIREMENTS.
An applicant requesting to become a Certified Adoption Professional must meet the following criteria: (3-15-22)

01. College Degree. A minimum of a bachelor's degree in a field deemed related to adoptions by the Department's Child and Family Services Program, such as social work, psychology, family counseling or other related behavioral science; (3-15-22)

02. Adoption Training. ~~Must have completed a~~ A minimum of twenty (20) hours of training in adoption services within the last four (4) years; ~~(3-15-22)~~( )

03. ~~Department Criminal History and~~ Background Clearance. ~~Must c~~ Complete a ~~Department criminal history and~~ background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks," and receive a clearance; ~~(3-15-22)~~( )

04. License. A current license to practice social work in the state of Idaho; (3-15-22)

05. Experience. A minimum of two (2) years of experience as a paid full-time employee providing adoption services with a licensed private or public children's agency; ~~(3-15-22)~~( )

06. References. Three (3) satisfactory references, one (1) of which must be from a previous employer for whom the applicant worked providing adoption services; (3-15-22)

07. Insurance. Verification of malpractice insurance that will provide coverage for the applicant's work as a certified adoption professional; and (3-15-22)

08. Application Fee. An application fee of one hundred dollars ($100) to be reimbursed, less a twenty-five dollar ($25) processing fee, in the event the application is denied. (3-15-22)

890. TERMS OF CERTIFICATION FOR ADOPTION PROFESSIONALS.

01. Certification. Certification for adoption professionals ~~will be~~ is completed through the Division of Family and Community Services ~~and will be~~. Certifications are effective for a period of two (2) years. ~~(3-15-22)~~( )

02. Types of Certification. Certified adoption professionals may ~~be certified for~~ provide any, some, or all of the following services: ~~(3-15-22)~~( )

a. Adoption home studies for families seeking domestic infant adoption. (3-15-22)

b. Adoption home studies for families seeking domestic special needs adoption. (3-15-22)

c. Adoption home studies for families seeking step-parent or relative adoption. (3-15-22)

d. Court ordered investigations for termination of parental rights for domestic private or independent

adoptions. (3-15-22)

e. Court reports for domestic private or independent adoptions. (3-15-22)

f. Supervision of adoptive placements for domestic private or independent adoptions. (3-15-22)

03. Limits of Certification. Certified adoption professionals may not provide the following services: (3-15-22)

a. Birth parent education or counseling. (3-15-22)

b. Services related to international adoption. (3-15-22)

04. Recertification. Certified adoption professionals must apply for renewal of their certificate every two (2) years and must provide the following: (3-15-22)

a. Documentation of ten (10) hours of adoption training taken during the previous two (2) years; (3-15-22)

b. Verification of malpractice insurance; (3-15-22)

c. A satisfactory recommendation from the Division of Family and Community Services designee responsible for the review of the certified adoption professional's work; and ~~(3-15-22)~~( )

~~**d.** Satisfactory recommendations from a minimum of two (2) families for whom the certified adoption professional has provided adoption services during the previous two (2) years; and~~ ~~(3-15-22)~~

~~e~~**d.** A certification fee of one hundred dollars ($100) to be reimbursed, less a twenty-five dollar ($25) processing fee, in the event the recertification is denied. (3-15-22)

05. Lapse of Certification. If a certified adoption professional does not apply for recertification within two (2) years in accordance with Subsection 890.04 of this rule, this will result in a lapse of certification. Any lapse in certification will require completion of a new certified adoption professional application, documentation of ten (10) hours of adoption training during the two (2) years previous to this new application, and a new ~~criminal history and~~ background check. ~~(3-15-22)~~( )

a. If the individual applying for certification has received a ~~Department criminal history and background check clearance~~ background check clearance in accordance with IDAPA 16.05.06 "Criminal History and Background Checks within three (3) years of the date of this application and has not lived outside the state of Idaho since their last ~~criminal history and~~ background check, all of the following must be conducted and no disqualifying crimes or appearance on a registry found: ~~(3-15-22)~~( )

i. A name-based background check by the Idaho State Police; (3-15-22)

ii. A check of the Idaho Child Protection Central Registry; (3-15-22)

iii. A check of the Idaho Adult Protection Registry; and (3-15-22)

iv. A check of the Idaho Sexual Offender Registry. (3-15-22)

b. If the individual has lived outside the state of Idaho for any amount of time during the three (3) years since the previous ~~Department criminal history and~~ background check clearance, ~~was completed, they must get~~ a new Department criminal history and background check clearance is required. ~~(3-15-22)~~( )

06. Denial of Recertification. The ~~D~~department may choose not to recertify a certified adoption professional. Notification of denial will be made ~~by the Department~~ by certified mail. The notice will state the specific grounds for denial of recertification. This decision may be appealed within twenty-eight (28) days of receipt

of notification under the provisions in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." Grounds for denial of recertification are one (1) or more of the following: ~~(3-15-22)~~( )

a. Substandard quality of work following the development of a quality improvement plan; (3-15-22)

b. Failure to gain ten (10) additional hours of adoption continuing education required for recertification; ~~or~~ ~~(3-15-22)~~( )

c. A demonstrated pattern of negligence or incompetence in performing the duties of a certified adoption professional. (3-15-22)

d. Failure to maintain malpractice insurance; or ~~(3-15-22)~~( )

e. Failure to maintain a license to practice social work in the state of Idaho. This requirement does not apply to a certified adoption professional who has maintained their initial certification that occurred prior to July 1, 2012. (3-15-22)

07. Decertification. A certified adoption professional can be decertified by the ~~D~~department at any time during a two (2) year period of certification. Notification of decertification will be made by the ~~D~~department by certified mail. The notice will state the specific grounds for decertification. This decision may be appealed within twenty-eight (28) days of receipt of notification under the provisions in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." Grounds for decertification are one (1) or more of the following: ~~(3-15-22)~~( )

a. Conviction for a felony; (3-15-22)

b. Negligence in carrying out the duties of a certified adoption professional; (3-15-22)

c. Misrepresentation of facts regarding their qualifications or the qualifications of a prospective adoptive family to adopt, or both; (3-15-22)

d. Failure to obtain ~~D~~departmental review and approval of ~~pre-placement~~ home studies ~~and~~ court reports, and/~~or~~ placement supervision reports, or both, on more than one (1) occasion; ~~(3-15-22)~~( )

e. Failure to maintain malpractice insurance; (3-15-22)

f. Suspension or loss of a license to practice social work in Idaho; or (3-15-22)

g. Practice as a certified adoption professional outside the scope of the certification. (3-15-22)

891. CERTIFIED ADOPTION PROFESSIONAL~~'S~~ CLIENT RELATIONSHIP.
A certified adoption professional may not assume a legal relationship with any child for whom they have been contracted to perform services and may not provide services for anyone with whom they have had a personal or professional relationship during the previous two (2) years. (3-15-22)

892. MINIMUM STANDARDS FOR SERVICE.
A certified adoption professional must meet the following service requirements: (3-15-22)

01. Description of Services Available. A written description of services will be provided to families by the certified adoption professional before any work is completed. The description of services must include information regarding Department oversight of the certified adoption professional and any limitations related to the use of the completed home study; (3-15-22)

02. Education. Provision of, or referral to, educational resources to adoptive applicants requesting non-relative adoption; (3-15-22)

03. Content. Standards for ~~pre-placement~~ home studies, home study updates, court reports, and

supervisory reports must, at a minimum, meet the standards for adoption services established ~~by the Department~~ in these rules; ~~(3-15-22)~~( )

04. Release of Information. A written release of information that gives consent to the exchange of information between the certified adoption professional and Child and Family Services must be obtained from a family that receives services from a certified adoption professional; and (3-15-22)

05. Disclosure of Non-Identifying Information. When providing adoption supervision or adoption finalization court report services, the certified adoption professional must provide disclosure of all known non-identifying information about the child, the child's birth parents, and the circumstances leading to the decision to place the child for adoption. (3-15-22)

893. RECORDS OF THE CERTIFIED ADOPTION PROFESSIONAL.
Records of the ~~pre-placement~~ home studies, court reports, and supervisory reports provided by the certified adoption professional must be made available to the Division of Family and Community Services designee two (2) weeks prior to the required court filing date. The designee will be responsible for monitoring of quality of the services provided. ~~(3-15-22)~~( )

894. FEES CHARGED BY THE DEPARTMENT.
Monitoring fees will accompany the submission of each report and be paid directly to the Department through the Division of Family and Community Services as follows:

Table 894 - Qualified Individuals	
Home Study or Court Report	$50
Supervision Report or Home Study Update	$30

(3-15-22)

895. DEPARTMENT RESPONSIBILITY TO CERTIFIED ADOPTION PROFESSIONAL.
The Division of Family and Community Services is responsible for: (3-15-22)

a. Reviewing and responding to submitted reports within five (5) business days; (3-15-22)

b. Initiation of corrective action plans when the documentation of a certified adoption professional is determined to be incorrect or substandard; and (3-15-22)

c. Dissemination of information to certified adoption professionals that may impact provided services. (3-15-22)

896. -- 899. (RESERVED)

ADOPTION AND GUARDIANSHIP ASSISTANCE
(Sections 900-999)

900. CONDITIONS FOR ADOPTION ASSISTANCE.
The purpose of the adoption assistance program is to encourage the legal adoption of children with special needs who would not be able to have the security of a permanent home without support payments. Applications are made through the Division of Family and Community Services, ~~Resource Development Unit~~ for a determination of eligibility. Eligibility is determined solely on the child's need. No means test may be applied to the adoptive family's income or resources. Once an application for adoption assistance is submitted to the Division of Family and Community Services, the Division will respond with a determination of the child's eligibility within forty-five (45) days. ~~(3-15-22)~~( )

~~**01. Determination of Eligibility for Title IV-E Adoption Assistance**. Child and Family Services will determine whether a child is a child with special needs. Children applying for adoption assistance benefits must meet~~

Idaho's definition of a child with special needs according to Section 473 (c) of P.L. 96-272 (The Adoption Assistance and Child Welfare Act of 1980). There are five (5) ways a child can be eligible for Title IV-E adoption assistance: (3-15-22)

a. Child is Aid to Families with Dependent Children (AFDC) eligible, is in the custody or care of the public child welfare agency or an Indian tribe with whom the state has a IV-E agreement and meets the definition of a child with special needs. For children whose adoption assistance eligibility is based on the child's AFDC eligibility, the child must meet the AFDC criteria at the time of removal from their home. (3-15-22)

i. If the child is removed from their home in accordance with the first judicial determination, such determination must indicate that it was contrary to the welfare of the child to remain in the home. (3-15-22)

ii. If the child is removed from the home in accordance with a voluntary out-of-home placement agreement, the child must receive at least one (1) Title IV-E foster care payment to be eligible for Title IV-E adoption assistance. (3-15-22)

b. Child is eligible for Supplemental Security Income (SSI) benefits and meets the definition of a child with special needs. (3-15-22)

i. A child is eligible for adoption assistance if, at the time the adoption petition is filed, the child has met the requirements for Title XVI (SSI) benefits; (3-15-22)

ii. The circumstances of a child's removal from their home or whether the public child welfare agency has responsibility for the child's placement and care are not relevant. (3-15-22)

c. Child has been voluntarily relinquished to a private non-profit adoption agency and meets the definition of a child with special needs. (3-15-22)

i. The child must meet the requirements, or would have met the requirements, of the AFDC program as such sections were in effect on July 16, 1996, in or for the month in which the relinquishment occurred, or court proceedings were held that led to the removal of the child from their home; (3-15-22)

ii. At the time of the voluntary relinquishment, the court must make a judicial determination that it would be contrary to the welfare of the child for the child to remain in the home. (3-15-22)

d. Child is eligible for Title IV-E adoption assistance as a child of a minor parent and at the time of the adoption petition the child meets the definition of a child with special needs. (3-15-22)

i. The child's parent is in foster care and receiving Title IV-E foster care maintenance payments that cover both the minor parent and child at the time the adoption petition is filed; and (3-15-22)

ii. The child continues to reside in the foster home with their minor parent until the adoption petition has been filed. If the child and minor parent have been separated in foster care prior to the time of the adoption petition, the child's eligibility for Title IV-E adoption assistance must be determined based on the child's current and individual circumstances. (3-15-22)

e. Child is eligible due to prior Title IV-E adoption assistance eligibility and meets the definition of a child with special needs. (3-15-22)

i. A child whose adoption later dissolves or the adoptive parent(s) die, may continue to be eligible for Title IV-E adoption assistance in a subsequent adoption. (3-15-22)

ii. The subsequent adoption of a child may be arranged through an independent adoption, private agency, or state agency. (3-15-22)

iii. No needs or eligibility redetermination is to be made upon a subsequent adoption. The child's need and eligibility remain unchanged from what they were prior to the initial adoption. (3-15-22)

~~iv. It is the responsibility of the placing state to determine whether the child meets the definition of special needs and to pay the subsidy in a subsequent adoption.~~ (3-15-22)

02~~2~~1. Special Needs Criteria. The definition of special needs includes the following factors: (3-15-22)

a. The child cannot or should not be returned to the home of the parents as evidenced by an order from a court of competent jurisdiction terminating parents rights or its equivalent; and (3-15-22)

b. The child has a physical, mental, emotional, or medical disability, or is at risk of developing such disability based on the child's experience of documented physical, emotional, or sexual abuse, or neglect; or (3-15-22)

c. The child's age makes it difficult to find an adoptive home; or (3-15-22)

d. The child is being placed for adoption with at least one (1) sibling; and (3-15-22)

e. ~~The State must make a r~~Reasonable but unsuccessful effort to place the child with special needs without a subsidy must be made, except in cases where it is not in the best interests of the child due to their significant emotional ties with the foster parent(s) or relative(s) who are willing to adopt the child. ~~(3-15-22)~~( )

~~**03. Determination of Eligibility for State Funded Adoption Assistance**. Children in state custody who meet the special needs criteria found in Subsection 900.02 of these rules and do not meet any of the criteria for Title IV-E adoption assistance found at Subsection 900.01 in these rules, may be eligible for state-funded adoption assistance benefits. If the child is determined ineligible for Title IV-E adoption assistance, the application will be evaluated for a state funded subsidy.~~ ~~(3-15-22)~~

~~**04. Interjurisdictional Adoptions**. When a child's adoption is arranged through the care and placement of a private non-profit adoption agency in another state and the adoptive family are residents of Idaho, the state of Idaho is responsible for the eligibility determination, negotiation, and payment of any subsequent Title IV-E adoption assistance benefits.~~ ~~(3-15-22)~~

~~**05. International Adoptions and Adoption Assistance**. A child who meets the criteria for special needs under Subsection 900.02 of this rule, who is not a citizen or resident of the United States, and who was adopted outside of the United States or was brought into the United States for the purpose of being adopted, is not eligible to receive adoption assistance. This restriction does not prohibit adoption assistance payments for a child described in this Subsection who is placed in foster care subsequent to the failure, as determined by the State, of the initial adoption of the child by the adoptive parents.~~ ~~(3-15-22)~~

~~**901. ATTEMPT TO PLACE WITHOUT ADOPTION ASSISTANCE.**~~
~~The Department is required to attempt to place all children for adoption without adoption assistance. However, all adoptive families are entitled to full information and disclosure regarding the adoption assistance program. Once the most suitable family is located for the child, the family will be informed of the needs and history of the child and asked if they can adopt the child without adoption assistance. If the family indicates that they need adoption assistance, the Department will begin the process of determining the amount and type of benefits for the child.~~
~~(3-15-22)~~

902~~2~~1. -- 909~~9~~7. (RESERVED)

908. TITLE IV-E ADOPTION ASSISTANCE.
The department will remain in compliance with the requirements and benefits for federally funded adoption assistance benefits per the Social Security Act, most recently updates by the Family First Prevention Services Act of 2018 (P.L. 115-123). ( )

909. STATE FUNDED ADOPTION ASSISTANCE.
Children in state custody who meet the special needs criteria found in Subsection 900.01 of these rules and do not qualify for Title IV-E adoption assistance found at Section 908 in these rules, may be eligible for state-funded

adoption assistance benefits. If the child is determined ineligible for Title IV-E adoption assistance, the application will be evaluated for a state-funded subsidy. ( )

910. TYPES AND AMOUNTS OF ASSISTANCE.
The needs of the child and the family, including any other children in the family, will be considered in determining the amount and type of support to be provided. Assistance may include the following: (3-15-22)

01. Nonrecurring Adoption Reimbursement. Payment for certain one-time expenses necessary to finalize the adoption may be paid when a family adopts a special needs child. The child's eligibility must be determined and the contract for reimbursement must be fully executed prior to the finalization of the adoption. The reimbursement is paid only after the adoption finalizes. (3-15-22)

a. The expenses are defined as reasonable and necessary adoption fees, court costs, attorney fees, and other expenses that are directly related to the legal adoption finalization ~~of a child with special needs~~ and which are not incurred in violation of state or federal law. ~~They may include mileage and lodging involved in visiting the child before placement occurs.~~ These expenses cannot be reimbursed if they are paid for the adoptive parents by other sources such as an employer. ~~(3-15-22)~~( )

b. Documentation of expenses must be submitted. (3-15-22)

c. Costs are reimbursable up to two thousand dollars ($2,000) per child and are entered on ~~the A~~adoption ~~A~~assistance ~~P~~program ~~A~~agreement. ~~(3-15-22)~~( )

d. Children for whom the adoption has been finalized without a negotiated ~~N~~nonrecurring ~~E~~expenses ~~R~~reimbursement ~~A~~agreement are not eligible to apply for these benefits. ~~(3-15-22)~~( )

02. Monthly Cash Payment. ~~Financial assistance in the form of a~~ A monthly cash payment may be established to assist the adoptive family in meeting the additional expenses of the child's special needs. The amount of the payment must be negotiated with the family by the ~~adoption~~ family services worker and based on the family's circumstances and what additional resources are needed to incorporate the child into the adoptive family. ~~(3-15-22)~~( )

a. The amount must not exceed the rate for family foster care ~~found in Subsections 483 and 484 of these rules~~, which would be made if the child were in a family foster home in Idaho. ~~(3-15-22)~~( )

b. Payments received for treatment foster care, gifts, clothing, and school fees are not considered part of the family foster care rate. (3-15-22)

~~**c.** For children who meet the definition of special needs at Subsection 900.02 of these rules, no monthly cash payment is allowable until such time as the specific disability for which the child is known to be at risk becomes evident. (3-15-22)~~

~~**d**~~**c.** For children who are currently eligible for Personal Care Services (PCS), the treatment foster care rate of up to a maximum of one thousand dollars ($1,000) per month may be used in negotiating the adoption assistance upon prior approval of the Department's Family and Community Services (FACS) Division Administrator. (3-15-22)

~~**e.** Benefits will continue until the child reaches eighteen (18) if the adoption was finalized prior to the child's sixteenth (16) birthday or twenty-one (21) years if finalized after the child's sixteenth (16) birthday, based upon an annual determination of continuing need. (3-15-22)~~

03. Title XIX -- Medicaid Coverage. Any child with special needs who has an adoption assistance agreement in effect is ~~also~~ eligible for medical coverage. ~~(3-15-22)~~( )

~~**a.** A Title IV-E adoption assistance agreement provides Medicaid coverage in the state of Idaho and in all other states. Under a state-funded adoption assistance agreement, a child living in Idaho is eligible for Medicaid. If the family moves to another state, Medicaid may or may not be available. If Medicaid is not available in the new~~

~~state, provisions for medical coverage must be contained in the adoption assistance agreement or in an amendment to the agreement.~~ ~~(3-15-22)~~

~~**b.** Families enrolled in a group health plan who plan to request to use Medicaid as the child's primary health care coverage must apply to the Idaho Health Insurance Premium Payment (HIPP) program at the time of benefit negotiation. Medicaid provides secondary coverage after the family's health insurance has reached its benefit limit.~~ ~~(3-15-22)~~

~~**c.** All services reimbursed by Medicaid must be determined to be medically necessary.~~ ~~(3-15-22)~~

~~**d.** Prior authorization may be required for some Medicaid reimbursable services.~~ ~~(3-15-22)~~

~~**e.** Medicaid benefits are available until the child reaches the age of eighteen (18) if the adoption was finalized prior to the child's sixteenth (16) birthday or twenty-one (21) years if finalized after the child's sixteenth (16) birthday, based upon an annual determination of continuing need.~~ ~~(3-15-22)~~

04. Title XX -- Social Services. Any child with special needs who has an ~~A~~adoption ~~A~~assistance ~~A~~agreement is also eligible for state-authorized Title XX - Federal Social Services Block Grant funded services. ~~(3-15-22)~~( )

911. ADOPTION ASSISTANCE PROGRAM AGREEMENT.
A written agreement must be negotiated and fully executed between the ~~D~~department and adopting family prior to the finalization of adoption and implementation of benefits. ~~(3-15-22)~~( )

01. Agreement Specifications. The agreement specifies the following: (3-15-22)

a. The type and amount of assistance to be provided; (3-15-22)

b. ~~That there will be a~~An annual review of each agreement will be conducted by the ~~D~~department to evaluate the need for continued ~~subsidy~~ monthly cash payment and the amount of the ~~subsidy~~ payment; ~~(3-15-22)~~( )

c. ~~That t~~The ~~agreed upon~~ type and amount of assistance may be adjusted only with the concurrence of the adoptive parent(s) based upon changes in the needs of the child or changes in the circumstances of the adoptive family; ~~(3-15-22)~~( )

d. ~~That t~~The adoptive parent(s) are required to inform the ~~D~~department of any circumstances that would make them ineligible for adoption assistance payments, or eligible for adoption assistance payments in a different amount. ~~(3-15-22)~~( )

02. Termination of Adoption Assistance. Adoption assistance ~~will be~~ benefits are terminated if: ( )

a. ~~t~~The adoptive parent(s) no longer have legal responsibility for the child; ( )

b. ~~as a result of termination of parental rights, t~~The child is no longer receiving any financial support from the parents, or ( )

c. ~~t~~The child has reached the age of eighteen (18) years if the adoption was finalized prior to the child's sixteenth (16) birthday or twenty-one (21) years if finalized after the child's sixteenth (16) birthday regardless of the child's educational status. ~~(3-15-22)~~( )

03. Suspension of Adoption Assistance. Adoption assistance monthly cash payments will be suspended if the child is placed in foster care in any state. Benefits will be reinstated upon the child's reunification with the adoptive parent(s). ( )

0~~3~~4. Adoption Assistance Follows the Child. If the adoptive parents are located in a state other than

Idaho, or move out of Idaho with the child, the adoption assistance payments initiated by Idaho will continue for the child. If the child is IV-E or state-funded adoption assistance eligible, r Referral for Medicaid or other state medical insurance and social service benefits will be forwarded to the new state of residence through the Interstate Compact on Adoption and Medical Assistance. Non-IV-E eligible c Children receiving a state funded adoption subsidy, may not be eligible for Medicaid in a state other than Idaho. (3-15-22)( )

912. -- 919. (RESERVED)

920. REQUEST FOR RECONSIDERATION ADMINISTRATE REVIEW FOR ADOPTION ASSISTANCE.

Families who adopted a child, or children with special needs on or after April 1, 1982, through either the Department or a licensed Idaho children's adoption agency, may be eligible for benefits through the Adoption Assistance program. Persons who adopted their relative children, may also be eligible for these adoption assistance benefitsAdoptive parents have twenty-eight (28) days from the date of the department's notification of Title IV-E adoption assistance eligibility determination or change in adoption assistance benefits to request an administrative review. Notification will be made by mail of their right to appeal and procedures for filing an appeal. (3-15-22)( )

01. Adoption Assistance AgreementRequest for Reconsideration. Per Public Law 96-272, the adoptive family must sign an adoption assistance agreement prior to the finalization of the adoption in order for the child to receive benefits. Adoptive families parents who were not informed of these benefits or who were wrongly denied these benefits of adoption assistance benefits prior to the finalization of their child's adoption may submit an application to the Ddepartment prior to the eighteenth birthday of the adopted child for a determination of eligibility for these benefits. (3-15-22)( )

02a. Eligibility Determination. The Division of Family and Community Services determines eEligibility is determined based on the eligibility factors determining for a special needs child that were in effect at the time of the child's adoption. (3-15-22)( )

ab. If the IV-E eligibility determination finds that a child was eligible for these benefits at the that time of the child's adoption, and an agreement was not signed prior to the finalization, the Ddepartment is required to deny benefits to the child, since no contract was in effect at the time of the adoption finalization. (3-15-22)( )

bc. The adoptive family parent(s) may request an administrative fair hearing for adoption assistance Title IV-E adoption assistance eligibility determination. (3-15-22)( )

i. The determinations to be made at this and administrative review hearing are is whether extenuating circumstances exist or whether the family was wrongly denied eligibility, or both. (3-15-22)( )

ii. The Division of Family and Community Services may not change its eligibility determination for a child eligible for IV-E adoption assistance benefitsA favorable ruling from a fair hearing officer is required for the department to change Title IV-E eligibility and provide adoption assistance based on extenuating circumstances without obtaining a favorable ruling from a fair hearing officer. (3-15-22)( )

921. BURDEN OF PROOF -- EXTENUATING CIRCUMSTANCES.

The family has the burden of proving extenuating circumstances at the fair hearing, although, if the state agency is in agreement that the family had erroneously been denied benefits, the agency may provide such facts to the family or present corroborating facts on behalf of the family to the fair hearing officer. Once the hearing officer rules in favor of a family that extenuating circumstance exist and that the child is eligible for IV-E adoption assistance benefits, the agency must negotiate an agreement with the adoptive family consistent with these rules. (3-15-22)

9221. RETROACTIVE ADOPTION ASSISTANCE BENEFITS.

The Ddepartment of Health and Welfare, Division of Family and Community Services may negotiate retroactive adoption assistance benefits for a maximum of twenty-four (24) months from the date of adoption assistance application, identified in Section 920.01 of these rules. (3-15-22)( )

922. CONDITIONS FOR GUARDIANSHIP ASSISTANCE.

The purpose of the guardianship assistance program is to encourage legal permanency of children with special needs who would not be able to have the security of a permanent home without support payments. Applications are made through the Division of Family and Community Services for a determination of eligibility. Eligibility is determined solely on the child's need. No means test may be applied to the income or resource of the prospective legal guardian(s). The following conditions must be met for a child to be eligible for guardianship assistance. ( )

01. Assessment of Suitability. The suitability of an individual to become a legal guardian for a specific child or sibling group will be determined through a home study. ( )

02. Eligibility for Guardianship Assistance. Guardianship assistance will be determined for each child placed in the legal custody of the department prior to the finalization of the guardianship. Eligibility is based on the child's needs. No means test may be applied to the prospective legal guardian family's income or resources in a determination of eligibility. The child will first be considered for eligibility for a federally-funded subsidy. Should the child be found ineligible for a federally-funded subsidy, the child will be considered for a state-funded subsidy. ( )

03. Guardianship and Foster Care Licensure. To receive guardianship assistance, a potential legal guardian must be licensed or approved to provide foster care. ( )

923. TITLE IV-E GUARDIANSHIP ASSISTANCE.
In addition to Sections 922 and 926-928 of these rules, the department will comply with the requirements and benefits of the Title IV-E Guardianship Assistance Program in the Social Security Act, made available by the Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351). ( )

924. STATE-FUNDED GUARDIANSHIP ASSISTANCE.

01. A Child Is Eligible For State-funded Guardianship Assistance If The Department Determines The Child Meets The Requirements In Section 922 Of These Rules In Addition To The Following: ( )

a. The child meets the special needs criteria in Subsection 900.01 of these rules; ( )

b. The child's parents have had their parental rights legally terminated or are deceased; and ( )

c. There is documentation of unsuccessful efforts to place the child for adoption. ( )

925. TYPES AND AMOUNTS OF GUARDIANSHIP ASSISTANCE.

01. Nonrecurring Expenses. The department will reimburse the cost, up to two thousand dollars ($2,000) of nonrecurring expenses associated with obtaining legal guardianship of a child eligible for Title IV-E or state-funded guardianship assistance. Financial assistance for legal fees may be provided regardless of the legal guardian's state of residence. ( )

02. Monthly Cash Payment. The cash payment for Title IV-E or state-funded guardianship assistance may not exceed the published foster care rate a child would receive if living in family foster care in Idaho. Monthly cash payments are prospective only. There will be no retroactive benefits or payments. ( )

03. Title XIX Medicaid. ( )

a. A child eligible for Title IV-E guardianship assistance is eligible for Medicaid in the state where the child resides. ( )

b. A child eligible for state-funded guardianship assistance living in Idaho is eligible for Medicaid benefits. If the legal guardian moves to another state, they will be required to apply for Medicaid for the child in the new state of residency. ( )

926. GUARDIANSHIP ASSISTANCE PROGRAM AGREEMENTS.
The department and the prospective legal guardian(s) must enter into a written agreement prior to the finalization of

the guardianship. The department will provide the prospective legal guardian(s) with a copy of the agreement. ( )

01. Agreement Specifications. All guardianship assistance agreements will specify the following: ( )

a. The amount and manner in which the guardianship assistance payment will be provided to the prospective legal guardian; ( )

b. The manner in which the payment may be adjusted periodically in consultation with the legal guardian, based on the circumstances of the legal guardian and the needs of the child; ( )

c. Any additional services and assistance for which the child and the legal guardian will be eligible under the agreement; ( )

d. The procedure by which the legal guardian may apply for additional services; ( )

e. A statement that the agreement will remain in effect without regard to the state of residency of the legal guardian; ( )

f. The procedure by which the department will make a mandatory annual evaluation of the need for continued assistance and the amount of the assistance; and ( )

02. Termination of Guardianship Assistance. Guardianship assistance benefits and cash payments are automatically terminated when: ( )

a. A court terminates the legal guardianship or removes the legal guardian; ( )

b. The child no longer resides in the home of the legal guardian, and the legal guardian no longer provides financial support for the child; ( )

c. The child has reached the age of eighteen (18) years if the guardianship was finalized prior to the child's sixteenth (16) birthday or twenty-one (21) years if finalized after the child's sixteenth (16) birthday, regardless of the child's educational status or physical or developmental delays; or ( )

d. The child marries, dies, or enters the military. ( )

03. Suspension of Guardianship Assistance. Guardianship assistance monthly cash payments will be suspended if the child is placed in foster care in any state. Benefits will be reinstated upon the child's reunification with the legal guardian(s). ( )

927. ADMINISTRATIVE REVIEW FOR GUARDIANSHIP ASSISTANCE.
The prospective legal guardian has twenty-eight (28) days from the date of the department's notification of the guardianship assistance determination, to request an administrative review. The determination will be reviewed by the FACS Division Administrator, and a decision will be rendered to either affirm, reverse, or modify, the decision. The department will notify the individual, by mail, of the FACS Division Administrator's decision, of their right to appeal, and procedures for filing an appeal. ( )

928. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.06.02 – FOSTER CARE LICENSING

DOCKET NO. 16-0602-2401 (CHAPTER REPEAL)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

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) 39-1211, 39-1213, 56-1003, 56-1004A, and 56-1005(8), 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 current chapter is being repealed and is replaced with Docket No. 16-0602-2402 which is also published in this bulletin.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the July 3rd, 2024 Idaho Administrative Bulletin, Vol. 24-7, pages 91 and 92.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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 will not be a negative fiscal impact greater than $10,000.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at 208-334-5500.

DATED this 17th day of July, 2024.

Alex J. Adams, PharmD, MPH
Director
Idaho Department of Health & Welfare
450 W. State Street, 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5500 phone
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Alex.Adams@dhw.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2024.

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. This rule chapter is promulgated pursuant to Sections 39-1211, 39-1213, 56-1003, 56-1004A, and 56-1005(8), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than July 17, 2024.

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 current chapter is being repealed and is replaced in Docket No. 16-0602-2402 which is also published in this bulletin.

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:

OPE and the Child Protection Oversight Committee have highlighted significant challenges with the current child welfare system and these changes are necessary to protect public health, safety, and welfare and to increase the number and types of foster homes available to serve Idaho youth.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the shortage of foster homes is at a level in which urgent action is needed. Because the major substantive changes are part of a national model act developed in partnership with many organizations, the major changes have been vetted.

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 Alex Adams, Director, 208-334-5500.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 24, 2024.

DATED this 6th day of June, 2024.

IDAPA 16.06.02 IS PROPOSED TO BE REPEALED IN ITS ENTIRETY.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.06.02 – FOSTER CARE LICENSING

DOCKET NO. 16-0602-2402 (CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

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) 39-1211, 39-1213, 56-1003, 56-1004A, and 56-1005(8), 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 rule makes three primary changes:

1. It expedites action on completed foster family applications from 30-days (current rule) to 1 business day.
2. It makes more evident that the Department will fund, within its appropriation, reasonable modifications necessary to meet home health and safety standards for foster homes to "license in" versus "licensing out." For example, if a family does not have a required fire extinguisher, the Department may provide one to the family rather than excluding them from licensure.
3. It moves closer to kin-specific licensure standards by defaulting to the ACF national model where appropriate, and deferring to the foster parent where appropriate.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the July 3rd, 2024 Idaho Administrative Bulletin, Vol. 24-7, pages 93 through 106.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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 will not be a negative fiscal impact greater than $10,000.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at 208-334-5500.

DATED this 17th day of July, 2024.

Alex J. Adams, PharmD, MPH
Director
Idaho Department of Health & Welfare
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THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2024.

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. This rule chapter is promulgated pursuant to Sections 39-1211, 39-1213, 56-1003, 56-1004A, and 56-1005(8), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than July 17, 2024.

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

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

This rule makes three primary changes:

1. It expedites action on completed foster family applications from 30-days (current rule) to 1 business day.
2. It makes more evident that the Department will fund, within its appropriation, reasonable modifications necessary to meet home health and safety standards for foster homes to "license in" versus "licensing out." For example, if a family does not have a required fire extinguisher, the Department may provide one to the family rather than excluding them from licensure.
3. It moves closer to kin-specific licensure standards by defaulting to the ACF national model where appropriate, and deferring to the foster parent where appropriate.

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:

OPE and the Child Protection Oversight Committee have highlighted significant challenges with the current child welfare system and these changes are necessary to protect public health, safety, and welfare and to increase the number and types of foster homes available to serve Idaho youth.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the shortage of foster homes is at a level in which urgent action is needed. Because the major substantive changes are part of a national model act developed in partnership with many organizations, the major changes have been vetted.

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 Alex Adams, Director, 208-334-5500.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 24, 2024.

DATED this 6th day of June, 2024.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0602-2402

16.06.02 – FOSTER CARE LICENSING

000. LEGAL AUTHORITY.
Sections 39-1211, 39-1213, 56-1003, 56-1004A, and 56-1005(8)Idaho Code, authorize the Department and the Board to adopt and enforce rules for licensing foster homes. ( )

001. -- 009. (RESERVED)

010. DEFINITIONS.
In addition to those terms used in Title 39, Chapter 12, the following apply: ( )

01. Caregiver. A foster parent with whom a child in foster care has been placed or a designated official for a child care institution in which a child in foster care has been placed. ( )

02. Child. Includes individuals age eighteen (18) to twenty-one (21) who are ordered into or voluntarily entered Extended Foster Care through the Department. ( )

03. Department. The Idaho Department of Health and Welfare or its authorized representatives. ( )

04. Foster Home. Includes both foster homes and relative foster homes as set forth in Idaho Code. ( )

05. Foster Parent. A person(s) residing in a private home under their direct control to whom a foster care license has been issued. ( )

06. Household Member. Any person, other than a foster child, who resides in, or on the property of, a foster home. ( )

07. Medical Professionals. Persons who have received a degree in nursing or medicine and are licensed as a registered nurse, nurse practitioner, physician's assistant, or medical doctor. ( )

08. Noncompliance. Violation of, or inability to meet, the requirements of these rules or terms of licensure. ( )

09. Plan of Correction. The detailed procedures and activities developed between the Department and caregiver required to bring a foster family into conformity with these rules. ( )

10. Restraint. Physical interventions to control the range and motion of a child. ( )

11. Supervision. Is defined as being within sight and normal hearing range of the child or children being cared for. ( )

12. Variance. A temporary non-application of a foster care licensing rule that is resolved within six (6) months of approval. ( )

13. Waiver. The permanent non-application of a foster care licensing rule, if in the Department's judgment, the health and safety of the child is not compromised. ( )

011. -- 101. (RESERVED)

102. DISPOSITION OF APPLICATIONS.
The Department will expeditiously initiate action on each completed application within one (1) business day after receipt that addresses each requirement for the specific type of home. ( )

01. Approval of Application. The Department will issue a license to any foster home complying with these rules. ( )

02. Regular License. The Department will issue a regular license to any foster home complying with these rules and will specify the terms of licensure, such as: ( )

a. The number of children who may receive care at any one (1) time; and ( )

b. Age range and sex if there are conditions in the foster home making such limitations necessary; ( )

c. The regular license for a foster home is in effect for one (1) year from the date of issuance unless suspended or revoked earlier; ( )

d. If the license for a foster home is for a specific child, the name of that child will be shown on the foster home license. ( )

03. Waiver or Variance. A regular license may be issued to the foster home who has received a waiver or variance of licensing rules provided: ( )

a. The approval is considered on an individual case basis; ( )

b. The approval will, in the judgement of the Department, maintain the safety of the child(ren); ( )

c. All other licensing requirements have been met; ( )

d. The Department will document a description of the reasons for issuing a waiver or variance, the rules involved, and assurance that the waiver or variance will not compromise the child's safety; and ( )

e. The approved waiver or variance must be reviewed for continued need and approved annually. ( )

04. Limited License. May be issued for the care of a specific child in a home which may not meet the requirements for a license, provided: ( )

a. The child is already in the home and has formed strong emotional ties with the foster parents; and ( )

b. It can be shown that the child's continued placement in the home would be more conducive to their welfare than removal to another home. ( )

05. Denial of Application. If an application is denied, a signed letter will be sent directly to the applicant by registered or certified mail, advising the applicant of the denial and stating the basis for such denial. An applicant whose application has been denied may not reapply until one (1) year after the date on the denial of application. ( )

06. Failure to Complete Application Process. Failure to complete the application process within six (6) months from the original date of application will result in vacation of the application. ( )

07. Facilitating Applications. ( )

a. The Department may, within its appropriation, cover reasonable expenses to ensure homes meet the requirements of these rules including the home health and safety requirements and sleeping arrangements. ( )

b. The Department will establish procedures to fast-track applications from candidates who have a successful track record of serving as a foster home in other states. ( )

103. RESTRICTIONS ON APPLICABILITY AND NONTRANSFER.

01. Department-Issued License. Applies only to the foster home or the person and premises designated. Each license is issued in the individual's name, and to the address specified on the application. A license issued in the name of a foster parent applies to the period and services specified in the license. Any change in address renders the license null and void, and the foster parent must immediately return the license to the Department. ( )

02. Nontransferable. A license is nontransferable from one (1) individual to another or from one (1) location to another. ( )

03. Change in Location. When there is a change in foster home location, the foster home parent must reapply for a license. ( )

104. (RESERVED)

105. REVISIT AND RELICENSE.
Revisit and relicense studies will document how the foster home continues to meet licensing standards. Consideration must be given to each standard, including a review of the previous study and original application to determine what changes have occurred. A renewal application must be made by the foster home on the Department-furnished form and filled out prior to the expiration date of the license in effect. The existing license will, unless officially revoked, remain effective until the Department has acted on the application for renewal. ( )

106. COMPLAINTS.

01. Investigation. The Department will investigate complaints regarding foster homes. The investigation may include further contact with the complainant, scheduled or unannounced visits to the foster home, collateral contacts including interviews with the victim, parents or guardian, consultants, children in care, other persons who may have knowledge of the complaint, and inspections by fire or health officials. ( )

02. Informed of Action. If an initial preliminary investigation indicates that a more complete investigation must be made, the foster parents will be informed of the investigation, and any action to be taken, including referral for civil or criminal action. ( )

107. SUSPENSION FOR CIRCUMSTANCES BEYOND CONTROL OF FOSTER PARENT.
When circumstances occur over which the foster parent has no control including illness, epidemics, fire, flood, or contamination, which temporarily place the operation of the foster home out of compliance with these rules, the license must be suspended until the nonconformity is remedied. ( )

108. (RESERVED)

109. ENFORCEMENT REMEDY OF SUMMARY SUSPENSION AND TRANSFER OF CHILDREN.
The Department may summarily suspend a foster home license. Children in a foster home require the program to transfer children when the Department has determined a child's health and safety are in immediate jeopardy. ( )

110. ENFORCEMENT REMEDY REVOCATION OF LICENSE AND TRANSFER OF CHILDREN.
The Department may revoke the license of a foster home when the Department determines the home is not in compliance with these rules. Revocation and transfer of children may occur under the following circumstances: ( )

01. Endangers Health or Safety. Any condition that endangers the health or safety of any child. ( )

02. Not in Substantial Compliance. A foster home is not in substantial compliance with these rules. ( )

03. No Progress to Meet Plan of Correction. A foster home has made little or no progress in correcting deficiencies within thirty (30) days from the date the Department accepted a plan of correction. ( )

04. Repeat Violations. Repeat violations of these rules or of Title 39, Chapters 11 and 12, Idaho Code. ( )

05. Misrepresented or Omitted Information. A foster home has knowingly misrepresented or omitted information on the application or other documents pertinent to obtaining a license. ( )

06. Refusal to Allow Access. Refusal to allow Department representatives full access to the foster home and its grounds, facilities, and records. ( )

07. Violation of Terms of Provisional License. A foster home, that has violated any of the terms of a provisional license. ( )

111. EFFECT OF PREVIOUS REVOCATION OR DENIAL OF A LICENSE.
An organization cannot apply and the Department will not accept an application from any person, corporation, or partnership, including any owner with a ten percent (10%) or more interest, who has had a license denied or revoked, until five (5) years has elapsed from the date of denial, revocation, or conclusion of a final appeal, whichever occurred last. ( )

112. -- 199. (RESERVED)

200. LICENSING PROVISIONS RELATED TO THE INDIAN CHILD WELFARE ACT.
These rules do not supersede the licensing authority of Indian tribes under the Indian Child Welfare Act, P.L. 95-608, 25 USC, Sections 1901 – 1963. ( )

201. FOSTER PARENT QUALIFICATIONS AND SUITABILITY.
An applicant for licensure as a foster parent must meet the following: ( )

01. Age. Be eighteen (18) years old or older. ( )

02. Communication. Be able to communicate with the child, the children's agency, and health care and other service providers. ( )

03. Income and Resources. Have a defined and sufficient source of income and be capable of managing that income to meet the needs of the foster family without relying on the payment made for the care of a foster child. ( )

04. Literacy. At least one (1) adult caretaker in the home must have functional literacy, such as the ability to read medication labels. ( )

202. BACKGROUND CHECKS.
All applicants for a foster care license and other adult members of the household must comply with IDAPA 16.05.06, "Criminal History and Background Checks," and the following: ( )

01. Change in Household Membership. By the next working day after another adult begins residing in a foster home, a foster parent must notify the children's agency of the change in household membership and assure that the new adult household member will complete a background check within fifteen (15) days of residence in the foster home. ( )

02. Foster Parent's Child Turns Eighteen. A foster parent's child who turns eighteen (18) and lives continuously in the home is not required to have a background check except as specified in this rule. ( )

a. After turning eighteen (18) years old, if the foster parent's adult child no longer lives in the foster parent's home and subsequently resumes living in the foster home, they will be considered an adult household member and must complete a background check within fifteen (15) days from the date they became an adult household member. ( )

b. If the adult child leaves the foster home for the purpose of higher education or military service, and periodically returns to the home for less than ninety (90) days, they are not considered to be an adult household member and are not required to complete a background check. While in the home, they cannot have any unsupervised direct care responsibilities for any foster children in the home. Should they remain in the foster home for more than ninety (90) days, they will immediately be considered an adult household member and must complete a background check within fifteen (15) days from the date they became an adult household member. ( )

c. If the adult child continues to live in their parent's foster home or on the same property, they must complete a background check within fifteen (15) days of turning twenty-one (21), This requirement is not necessary if the adult child has completed a background check between the ages of eighteen (18) and twenty-one (21). ( )

03. Background Check at Any Time. The Department retains the authority to require a background check at any time on individuals who are residing in a foster home or on the foster parent's property. ( )

04. Emergency Placement of Children. An emergency occurs when a child enters or experiences an unplanned placement change in foster care. The Department may request that a criminal justice agency perform a Federal Interstate Identification Index name-based criminal history record check of each adult residing in the home. This refers to those limited instances when placing a child in the home of relatives or kin, as a result of a sudden unavailability of the child's parent or caretaker. ( )

a. All adult household members will submit fingerprints to the Department's Background Check Unit within ten (10) calendar days and follow requirements outlined in IDAPA 16.05.06, "Criminal History and Background Checks." The Department forwards the fingerprints to the State Central Record Repository for submission to the FBI within fifteen (15) calendar days from the date the name search was conducted. The Department's background check unit will positively identify the individual that is being considered to receive the child in an emergency situation as their fingerprints are submitted. ( )

b. When placement of a child in a home is denied as a result of the Department review of the name-based criminal history record check of any adult household member, all adults must still comply with Subsection 202.05.a. of this rule and IDAPA 16.05.06, "Criminal History and Background Checks." ( )

c. The child will be removed from the home immediately if any adult household member fails to provide written permission to perform a federal criminal history record check, submit fingerprints, or any adult household member is denied a Department background check clearance. ( )

05. Exceptions to Background Checks. Background checks are optional for certain youth in foster care who reach the age of eighteen (18) but are less than twenty-one (21) years of age and continue to reside in the same licensed foster home. ( )

203. INITIAL AND ONGOING EVALUATION.
An applicant must participate in the process and tasks to complete an initial evaluation for foster care licensure. ( )

01. Applicant Participation. The applicant must do all the following: ( )

a. Cooperate with and allow the children's agency to determine compliance with these rules to conduct an initial foster home study; ( )

b. Inform the children's agency if the applicant is currently licensed or has been previously licensed as a foster parent or the applicant has been involved in the care and supervision of children or adults; ( )

c. All household members must disclose current mental health and/or substance abuse issues. ( )

d. All household members must provide information on their physical and mental health history, including any history of drug or alcohol abuse or treatment. ( )

e. Provide two (2) satisfactory references, one (1) of which may be from a person related to the applicant(s). An applicant will provide additional references upon the request of the children's agency. ( )

02. Disclosure of Information and Assurances. An applicant must provide the children's agency with the following or any additional information the children's agency deems necessary to complete the initial family home study: ( )

a. Names, including maiden or other names used, and ages of the applicant(s); ( )

b. Social Security Number; ( )

c. Education; ( )

d. Verification of marriages and divorces; ( )

e. Religious and cultural practices of the applicant including their willingness and ability to accommodate or provide care to a foster child of a different race, religion, or culture; ( )

f. Statement of income and financial resources and the family's management of these resources; ( )

g. Reasons for applying to be a foster parent; ( )

h. Report any prior arrest, investigation, or other official action regarding a sexual offense or impropriety. ( )

i. Provide and abide by the following written assurances: ( )

i. Applicants will not use corporal or degrading punishment. ( )

ii. Applicants will not use any illegal substances, abuse alcohol by consuming it in excess amounts, or abuse legal prescription and/or nonprescription drugs by consuming them in excess amounts or using them contrary to as indicated. ( )

iii. Applicants and their guests will not smoke in the foster family home, in any vehicle used to transport the child, or in the presence of the child in foster care. ( )

iv. Applicants will adhere to the Department’s reasonable and prudent parent standard. ( )

03. Home Study. The applicant must complete an agency home study, which is a written comprehensive family assessment to include the following elements: ( )

a. At least one scheduled on-site visit to assess the home to ensure that it meets the standards set forth in these rules; ( )

b. At least one scheduled in-home interview for each household member to observe family functioning and assess the family's capacity to meet the needs of a child or children in foster care; ( )

c. The Department has discretion on whether to interview or observe each household member based on his or her age and development. ( )

204. SUBSEQUENT EVALUATIONS.
A foster parent must comply with the following: ( )

01. Reasonable Access. A foster parent will allow the children's agency reasonable access to the foster home, including interviewing each foster parent, each foster child, and any household member to determine compliance with these rules, for child supervision purposes, and to conduct a relicense study. ( )

02. Update Information. Provide all changes to the information in the initial evaluation and subsequent evaluations. ( )

03. Family Functioning. Provide information on changes in family functioning and inter-relationships. ( )

04. Other Circumstances. Provide the children's agency with any information regarding circumstances within the family that may adversely impact the foster child. ( )

05. Plan of Correction. Cooperate with the children's agency in developing and carrying out a written plan required to correct any rule noncompliance identified by any evaluation conducted by the children's agency. ( )

205. FOSTER PARENT DUTIES.
A foster parent must do the following: ( )

01. Case Plan Implementation. Cooperate with, and assist the children's agency with implementation of the case plan for children and their families. ( )

02. Reporting Progress and Problems. Promptly and fully disclose to the children's agency information concerning a child's progress and problems. ( )

03. Termination of Placement. Provide notification to the children's agency of the need for a child to be moved from the foster home not less than fourteen (14) days before the move, except when a delay would jeopardize the child's care or safety, or the safety of members of the foster family. ( )

206. FOSTER PARENT TRAINING.

01. Reasonable and Prudent Parent Standard. Each caregiver will complete training on knowledge and skills relating to the reasonable and prudent parent standard for the participation of the child in age or developmentally appropriate activities. ( )

02. Additional Training. The department will make available training on the following topics: rights, roles, responsibilities and expectations of foster parents; laws and regulations; the impact of childhood trauma; managing child behaviors; first aid and medication administration; and the importance of maintaining meaningful connections between the child and parents, including regular visitation. The department will also make available ongoing training to receive instruction to support their parental roles and ensure the parent is up to date with agency requirements. Further, this training may also include child-specific training and/or may address issues relevant to the general population of children in foster care. ( )

207. -- 229. (RESERVED)

230. HOME HEALTH AND SAFETY REQUIREMENTS.

01. Living Space. The living space or structure of a foster home will be a house, mobile home (as defined under Title 39, Chapter 41, Idaho Code), housing unit, or apartment occupied by an individual or family. The home must have: ( )

a. An adequate supply of safe drinking water. In cases of non-municipal water, the department may test for safety; ( )

b. A properly operating kitchen with a sink, refrigerator, stove, and oven; ( )

c. At least one toilet, sink and tub or shower in operating condition; ( )

d. Heating and/or cooling as required by the geographic area, consistent with accepted community standards and in safe operating condition; and ( )

e. A working phone or access to a working phone in close walking proximity. ( )

02. Condition of the Home. The applicant's home, grounds, and all structures on the grounds of the property must be properly maintained in a clean, safe, and sanitary condition and in a reasonable state of repair within community standards. The interior and exterior must be free from dangerous objects and conditions, and from hazardous materials. The home must meet the following requirements: ( )

a. Have adequate lighting, ventilation and proper trash and recycling disposal, if recycling is available; ( )

b. Be free from rodents and insect infestation. ( )

c. Proper water heater temperature; ( )

d. Weapons and ammunition (separately) stored, locked, unloaded, and inaccessible to children; ( )

e. Have conditions that prevent the child's access, as appropriate for his or her age and development, to all medications, poisonous materials, cleaning supplies, other hazardous materials, and alcoholic beverages; ( )

f. Any pet or domestic animal that is suspected or known to be dangerous must be kept in an area inaccessible to children. Dogs must be vaccinated for rabies and comply with Section 25-2810, Idaho Code. ( )

g. Swimming pools, hot tubs, and spas must meet the following to ensure they are safe and hazard free (and additionally must meet all state, tribal and/or local safety requirements): ( )

i. Swimming pools must have a barrier on all sides. ( )

ii. Swimming pools must have their methods of access through the barrier equipped with a safety device, such as a bolt lock. ( )

iii. Swimming pools must be equipped with a life saving device, such as a ring buoy. ( )

iv. If the swimming pool cannot be emptied after each use, the pool must have a working pump and filtering system. ( )

v. Hot tubs and spas must have safety covers that are locked when not in use. ( )

231. (RESERVED)

232. FIRE SAFETY, EMERGENCY PLANNING, AND EVACUATION PLAN.

Each foster home must meet the following: ( )

01. Smoke Detectors. Have at least one smoke detector on each level of occupancy of the home and at least one near all sleeping areas. ( )

02. Carbon Monoxide Detectors. Have at least one carbon monoxide detector on each level of occupancy of the home and at least one near all sleeping areas. Living space that does not have equipment that produces carbon monoxide or does not have an attached garage is exempt from this requirement. ( )

03. Additional Fire Safety Requirements. To be within the structure of the home: ( )

a. Have at least one (1) operable fire extinguisher that is readily accessible; ( )

b. Be free of obvious fire hazards such as defective heating equipment or improperly stored flammable materials; ( )

c. Have a written emergency evacuation plan posted in a prominent place in the home and reviewed with children placed for foster care; ( )

d. Maintain a comprehensive list of emergency telephone numbers including poison control and posted in a prominent place in the home; and ( )

e. Maintain first aid supplies. ( )

233. SLEEPING ARRANGEMENTS.
Applicants must provide a safe sleeping space including sleeping supplies, such as a mattress and linens or appropriate cribs for each individual child, as appropriate for the child's needs and age and similar to other household members. Foster parents must not co-sleep or bed-share with infants. ( )

234. -- 238. (RESERVED)

239. TRANSPORTATION.
Applicants must ensure that the family has reliable, legal and safe transportation. Reliable transportation includes a properly maintained vehicle or access to reliable public transportation; if a privately-owned vehicle owned by the applicant’s family or friends is used to transport the child in foster care, legal transportation includes having a valid driving license, insurance and registration; and safe transportation includes safety restraints as appropriate for the child. ( )

240. -- 241. (RESERVED)

242. CHILD PLACEMENT REQUIREMENTS.
A foster family may mutually accept the placement of children into the home within the terms of the foster home license and the children's agency placement agreement. The following provisions will be considered for determining placement: ( )

01. Determining Factors. The number and the age group of children placed in a foster home will be determined by the following: ( )

a. The accessibility, accommodations, and the space in the home; ( )

b. The interest of the foster family; and ( )

c. The experience, training, or skill of the foster family. ( )

02. Maximum Number of Children. Except as specified, the maximum number of children in care at any time, including the foster family's own children, or daycare children, will be limited to not more than six (6) children. ( )

03. Children Under Two Years Old. Except as specified in Subsection 242.04 of this rule, the maximum number of children under two (2) years old, including those of the foster family, will be limited to two (2) children or less. ( )

04. Special Circumstances Regarding Maximum Numbers of Children. The maximum number of children in care at any time may be based on the children's agency assessment and at a minimum one (1) of the following: ( )

a. To allow siblings to remain together; ( )

b. To allow a child who has an established, meaningful relationship with the family to remain with the family; ( )

c. To allow a family with special training or skills to provide care for a child who has a severe disability; or ( )

d. To allow a parenting youth in foster care to remain with the child of the parenting youth. ( )

05. Continued Care. A foster child who reaches the age of eighteen (18) may continue in foster care placement until the age of twenty-one (21) if the safety, health, and well-being of other foster children residing in the home is not jeopardized. ( )

243. INTERAGENCY PLACEMENT OF CHILDREN.
A foster family must only accept for placement children referred from the children's agency that licenses the foster home. A foster family may accept for placement a foster child from another children's agency only if that children's agency and the foster family have received prior approval for the placement of a child from the children's agency that licensed the home. ( )

244. SUBSTITUTE CARE PLACEMENT AND CHILDREN'S AGENCY NOTIFICATION.
A foster parent must: ( )

01. Substitute Care. Place a child in substitute care only with the prior knowledge and consent of the children's agency; and ( )

02. Notification to Agency. Notify the children's agency before the beginning of any planned absence that requires substitute care of a child for a period of twenty-four (24) hours or more. ( )

245. (RESERVED)

246. BEHAVIOR MANAGEMENT AND DISCIPLINE.
Methods of behavior management and discipline for children must be positive and consistent. These methods must be based on each child's needs, stage of development, and behavior. Discipline is to promote self-control, self-esteem, and independence. ( )

01. Prohibitions. The following types of punishment of a foster child are prohibited: ( )

a. Physical force or any kind of punishment inflicted on the body, including spanking; ( )

b. Cruel and unusual physical exercise or forcing a child to take an uncomfortable position; ( )

c. Use of excessive physical labor with no benefit other than for punishment; ( )

d. Mechanical, medical, or chemical restraint; ( )

e. Locking a child in a room or area of the home; ( )

f. Denying necessary food, clothing, bedding, rest, toilet use, bathing facilities, or entrance to the foster home; ( )

g. Mental or emotional cruelty; ( )

h. Verbal abuse, ridicule, humiliation, profanity, threats, or other forms of degradation directed at a child or a child's family; ( )

i. Threats of removal from the foster home; ( )

j. Denial of visits or communication with a child's family unless authorized by a children's agency in its service plan for the child and family; and ( )

k. Denial of necessary educational, medical, counseling, or social services. ( )

02. Restraint. A foster parent who has received specific training in the use of child restraint may use reasonable restraint methods, approved by the children's agency, to prevent a child from harming themselves, other persons or property, or to allow a child to gain control of themselves. ( )

03. Authority. The authority for the discipline of a foster child must not be delegated by a foster parent to other members of the household. ( )

04. Agency Consultation. A foster parent must consult with the children's agency prior to using any behavior management or discipline technique that exceeds the scope of these rules. ( )

247. MEDICAL AND DENTAL CARE.

01. Health Care Services. A foster parent must follow and carry out the health or dental care plan for a child as directed by a medical professional. ( )

02. Child Injury and Illness. Follow the children's agency approved policies for medical care of a child who is injured or ill. ( )

03. Dispensing of Medications. Provide prescription medication as directed by a medical professional. A foster parent must not discontinue or in any way change the medication provided to a child unless directed to do so by a medical professional. ( )

248. -- 253. (RESERVED)

254. RELIGIOUS AND CULTURAL PRACTICES.
A foster parent must provide a child in care with opportunity for spiritual development and cultural practices according to the wishes of the child and the child's parent or tribe. ( )

255. -- 256. (RESERVED)

257. REASONABLE AND PRUDENT PARENT STANDARD.
A caregiver must follow the reasonable and prudent parent standard. ( )

01. Reasonable and Prudent Parent Standard Defined. "Age or developmentally appropriate" means the following: ( )

a. Activities or items that are generally accepted as suitable for children of the same chronological age or level of maturity or that are determined to be developmentally appropriate for a child, based on the development of cognitive, emotional, physical, and behavioral capacities that are typical for an age or age group; and ( )

b. In the case of a specific child, activities or items that are suitable for the child based on the developmental stages attained by the child with respect to the cognitive, emotional, physical, and behavioral

capacities of the child. ( )

c. The foster parents will seek approval from the children's agency before altering a child's physical appearance including haircuts, body piercing, and tattooing. ( )

258. -- 269. (RESERVED)

270. RECORD MANAGEMENT AND REPORTING REQUIREMENTS.
A foster parent must maintain a record for each child in the home that will include all written material provided to the foster home by the children's agency and additional information gathered by the foster parent that includes the following: ( )

01. Personal Data. The child's name, sex, date of birth, religion, race, and tribe, if applicable; ( )

02. Any Known History of Abuse and Neglect of the Child. ( )

03. Any Known Emotional and Psychological Needs of the Child. ( )

04. Any Information Known about the Child's Health. ( )

05. Any Known Behavioral Problems of the Child. ( )

271. REPORTING FOSTER HOME CHANGES.
A foster parent must report to the children's agency any significant change in the foster home by the next working day from the time a foster parent becomes aware of a change, including the following: ( )

01. Serious Illness Including Physical or Mental Health, Injury, or Death of a Foster Parent or Household Member. ( )

02. Arrests, Citations, Withheld Judgments, or Criminal Convictions of a Foster Parent or Household Member. ( )

03. Initiation of Court-Ordered Parole or Probation of a Foster Parent or Household Member. ( )

04. Admission or Release From Facilities. Admission to, or release from, a correctional facility, a hospital, or an institution for the treatment of an emotional, mental health, or substance abuse issue of a foster parent or household member. ( )

05. Change of Employment Status of a Foster Parent. ( )

06. Counseling, Treatment, or Therapy. Counseling or other methods of therapeutic treatment on an outpatient basis for an emotional, mental, or substance abuse issue of a foster parent or household member. ( )

07. Change of Residence. A foster parent will inform the children's agency of any planned change in residence and apply for licensure at the new address not less than two (2) weeks prior to a change in residence. ( )

08. Household Members. Inform the children's agency of changes in household members including minor children. ( )

09. Additional Licensing Application. A foster parent will notify the children's agency within five (5) days after filing an application for a certified family home, daycare, or group daycare license. ( )

272. CONFIDENTIALITY.
A foster parent must maintain the confidentiality of any information and records regarding a foster child and the child's parents and relatives. A foster parent will release information about the foster child only to persons authorized

by the children's agency responsible for the foster child. Foster parents will follow the Department's policies for the use of social media and posting of pictures of children in foster care. ( )

273. CRITICAL INCIDENT NOTIFICATION.
The foster parent must immediately notify the responsible children's agency of any of the following incidents: ( )

01. Death. Death or near death of a child in care. ( )

02. Suicide. Suicidal ideation, threats, or attempts to commit suicide by the foster child. ( )

03. Missing. When a foster child is missing from a foster home. ( )

04. Illness. Any illness or injury that requires medical treatment of hospitalization of a foster child. ( )

05. Law Enforcement Authorities. A foster child's detainment, arrest, or other involvement with law enforcement authorities. ( )

06. Removal of Child. Attempted removal or removal of a foster child from the foster home by any person who is not authorized by the children's agency. ( )

274. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.06.02 – FOSTER CARE LICENSING

DOCKET NO. 16-0602-2403

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

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 39-1211, 39-1213, 56-1003, 56-1004A, and 561005(8), 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 rule change allows individuals who have been a licensed foster parent in the last 12 months, but has let their license lapse, renew their foster license with a fast-tracked process so long as they were in good standing while licensed.

There has been a demonstrated need to increase the number of resource families in the foster system throughout the state. Achieving a higher ratio of eligible foster families to foster kids in need has become the top priority of the Department. This change is needed to help support that mission, and in doing so also reduces the regulatory burden imposed by the state.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 4th, 2024, Idaho Administrative Bulletin, Vol. 24-9, pages 424-426.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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 will not be an impact to the General Fund greater than $10,000.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at 208-334-5500.

DATED this 6th day of December, 2024.

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THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is August 15th, 2024.

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. This rule chapter is promulgated pursuant to Sections 39-1211, 39-1213, 56-1003, 56-1004A, and 56-1005(8), 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 18th, 2024.

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

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

This rule change allows individuals who have been a licensed foster parent in the last 12 months, but has let their license lapse, renew their foster license with a fast-tracked process so long as they were in good standing while licensed.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(a) and (c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

There has been a demonstrated need to increase the number of resource families in the foster system throughout the state. Achieving a higher ratio of eligible foster families to foster kids in need has become the top priority of the Department. This change is needed to help support that mission, and in doing so also reduces the regulatory burden imposed by the state.

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

Fees will not be increased as a result of this rulemaking.

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

There will not be a negative fiscal impact exceeding $10,000.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the shortage of foster homes is at a level in which urgent action is needed.

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 Jared Larsen, 208-334-5500.

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 25th, 2024.

DATED this 15th day of August, 2024.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0602-2403

16.06.02 – FOSTER CARE LICENSING

102. DISPOSITION OF APPLICATIONS.
The Department will expeditiously initiate action on each completed application within one (1) business day after receipt that addresses each requirement for the specific type of home. (7-1-24)T

01. Approval of Application. The Department will issue a license to any foster home complying with these rules. (7-1-24)T

02. Regular License. The Department will issue a regular license to any foster home complying with these rules and will specify the terms of licensure, such as: (7-1-24)T

a. The number of children who may receive care at any one (1) time; and (7-1-24)T

b. Age range and sex if there are conditions in the foster home making such limitations necessary; (7-1-24)T

c. The regular license for a foster home is in effect for one (1) year from the date of issuance unless suspended or revoked earlier; (7-1-24)T

d. If the license for a foster home is for a specific child, the name of that child will be shown on the foster home license. (7-1-24)T

03. Waiver or Variance. A regular license may be issued to the foster home who has received a waiver or variance of licensing rules provided: (7-1-24)T

a. The approval is considered on an individual case basis; (7-1-24)T

b. The approval will, in the judgment of the Department, maintain the safety of the child(ren); (7-1-24)T

c. All other licensing requirements have been met; (7-1-24)T

d. The Department will document a description of the reasons for issuing a waiver or variance, the rules involved, and assurance that the waiver or variance will not compromise the child's safety; and (7-1-24)T

e. The approved waiver or variance must be reviewed for continued need and approved annually. (7-1-24)T

04. Limited License. May be issued for the care of a specific child in a home which may not meet the requirements for a license, provided: (7-1-24)T

a. The child is already in the home and has formed strong emotional ties with the foster parents; and (7-1-24)T

b. It can be shown that the child's continued placement in the home would be more conducive to their welfare than removal to another home. (7-1-24)T

05. Denial of Application. If an application is denied, a signed letter will be sent directly to the applicant by registered or certified mail, advising the applicant of the denial and stating the basis for such denial. An applicant whose application has been denied may not reapply until one (1) year after the date on the denial of application. (7-1-24)T

06. Failure to Complete Application Process. Failure to complete the application process within six (6) months from the original date of application will result in vacation of the application. (7-1-24)T

07. Facilitating Applications. (7-1-24)T

a. The Department may, within its appropriation, cover reasonable expenses to ensure homes meet the requirements of these rules including the home health and safety requirements and sleeping arrangements. (7-1-24)T

b. The Department will establish procedures to fast-track applications from candidates who have a successful track record of serving as a foster home in other states. (7-1-24)T

08. Reactivating an Idaho License. If less than twelve (12) months has elapsed from the last licensed foster home visit required by Section 39-1217, Idaho Code, the Department may fast-track reactivating the license if the prior licensee: ( )

a. Relinquished the license in good standing; and ( )

b. Attests to maintaining conformity with the standards established by the Department. ( )

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.06.05 – ALLEGED MEDICAL NEGLECT OF DISABLED INFANTS

DOCKET NO. 16-0605-2401 (CHAPTER REPEAL)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202, Idaho Code, as well as 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:

This proposed rule repeals IDAPA 16.06.05 because nearly all regulations in this chapter are already repeated in 16.06.01. The remaining rules exclusive to this chapter have been proposed to be included in chapter rewrite of 16.06.01, thus by repealing this chapter, only duplicative regulations are eliminated.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 4th, 2024, Idaho Administrative Bulletin, Vol. 24-9, page 427.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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 will not be a negative fiscal impact exceeding $10,000 to the state by this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at 208-334-5500.

DATED this 26th day of September, 2024.

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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 56-202, Idaho Code, as well as 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 September 18, 2024.

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 proposed rule repeals IDAPA 16.06.05 because nearly all regulations in this chapter are already repeated in 16.06.01. The remaining rules exclusive to this chapter have been proposed to be included in chapter rewrite of 16.06.01, thus by repealing this chapter, only duplicative regulations are eliminated.

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

Fees will not be increased by the elimination of this chapter.

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 will not be an impact to the general fund greater than $10,000.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted as this is a repeal of the chapter and the agency deems negotiated rulemaking as not necessary.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jared Larsen at 208-334-5500.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 25, 2024.

DATED this 11th day of July, 2024.

IDAPA 16.06.05 IS PROPOSED TO BE REPEALED IN ITS ENTIRETY.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.07.17 – SUBSTANCE USE DISORDERS SERVICES

DOCKET NO. 16-0717-2401

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

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, Idaho Code, and 56-1003, 56-1004, 56-1004A, 56-1007, 56-1009, 39-305, 39-306, and 39-311, Idaho Code.

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

The rule change strives to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. This also coincides with the recent go-live status of the Idaho Behavioral Health Plan and seeks to update this rule chapter in association with similarly effected chapters including 16.07.33 and 16.07.37. Changes were made to the proposed rule following comments received from stakeholders. These changes included clarifying certifying entities and allowing for waiver authority to encompass additional individuals seeking to provide substance use disorder services.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the November 6th, 2024, Idaho Administrative Bulletin, Vol. 24-11, pages 84-93.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: Fees are not being increased as a result of this proposed rulemaking.

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

There will not be a negative fiscal impact exceeding $10,000 as a result of this proposed rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at 208-334-5500.

DATED this 5th day of December, 2024.

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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, Idaho Code, and 56-1003, 56-1004, 56-1004A, 56-1007, 56-1009, 39-305, 39-306, and 39-311, Idaho Code.

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

VIRTUAL TELECONFERENCE Via WebEx
Wednesday, November 13th, 2024
1:30 p.m. MST

Virtual Meeting Link:
https://idhw.webex.com/idhw/j.php?MTID=mffe0f7bbaf6bf38f9b758ffd5d0a6ecc

Join by meeting number:
Meeting number (access code): 2824 442 2379
Meeting password: qFhYtEih635 (when dialing from a phone or video system) 73498344

Join by phone:
+1-415-527-5035,,28244422379#73498344# United States Toll
+1-303-498-7536,,28244422379#73498344# United States Toll (Denver)

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

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

The rule change strives to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. This also coincides with the recent go-live status of the Idaho Behavioral Health Plan and seeks to update this rule chapter in association with similarly effected chapters including 16.07.33 and 16.07.37.

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

Fees are not being increased as a result of this proposed 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 as a result of this rulemaking:

There will not be a negative fiscal impact exceeding $10,000 as a result of this proposed rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted on this rule chapter however public comments will be collected at the public hearing scheduled above.

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 Jared Larsen at 208-334-5500.

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 November 27th, 2024.

DATED this 11th day of October, 2024.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0717-2401

Italicized red text that is *double underscored* indicates amendments to the proposed text as adopted in the pending rule.

16.07.17 – SUBSTANCE USE DISORDERS SERVICES

002. ~~(RESERVED)~~

~~003. ADMINISTRATIVE APPEALS.~~

~~01. Appeal of Denial Based on Eligibility Requirements~~. ~~Administrative appeals from a denial of substance use disorder services based on eligibility requirements are governed by the provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings."~~ ~~(3-17-22)~~

~~02. Appeal of Decision Based on Clinical Judgment~~. ~~Decisions involving ASAM clinical judgment, including the category of services, the particular provider of services, or the duration of services, are reserved to the Department, and are not subject to appeal, administratively or otherwise, under Maresh v. State, 132 Idaho 221, 970 P.2d 14 (Idaho 1999).~~ ~~(3-17-22)~~

~~03. Appeal by a Substance Use Disorder Services Provider or Program~~. ~~Administrative appeals from a decision that a substance use disorder services provider or program is out of compliance with these rules are governed by the provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." An appeal does not stay Department action.~~ ~~(3-17-22)~~

~~004. INCORPORATION BY REFERENCE.~~
~~The following are incorporated by reference in this chapter of rules:~~ ~~(3-17-22)~~

~~01. ASAM~~. ~~American Society of Addiction Medicine (ASAM) Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition, 2013. A copy of this manual is available by mail at the American Society of Addiction Medicine, 4601 North Park Ave., Suite 101, Chevy Chase, MD 20815; by telephone and fax, (301) 656-3920 and (301) 656-3815 (fax); or on the internet at http://www.asam.org.~~ ~~(3-17-22)~~

~~02. DSM-5~~. ~~American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5) Washington, DC, American Psychiatric Association, 2000. Copies of the manual are available from the American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington VA 22209-3901.~~
~~(3-17-22)~~

~~03. Federal Guidelines for Opioid Treatment Programs (OTP)~~. ~~Substance Abuse and Mental~~

~~Health Services Administration. HHS Publication No. (SMA) PEP15-FEDGUIDEOTP, March 2015. Center for Substance Abuse Treatment, Division of Pharmacologic Therapies for the Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857. This manual is available on the internet at https://store.samhsa.gov/product/Federal-Guidelines-for-Opioid-Treatment-Programs/PEP15-FEDGUIDEOTP.~~ ~~(3-17-22)~~

~~005.~~ -- 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

~~01. Criminal History and Background Check~~. ~~All employees, volunteers, interns, and contractors of substance use disorder treatment and recovery support services must comply with the provisions of IDAPA 16.05.06, "Criminal History and Background Checks.~~ ~~(3-17-22)~~

~~02. Availability to Work or Provide Service~~. ~~An individual listed in Subsection 009.01 of this rule is available to work on a provisional basis at the discretion of the employer or agency once the individual has submitted their completed criminal history and background check application, it has been reviewed by the employer or agency, and no disqualifying crimes or relevant records are disclosed on the application. An individual must be fingerprinted within twenty-one (21) days of submitting their criminal history and background check.~~ ~~(3-17-22)~~

~~a.~~ ~~An individual is allowed to work or have access to participants only under supervision until the criminal history and background check is completed.~~ ~~(3-17-22)~~

~~b.~~ ~~An individual, who does not receive a criminal history and background check clearance or have a Behavioral Health waiver granted under the provisions in Subsection 009.03 of this rule, must not provide direct care or services, or serve in a position that requires regular contact with participants.~~ ~~(3-17-22)~~

0~~3~~1. Waiver of Criminal History and Background Check Denial.

a. A certified ~~*or uncertified*~~ individual *from a certifying body that is recognized by the Department* who is seeking to provide ~~*Peer Support Specialist, Family Support Partner, or Recovery Coach*~~ *substance use disorder treatment or recovery support* services, *or an uncertified individual* that receives an unconditional denial or a denial after an exemption review by the Department's Criminal History Unit, may apply for a Behavioral Health waiver. ~~*(3-17-22)*~~*( )*

b. An individual is allowed to work or have access to participants only under supervision until the waiver request is processed. (3-17-22)

010. DEFINITIONS - A THROUGH F.
For the purposes of these rules, the following terms apply: (3-17-22)

01. Adolescent. A youth twelve (12) through seventeen (17) years of age. (3-17-22)

02. Adult. An individual eighteen (18) years or older. (3-17-22)

03. ASAM. Refers to the manual of the patient placement criteria for the treatment of substance-related disorders, published by the American Society of Addiction Medicine, incorporated by reference in Section 004 of these rules. (3-17-22)

04. ASAM Level of Care Certification. Verifies a treatment program's capacity to deliver services consistent with the Level III standards of care described in the ASAM criteria. (3-17-22)

~~05. Clinical Assessment~~. ~~The gathering of historical and current clinical information through a clinical interview and from other available resources to identify an individual's strengths, weaknesses, problems, needs, and determine priorities so that a service plan can be developed.~~ ~~(3-17-22)~~

~~06. Clinical Judgment~~. ~~Refers to observations and perceptions based upon education, experience, and~~

~~clinical assessment. This may include psychometric, behavioral, and clinical interview assessments that are structured, integrated, and then used to reach decisions, individually or collectively, about an individual's functional, mental, and behavioral attributes and substance use disorders service needs.~~ ~~(3-17-22)~~

07~~5~~. **Department**. The Idaho Department of Health and Welfare or its designee. (3-17-22)

08~~6~~. **Eligibility Screening**. The collection and review of information directly related to the individual's substance use and level of functioning, which the Department uses to determine whether an individual is eligible for adult or adolescent substance use disorder services available through the Department's Division of Behavioral Health. (3-17-22)

~~**09. Federal Poverty Guidelines**. Guidelines issued annually by the Federal Department of Health and Human Services establishing the poverty income limits. The federal poverty guidelines for the current year may be found at: http://aspe.hhs.gov/poverty/.~~ ~~(3-17-22)~~

011. DEFINITIONS - G THROUGH Z.
For the purposes of these rules, the following terms apply: (3-17-22)

01. Idaho Board of Alcohol/Drug Counselor Certification, Inc. (IBADCC). A board *recognized by the Department* affiliated with the International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse (ICRC). The IBADCC is the certifying entity that oversees credentialing of Idaho Student of Addiction Studies (ISAS), and Certified Alcohol/Drug Counselors (CADC) in the state of Idaho. ~~*(3-17-22)*~~*( )*

~~**02. Individualized Service Plan**. A written action plan based on an eligibility screening and clinical assessment, that identifies the individual's clinical needs, the strategy for providing services to meet those needs, treatment goals and objectives and the criteria for terminating the specified interventions.~~ ~~(3-17-22)~~

~~**03. Intensive Outpatient Services**. Educational classes and individual or group counseling consisting of regularly scheduled sessions within a structured program, for a minimum of nine (9) hours of treatment per week for adults and six (6) hours of treatment per week for adolescents.~~ ~~(3-17-22)~~

~~**04. Medication-Assisted Treatment (MAT)**. The use of medications, approved by the Food and Drug Administration (FDA), in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders.~~ ~~(3-17-22)~~

~~**05. Network Treatment Provider**. Any provider, group of providers, or entity that has a network provider agreement with the Department's Division of Behavioral Health contractor to provide behavioral health services.~~ ~~(3-17-22)~~

~~**06. Opioid Treatment Program (OTP)**. A program that provides MAT for persons diagnosed with opioid use disorder (OUD). OTPs provide all FDA approved MAT medications. In addition, participants receiving MAT medications must also receive counseling and other behavioral therapies to provide participants with a whole-person approach.~~ ~~(3-17-22)~~

~~**07. Outpatient Services**. Educational classes and individual or group counseling consisting of regularly scheduled sessions within a structured program for up to eight (8) hours of treatment per week for adults and five (5) hours of treatment per week for adolescents.~~ ~~(3-17-22)~~

***02. National Certification Commission for Addiction Professionals (NCC AP)**. A certifying body recognized by the Department that provides counselor certifications and endorsements.* *( )*

08~~3~~. **Priority Population**. Priority populations consist of individuals who receive services ahead of other persons. Priority populations are determined yearly by the Department and align with federally mandated priorities. (3-17-22)

~~**09. Recovery Support Services**. Non-clinical services designed to initiate, support, and enhance recovery. These services may include: safe and sober housing, transportation, child care, life skills education, drug~~

~~testing, recovery coaching, and case management.~~ ~~(3-17-22)~~

~~**10. Residential Treatment Services**. A planned and structured regimen of treatment provided in a 24-hour residential setting. Residential programs serve individuals who, because of function limitations need safe and stable living environments and 24-hour care.~~ ~~(3-17-22)~~

~~**11. Substance-Related Disorders**. Clinical presentations due to substance use that may or may not demonstrate sufficient signs or symptoms to substantiate a diagnosis of a substance use disorder.~~ ~~(3-17-22)~~

~~**12. Substance Use Disorder**. A disorder evidenced by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using a substance despite significant substance-related problems. According to the DSM-5, diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to use of the substance.~~ ~~(3-17-22)~~

012. -- 099. (RESERVED)

PARTICIPANT ELIGIBILITY
(Sections 100-199)

100. ~~ACCESSING SUBSTANCE USE DISORDERS SERVICES.~~(RESERVED)
~~Individuals may access substance use disorders services administered by the Department's Division of Behavioral Health through an eligibility screening.~~ ~~(3-17-22)~~

(BREAK IN CONTINUITY OF SECTIONS)

~~103. NOTICE OF CHANGES IN ELIGIBILITY FOR SUBSTANCE USE DISORDERS SERVICES.~~
~~The Department may, upon ten (10) days' written notice, reduce, limit, suspend, or terminate eligibility for substance use disorders services.~~ ~~(3-17-22)~~

~~104. NOTICE OF DECISION ON ELIGIBILITY AND RIGHT TO APPEAL.~~

~~**01. Notification of Eligibility Determination**. Within two (2) business days of receiving a completed screening, the Department will notify the individual or the individual's designated representative of its eligibility determination. When the individual is not eligible for services through the Department, the individual or the individual's designated representative will be notified in writing.~~ ~~(3-17-22)~~

~~**02. Notice of Right to Appeal**. When the individual is not eligible for services through the Department, the Department will notify the individual or the applicant's individual's designated representative. The written notice will include:~~ ~~(3-17-22)~~

~~**a.** A statement of the decision and the concise reasons for it;~~ ~~(3-17-22)~~

~~**b.** The process and timeline for pursuing an appeal of the decision under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings"; and;~~ ~~(3-17-22)~~

~~**c.** The right to be represented on appeal.~~ ~~(3-17-22)~~

105~~3~~. -- 119. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

SUBSTANCE USE DISORDER SERVICES
(Sections 200-600)

200. QUALIFIED SUBSTANCE USE DISORDERS PROFESSIONAL PERSONNEL REQUIRED.
Each behavioral health program providing substance use disorders services must employ the number and variety of staff needed to provide the services and treatments offered by the program as a multidisciplinary team. The program must employ at least one (1) qualified substance use disorders professional for each behavioral health program location. A qualified substance use disorders professional includes individuals ~~with the~~ as follow~~ing~~s ~~qualifications~~: ~~(3-17-22)~~( )

01. Idaho Board of Alcohol/Drug Counselor Certification - Certified Advanced or Certified Alcohol/Drug Counselor. (3-17-22)

~~**02. Northwest Indian Alcohol/Drug Specialist Certification - Counselor II or Counselor III**.~~ ~~(3-17-22)~~

0~~3~~2. **National Board for Certified Counselors (NBCC) - Master Addictions Counselor (MAC)**. (3-17-22)

~~**04. Clinical Social Worker (LCSW) or Masters Social Worker (LMSW)**. Licensed under Title 54, Chapter 32, Idaho Code;~~ ~~(3-17-22)~~

~~**05. Marriage and Family Therapist or Associate Marriage and Family Therapist**. Licensed under Title 54, Chapter 34, Idaho Code;~~ ~~(3-17-22)~~

~~**06. Nurse Practitioner**. Licensed under Title 54, Chapter 14, Idaho Code;~~ ~~(3-17-22)~~

~~**07. Clinical Nurse Specialist**. Licensed under Title 54, Chapter 14, Idaho Code;~~ ~~(3-17-22)~~

~~**08. Physician Assistant**. Licensed under Title 54, Chapter 18, Idaho Code;~~ ~~(3-17-22)~~

~~**09. Professional Counselor (LPC) or Clinical Professional Counselor (LCPC)**. Licensed under Title 54, Chapter 34, Idaho Code;~~ ~~(3-17-22)~~

~~**10. Psychologist or Psychologist Extender**. Licensed under Title 54, Chapter 23, Idaho Code;~~ ~~(3-17-22)~~

~~**11. Physician**. Licensed under Title 54, Chapter 18, Idaho Code; and;~~ ~~(3-17-22)~~

~~**12. Registered Nurse (RN)**. Licensed under Title 54, Chapter 14, Idaho Code.~~ ~~(3-17-22)~~

~~**13. Pharmacist**. Licensed under Title 54, Chapter 17, Idaho Code.~~ ~~(3-17-22)~~

03. NCC AP – Master Addiction Counselor (MAC). ***( )***

0~~3~~*4.* **Licensed Professional**. Hold an active license or registration with the applicable jurisdiction for the profession and provide services within the practice authority for the applicable profession consistent with the laws and regulations of the state where services are provided and consistent with the applicable standard of care. ( )

201. -- 209. (RESERVED)

210. QUALIFIED SUBSTANCE USE DISORDERS PROFESSIONAL TRAINEE.
Each qualified substance use disorders professional trainee practicing in the provision of substance use disorders services must meet the following requirements. (3-17-22)

01. Work Qualifications for Qualified Substance Use Disorders Professional Trainee. A qualified substance use disorders professional trainee must meet one (1) of the following qualifications to begin work: (3-17-22)

a. Substance Use Disorder Associate certification; (3-17-22)

~~**b.** Formal documentation as a Northwest Indian Alcohol/Drug Specialist Counselor I; or (3-17-22)~~

~~**c**~~**b.** Formal documentation of current enrollment in a program for~~ qualifications in~~ any licensed professional consistent with Section 200 of these rules. ~~(3-17-22)~~( )

02. Continue as Qualified Substance Use Disorders Professional Trainee. An individual who has completed a program listed in Section 200 of these rules and is awaiting licensure can continue as a qualified substance use disorders professional trainee at the same agency for a period of six (6) months from the date of program completion. (3-17-22)

211. -- ~~299.~~ ~~(RESERVED)~~

~~**300. SERVICES FOR ADOLESCENTS.**~~
~~Behavioral health programs providing substance use disorders treatment to adolescents must comply with the following requirements: (3-17-22)~~

~~**01. Separate Services From Adults**. Each program providing adolescent program services must provide the services separate from adult program services. The program must ensure the separation of adolescent participants from adult participants except as specified in Subsections 300.03 and 300.04 of this rule. (3-17-22)~~

~~**02. Residential Care as an Alternative to Parental Care**. Any program that provides care, control, supervision, or maintenance of adolescents for twenty-four (24) hours per day as an alternative to parental care must meet the following criteria: (3-17-22)~~

~~**a.** Be licensed under the "Child Care Licensing Act," Title 39, Chapter 12, Idaho Code; or (3-17-22)~~

~~**b.** Be certified by the Department of Juvenile Corrections. (3-17-22)~~

~~**03. Continued Care of an Eighteen-Year-Old**. An adolescent who turns the age of eighteen (18), and is receiving outpatient or intensive outpatient treatment in a state-approved behavioral health program, may remain in the program under continued care described in this rule. The individual may remain in the program for: (3-17-22)~~

~~**a.** Up to ninety (90) days after their eighteenth birthday; or (3-17-22)~~

~~**b.** Until the close of the current school year for an individual attending school. (3-17-22)~~

~~**04. Documentation Requirements for Continued Care**. Prior to accepting an individual into continued care, the program must assure and document the following; (3-17-22)~~

~~**a.** A signed voluntary agreement to remain in the program or a copy of a court order authorizing continued placement after the individual's eighteenth birthday; (3-17-22)~~

~~**b.** Clinical staffing for appropriateness of continued care with clinical documentation; (3-17-22)~~

~~**c.** Verification the individual in continued care was in the care of the program prior to their eighteenth birthday; and (3-17-22)~~

~~**d.** Verification that the individual needs to remain in continued care to complete treatment, education, or other similar needs. (3-17-22)~~

~~**05. Licensed Hospital Facilities**. Facilities licensed as hospitals under Title 39, Chapter 13, Idaho Code, are exempt from the requirements in this rule. (3-17-22)~~

~~**301. -- 349. (RESERVED)**~~

~~350. RECOVERY SUPPORT SERVICES.~~
~~Recovery Support Services are administered through contract. Recovery Support Services are non-clinical services that support recovery from a substance use disorder and are based on an individual participant's needs. Recovery Support Services may include:~~ ~~(3-17-22)~~

~~01. Case Management.~~ ~~(3-17-22)~~

~~02. Alcohol and Drug Screening.~~ ~~(3-17-22)~~

~~03. Child Care.~~ ~~(3-17-22)~~

~~04. Transportation.~~ ~~(3-17-22)~~

~~05. Life Skills.~~ ~~(3-17-22)~~

~~06. Recovery Residence-Staffed Safe and Sober Housing for Adults.~~ ~~(3-17-22)~~

~~07. Recovery Residence-Enhanced Staffed Safe and Sober Housing for Adults.~~ ~~(3-17-22)~~

~~08. Recovery Coaching.~~ ~~(3-17-22)~~

~~351. --~~394. (RESERVED)

395. RESIDENTIAL TREATMENT SERVICES.

~~01. Residential Treatment Services.~~ Residential Treatment Services are administered under the Department through a contractor and must be nationally accredited by the Joint Commission, the Council on Accreditation (COA), or Commission on Accreditation of Rehabilitation Facilities (CARF) and have an ASAM Level of Care certification. ~~(3-17-22)~~( )

~~02. Licensed for Adolescent Residential Treatment. Each adolescent residential treatment program must be licensed as a Children's Residential Care Facility under IDAPA 16.06.02, "Child Care Licensing."~~ ~~(3-17-22)~~

396. -- ~~409.~~ ~~(RESERVED)~~

~~410. OUTPATIENT TREATMENT SERVICES.~~
~~Outpatient substance use disorder treatment services are contained in the Medicaid Idaho Behavioral Health Plan (IBHP) and delivered under contract.~~ ~~(3-17-22)~~

~~01. Treatment Services. Services are delivered according to ASAM criteria and Level of Care Placement guidelines. Services include:~~ ~~(3-17-22)~~

~~a. Assessments;~~ ~~(3-17-22)~~

~~b. Service planning and placement;~~ ~~(3-17-22)~~

~~c. Group therapy; and~~ ~~(3-17-22)~~

~~02. Treatment Providers. Outpatient treatment services are delivered by network providers enrolled with the Medicaid IBHP contractor.~~ ~~(3-17-22)~~

~~411. -- 414. (RESERVED)~~

~~415. MEDICATION-ASSISTED TREATMENT.~~

~~01. Medication-Assisted Treatment Services. A behavioral health program providing medication assisted treatment for substance use disorders must make counseling and behavioral therapies available in~~

combination with MAT services. (3-17-22)

02. Opioid Treatment Program. OTP must meet all requirements established under 42 CFR, Section 8.12, Federal Opioid Treatment Standards. (3-17-22)

QUALITY ASSURANCE AND INSPECTIONS (Sections 416-419)

416. INSPECTIONS.

As the State substance abuse authority, the Department will periodically inspect substance use disorder services providers or programs as provided in Section 39-305, Idaho Code, to determine compliance with these rules and Title 39, Chapter 3, Idaho Code. (3-17-22)

01. Department Inspection. The Department may inspect a substance use services provider or program at any reasonable time during regular business hours. Inspections may be made without prior notice to the substance use services provider or program. (3-17-22)

02. Program Compliance with Inspection. The program or provider must, in compliance with federal and state confidentiality requirements, provide for review of participant treatment records, behavioral health records, logbooks, staffing charts, time reports, claims data, administrative documents, complaints, grievances, and any other requested documents or data required by the Department. (3-17-22)

03. Department Protection of Participants. The Department will take steps to protect individuals receiving substance use disorder services during its inspections. (3-17-22)

417. INVESTIGATIONS AND FINDINGS.

The Department may conduct inspections as provided in Section 416 of these rules, to investigate complaints, incidents, accidents, allegations of abuse, neglect, or exploitation. If the Department chooses to investigate, the investigation and a report of the Department's findings must be completed within thirty (30) calendar days of the date the Department learned of the complaint, incident, accident, or allegation. The Department may take any of the following actions: (3-17-22)

01. Corrective Action Plan. Require the substance use disorders services provider, program, or the Department contractor administering the provider network to engage in a corrective action plan as determined and monitored by the Department or the contractor administering the provider network; or (3-17-22)

02. Program Improvement Plan. Require the substance use disorder services provider, program, or the Department contractor administering the provider network to develop a program improvement plan to be implemented and monitored over time. (3-17-22)

418. NOTICES FOLLOWING INVESTIGATION.

Within thirty (30) calendar days of the date the Department learned of the complaint, incident, accident, or allegation, the Department must issue a notice to the provider, program, or the contractor administering the provider network. The notice must include: (3-17-22)

01. Statement of Department Findings. A statement of the Department's findings about whether the program, provider, or contractor is in compliance with these rules or has engaged in abuse, neglect, or exploitation; or whether an incident or accident occurred; (3-17-22)

02. Department Plan Requirement. Whether the Department will require a corrective action plan or program improvement plan; (3-17-22)

03. Department Notifications. Whether the Department will be notifying the program or provider's accrediting entity or licensing authority, if applicable; and (3-17-22)

04. Appealing the Decision. The process and timeline for appealing the decision under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." (3-17-22)

~~**419. NOTIFICATION TO ACCREDITING OR LICENSING AUTHORITY.**~~
~~When the Department issues a notice requiring corrective action or a program improvement plan, the Department:~~ ~~(3-17-22)~~

~~**01. Notification of Accrediting Entity**. May notify the program or provider's accrediting entity, if any, of the Department decision; and~~ ~~(3-17-22)~~

~~**02. Notification of Licensing Authority**. Must notify the licensing authority of any program or provider that must be licensed, of the Department decision.~~ ~~(3-17-22)~~

~~**420. —**~~**999. (RESERVED)**

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.07.33 – ADULT MENTAL HEALTH SERVICES

DOCKET NO. 16-0733-2401

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202, Idaho Code, and Sections 39-3140, 56-1003, 56-1004, 56-1004A, 56-1007, and 56-1009, Idaho Code.

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

The rule change strives to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. This also coincides with the recent go-live status of the Idaho Behavioral Health Plan and seeks to update this rule chapter in association with similarly effected chapters including 16.07.17 and 16.07.37.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the November 6th, 2024, Idaho Administrative Bulletin, Vol. 24-11, pages 94-99.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

Fees are not being increased as a result of this proposed rulemaking.

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

There will not be a negative fiscal impact exceeding $10,000 as a result of this proposed rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at 208-334-5500.

DATED this 27th day of November, 2024.

Alex J. Adams, PharmD, MPH
Director
Idaho Department of Health & Welfare
450 W. State Street, 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5500 phone; (208) 334-6558 fax
Alex.Adams@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 56-202, Idaho Code, and 39-3140, 56-1003, 56-1004, 56-1004A, 56-1007, and 56-1009, Idaho Code.

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

VIRTUAL TELECONFERENCE Via WebEx

Wednesday, November 13, 2024
2:30 p.m. (MST)

Join from the meeting link:
https://idhw.webex.com/idhw/j.php?MTID=m268521f0e14217752d8ecbfda943e4d2

Join by meeting number:
Meeting number (access code): 2830 965 8425
Meeting password: mFjKUBQM528 (when dialing from a phone or video system) 63558276

Join by phone:
+1-415-527-5035,,28309658425#63558276# United States Toll
+1-303-498-7536,,28309658425#63558276# United States Toll (Denver)

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

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

The rule change strives to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. This also coincides with the recent go-live status of the Idaho Behavioral Health Plan and seeks to update this rule chapter in association with similarly effected chapters including 16.07.17 and 16.07.37.

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

Fees are not being increased as a result of this proposed 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 as a result of this rulemaking:

There will not be a negative fiscal impact exceeding $10,000 as a result of this proposed rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted on this rule chapter however public comments will be collected at the public hearing scheduled above.

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 Jared Larsen at 208-334-5500.

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 November 27th, 2024.

DATED this 11th day of October, 2024.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0733-2401

16.07.33 – ADULT MENTAL HEALTH SERVICES

001 – 00~~2~~3. (RESERVED)

~~003. ADMINISTRATIVE APPEALS.~~
~~Administrative appeals from a denial of eligibility under Section 102 of these rules are governed by IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings."~~ ~~(4-6-23)~~

(BREAK IN CONTINUITY OF SECTIONS)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

~~01. Background Checks~~. ~~All employees, interns, contractors, and volunteers of adult mental health services must comply with IDAPA 16.05.06, "Criminal History and Background Checks," Section 101.~~ ~~(4-6-23)~~

~~02. Availability to Work or Provide Service~~. ~~An individual under Subsection 009.01 of this rule is available to work on a provisional basis at the discretion of the employer or agency once the individual has submitted their background check application, it has been reviewed by the employer or agency, and no disqualifying crimes or relevant records are disclosed on the application. An individual is fingerprinted within twenty one (21) days of submitting their background check.~~ ~~(4-6-23)~~

~~a.~~ ~~An individual is allowed to work or have access to participants only under supervision until the background check is completed.~~ ~~(4-6-23)~~

~~b.~~ ~~An individual, who does not receive a background check clearance or have a Behavioral Health waiver granted under these rules, may not provide direct care or services, or serve in a position that requires regular contact with participants.~~ ~~(4-6-23)~~

0~~3~~1. Waiver of Background Check Denial. (4-6-23)

a. A certified individual who is seeking to provide Peer Support Specialist, Family Support Partner, or Recovery Coach services that receives an unconditional denial or a denial after an exemption review by the Department's Criminal History Unit, may apply for a Behavioral Health waiver. (4-6-23)

b. An individual is allowed to work with or have access to participants only under supervision until

the waiver request is processed. (4-6-23)

010. DEFINITIONS

01. Adult. An individual eighteen (18) years or older. (4-6-23)

02. Adult Mental Health Services (AMHS). Are listed in Section 301 of these rules. These services are provided in response to the mental health needs of adults eligible for services required in Title 39, Chapter 31, Idaho Code, the Regional Behavioral Health Service Act, and under Section 102 of these rules. (4-6-23)

03. Applicant. An adult individual who is seeking mental health services through the Department who has completed, or had completed on their behalf, an application for mental health services. (4-6-23)

~~**04. Clinical Assessment**. The gathering of historical and current clinical information through a clinical interview and from other available resources to identify a participant's mental health issues, strengths, and service needs.~~ ~~(4-6-23)~~

~~**05. Clinical Team**. A proposed participant's clinical team may include: clinicians, behavioral health professionals, professionals other than behavioral health professionals, behavioral health technicians, and any other individual deemed appropriate and necessary to ensure that the treatment is comprehensive and meets the needs of the proposed participant.~~ ~~(4-6-23)~~

~~**06. Crisis Intervention Services**. A set of planned activities designed to reduce the risk of life-threatening harm to self or another person. Crisis intervention services include evaluation, assessment, intervention, stabilization, and follow-up planning.~~ ~~(4-6-23)~~

0~~7~~4. **Department**. The Idaho Department of Health and Welfare or its designee. (4-6-23)

0~~8~~5. **Eligibility Screening**. The collection and review of information directly related to the applicant's mental health and level of functioning, which the Department uses to determine whether an applicant is eligible for adult mental health services available through the Department's Division of Behavioral Health. (4-6-23)

~~**09. Mental Health Crisis**. Occurs when a sudden loss of an adult individual's ability to use effective problem-solving and coping skills leads to an imminent risk of harm to self or others, or decompensation to the point of the individual's inability to protect themselves.~~ ~~(4-6-23)~~

~~**10. Network Treatment Provider**. Any provider, group of providers, or entity that has a network provider agreement with the Department's Division of Behavioral Health contractor to provide behavioral health services.~~ ~~(4-6-23)~~

~~1~~106. **Participant**. A person receiving mental health services through the Department. (4-6-23)

~~12~~07. **Serious Mental Illness (SMI)**. Any of the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, (DSM-5-TR), incorporated in these rules: (4-6-23)

a. Schizophrenia spectrum and other psychotic disorders; (4-6-23)

b. Bipolar disorders (mixed, manic, and depressive); (4-6-23)

c. Major depressive disorders (single episode or recurrent); (4-6-23)

d. Obsessive-compulsive disorders. (4-6-23)

~~13~~08. **Serious and Persistent Mental Illness (SPMI)**. A primary diagnosis under DSM-5-TR of Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified (NOS) for a maximum of one

hundred twenty (120) days without a conclusive diagnosis. The psychiatric disorder must be of sufficient severity to cause a substantial disturbance in role performance or coping skills in at least two (2) of the following functional areas in the last six (6) months: (4-6-23)

a. Vocational or educational, or both. (4-6-23)

b. Financial. (4-6-23)

c. Social relationships or support, or both. (4-6-23)

d. Family. (4-6-23)

e. Basic daily living skills. (4-6-23)

f. Housing. (4-6-23)

g. Community or legal, or both. (4-6-23)

h. Health or medical, or both. (4-6-23)

(BREAK IN CONTINUITY OF SECTIONS)

101. ELIGIBILITY SCREENING AND MENTAL HEALTH ASSESSMENT.

~~**01. Eligibility Screening.**~~ The eligibility screening must be directly related to the participant's mental illness and level of functioning and is based on the eligibility criteria under Section 102 of these rules. (4-6-23)

~~**02. Clinical Assessment**. Once an individual is found eligible for AMHS the individual will be authorized to receive a clinical assessment from a treatment provider in the Division of Behavioral Health's AMHS network to determine level of care. (4-6-23)~~

102. ELIGIBILITY DETERMINATION.

01. Determination of Eligibility for Mental Health Services. The Department may 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. (4-6-23)

02. Eligibility Requirements. To be eligible for voluntary mental health services, the individual must: (4-6-23)

a. Be an adult; (4-6-23)

b. Be a resident of the state of Idaho; and (4-6-23)

c. Have a primary diagnosis of SMI or SPMI. (4-6-23)

~~**03. Court-Ordered Assessment, Treatment, and Services**. The court may order the Department to provide assessment, treatment, and services according to Sections 18-212, 19-2524, and 66-329, Idaho Code. (4-6-23)~~

~~**04. Ineligible Conditions**. An individual who has a neurological disorder, a neurocognitive disorder as defined in Section 66-317, Idaho Code, a developmental disability as defined in Section 66-402, Idaho Code, a physical disability, or any medical disorder that includes psychiatric symptomology or is primarily impaired by substance use, unless in addition to such condition, such person is mentally ill. (4-6-23)~~

~~**103. NOTICE OF CHANGES IN ELIGIBILITY FOR MENTAL HEALTH SERVICES.**~~
~~The Department may, upon ten (10) days' written notice, reduce, limit, suspend, or terminate eligibility for mental health services.~~ ~~(4-6-23)~~

~~**104. CRISIS INTERVENTION SERVICES.**~~
~~Crisis intervention services are available twenty-four (24) hours per day, seven (7) days per week to adults experiencing a mental health crisis as defined under Section 010 of these rules. Crisis intervention services include evaluation, assessment, intervention, stabilization, and follow-up planning.~~ ~~(4-6-23)~~

~~**01. Determination of the Need for Crisis Intervention Services**. The Department or its contractors will assess an adult experiencing a mental health crisis to determine whether services are needed to alleviate the crisis.~~ ~~(4-6-23)~~

~~**02. Identification of the Crisis Intervention Services Needed**. If crisis intervention services are clinically necessary, as determined by the Department or its contractors, the Department or its contractors will:~~ ~~(4-6-23)~~

~~**a.** Identify the services needed to stabilize the crisis;~~ ~~(4-6-23)~~

~~**b.** Arrange for the provision of the crisis intervention services; and~~ ~~(4-6-23)~~

~~**c.** Document in the individual's record the crisis services that are to be provided to the individual.~~ ~~(4-6-23)~~

~~**03. Immediate Intervention**. If the Department determines that a mental health crisis exists necessitating immediate intervention, crisis services will be arranged immediately.~~ ~~(4-6-23)~~

~~**105. NOTICE OF DECISION ON ELIGIBILITY AND RIGHT TO APPEAL.**~~

~~**01. Notification of Eligibility Determination**. Within two (2) business days of receiving a completed screening, the Department or its contractors will notify the applicant or the applicant's designated representative in writing of its eligibility determination.~~ ~~(4-6-23)~~

~~**02. Notice of Right to Appeal**. When the applicant is not eligible for services through the Department or its contractor(s), the Department or its contractor(s) will notify the applicant or the applicant's designated representative. The written notice will include:~~ ~~(4-6-23)~~

~~**a.** A statement of the decision and the concise reasons for it;~~ ~~(4-6-23)~~

~~**b.** The process and timeline for pursuing an appeal of the decision under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings"; and~~ ~~(4-6-23)~~

~~**c.** The right to be represented on appeal.~~ ~~(4-6-23)~~

~~**106. -- 119. (RESERVED)**~~

~~**120. PARTICIPANT'S RIGHTS AND RESPONSIBILITIES.**~~
~~The Department will inform each participant receiving AMHS through the Department of their rights and responsibilities prior to the delivery of mental health services. Each participant is given a written statement of participant rights and responsibilities, which includes who the participant may contact with questions, concerns, or complaints regarding services provided.~~ ~~(4-6-23)~~

1~~21~~03. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.07.37 – CHILDREN'S MENTAL HEALTH SERVICES

DOCKET NO. 16-0737-2401 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202, Idaho Code, and Sections 16-2404, 16-2406, 16-2423, 16-2433, 56-202(b), 56-203B, 56-204A, 56-1003, 56-1004, and 56-1004A, Idaho Code.

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

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 4th, 2024, Idaho Administrative Bulletin, Vol. 24-9, page 428 through 446.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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 will not be a negative fiscal impact exceeding $10,000 to the state by this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at 208-334-5500.

DATED this 26th day of September, 2024.

Alex J. Adams, PharmD, MPH
Director
Idaho Department of Health & Welfare
450 W. State Street, 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5500 phone; (208) 334-6558 fax
Alex.Adams@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 Section 56-202, Idaho Code, and Sections 16-2404, 16-2406, 16-2423, 16-2433, 56-202(b), 56-203B, 56-204A, 56-1003, 56-1004, and 56-1004A, Idaho Code.

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

VIRTUAL TELECONFERENCE Via WebEx

Tuesday, September 17, 2024
10:00-11:00 a.m. (MT)

Join from the meeting link
https://idhw.webex.com/idhw/j.php?MTID=m11933a531a680e487e4331b21ac72d79

Join by meeting number
Meeting number (access code): 2821 443 5081
Meeting password: tM3J3VMNW9P (86353866 when dialing from a phone or video system)

Join by phone
+1-415-527-5035,,28214435081#86353866# United States Toll
+1-303-498-7536,,28214435081#86353866# United States Toll (Denver)

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:

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language.

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

Fees will not be increased by 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 as a result of this rulemaking:

There will not be a negative fiscal impact exceeding $10,000 by this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the February 7th, 2024 Idaho Administrative Bulletin, Volume 24-2, and was later published in the March 6th, 2024 Idaho Administrative Bulletin, Volume 24-3. Negotiated Rulemaking was conducted on March 13th and March 20th.

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 Jared Larsen at 208-334-5500.

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 25th, 2024.

DATED this 31st day of July, 2024.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0737-2401

16.07.37 – CHILDREN'S MENTAL HEALTH SERVICES

000. LEGAL AUTHORITY.
Under 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, the Idaho Legislature has delegated to the Department the responsibility to establish and enforce rules and methods of administration needed to provide children's mental health services in accordance with the Children's Mental Health Services Act. (3-17-22)

001. ~~TITLE AND~~ SCOPE.

~~**01. Title**. These rules are titled IDAPA 16.07.37, "Children's Mental Health Services." (3-17-22)~~

~~**02. Scope.**~~ This chapter sets the standards for providing ~~defines the appeal process, scope of services, eligibility criteria, and application requirements for the provision of~~ children's mental health services by the Department. ~~(3-17-22)~~( )

002. (RESERVED)

003. ADMINISTRATIVE APPEALS.

01. Appeal from a Denial Based on Eligibility Criteria. Administrative appeals from a denial ~~of children's mental health services based on the eligibility~~ pursuant to criteria ~~under~~ in Section 107 of these rules are governed by the provisions of IDAPA 16.05.03, "~~Rules Governing~~ Contested Case Proceedings and Declaratory Rulings." ~~(3-17-22)~~( )

~~**02. Grievances and Expedited Hearings**. Grievances and expedited hearings related to non-Medicaid Youth Empowerment Services (YES) will be provided as described in IDAPA 16.05.03 "Rules Governing Contested Case Proceeding and Declaratory Ruling," Sections 750 and 751. (3-17-22)~~

~~**03. Appeal of Decision Based on Clinical Judgment**. All decisions involving clinical judgment, which may include the category of services, the particular provider of services, or the duration of services, are reserved to the Department, and are not subject to appeal, administratively or otherwise, in accordance with Maresh v. State, 132 Idaho 221, 970 P.2d 14 (Idaho 1999). (3-17-22)~~

004. INCORPORATION BY REFERENCE.
American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Test Revision (DSM-5-TR), Washington, D.C., American Psychiatric Association, 2013, is hereby incorporated by reference under this chapter of rules. Copies of the manual are available from the American Psychiatric Association, ~~1000 Wilson Boulevard~~ 800 Maine Avenue, S.W Suite ~~1825~~ 900, ~~Arlington, VA~~ Washington, DC ~~22209-3901~~ 20024. ~~A copy of the manual is also available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702.~~ ~~(3-17-22)~~( )

005. -- 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. ~~Compliance with Department~~ Criminal History and Background Check. ~~Department~~ All employees, applicants, ~~transfers, reinstated former employees,~~ student interns, contract employees, volunteers, and others assigned to programs ~~that involve direct contact with children or vulnerable adults as defined under Section 39-5302, Idaho Code,~~ of children's mental health services must comply with the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~( )

02. Availability to Work or Provide Service. Certain individuals are allowed to provide services after the criminal history and background check is completed as provided in Section 56-1004A, Idaho Code, except when they have disclosed a designated crime listed in IDAPA 16.05.06, "Criminal History and Background Checks." The criminal history and background check requirements applicable to each provider type are found in the rules that state the qualifications or certification of those providers. (3-17-22)

010. DEFINITIONS ~~AND ABBREVIATIONS A THROUGH E~~.
~~For the purposes of these rules,~~ In addition to Section 16-2403, Idaho Code, the following terms apply:
~~(3-17-22)~~( )

01. Alternate Care. Temporary living arrangements outside the family home that may include licensed foster care, residential treatment, and other facilities licensed by the state to provide twenty-four (24) hour care for children in accordance with IDAPA 16.06.02, "Child Care Licensing," or IDAPA 16.03.14, "Hospitals." (3-17-22)

~~**02. Alternate Care Plan**. A component of the treatment plan for children in alternate care. The alternate care plan contains elements related to the justification of the need for Alternate Care Placement, the provision of treatment while in Alternate Care Placement, the child's alternate care provider, education, immunization, medical and other information important to the day-to-day care of the child.~~ ~~(3-17-22)~~

~~**03. Area(s) of Concern**. A circumstance or circumstances that brought a child and family to the attention of the Department.~~ ~~(3-17-22)~~

0~~4~~2. Clinical Assessment. The gathering of historical and current clinical information through a clinical interview and from other available resources to identify the child's mental health issues, the child's strengths, the family's strengths, and the service needs. (3-17-22)

~~**05. Behavioral Health**. An integrated system for evaluation and treatment of mental health and substance use disorders.~~ ~~(3-17-22)~~

~~**06. Case Management**. A change-oriented service provided to families that assures and coordinates the provision of an assessment, treatment planning, treatment and other services, protection, advocacy, review and reassessment, documentation, and timely closure of a case.~~ ~~(3-17-22)~~

~~**07. Case Record**. Compilation of all electronic and hard copy documentation relating to a child who is receiving or has received children's mental health services including legal documents, identifying information, and assessments.~~ ~~(3-17-22)~~

~~**08. Child**. An individual who is under the age of eighteen (18) years.~~ ~~(3-17-22)~~

~~**09. Children's Mental Health Services**. The children's mental health services are listed under Section 100 of these rules. These services are provided in response to the mental health needs of children eligible for services under Section 107 of these rules and their families in accordance with the provisions of the Children's Mental Health Services Act, Title 16, Chapter 24, Idaho Code. (3-17-22)~~

~~10~~03. **Clinician**. Any of the direct service personnel with a Master's degree working in regional Children's Mental Health programs, including master's level social workers, psychologists, counselors, and family therapists. (3-17-22)

~~11~~04. **Crisis Intervention Services**. A set of planned activities for a ~~child eligible for services under Section 107 of these rules~~ designed to reduce the risk of life-threatening harm to self or another person. Crisis intervention services include evaluation, assessment, intervention, stabilization, and follow-up planning. ~~(3-17-22)~~( )

~~**12. Crisis Plan**. As part of the treatment plan, the individualized crisis plan is developed to prevent a crisis or prepare for a crisis situation and to keep the child and others safe. The crisis plan may include the child's trigger behaviors, preferred strategies for resolving a crisis, interventions to be avoided, and contact information of community resources and natural supports. (3-17-22)~~

~~**13. Crisis Response**. A service for a child that involves immediate actions taken to assess risk or intervene in an emergency as defined in Section 16-2403(6), Idaho Code. A determination of eligibility under Section 107 of these rules is not required for crisis response. (3-17-22)~~

~~**14. Day Treatment Services**. Intensive nonresidential services that include an integrated set of educational, clinical, social, vocational, and family interventions provided on a regularly scheduled, typically daily, basis. (3-17-22)~~

~~**15. Department**. The Idaho Department of Health and Welfare or its designee. The Department is designated as the State Behavioral Health Authority under Section 39-3123, Idaho Code. (3-17-22)~~

~~16~~05. **Desired Result**. Behaviorally-specific description of the child's and family's circumstances when the factors that brought the child and family to the Department's attention, either no longer exist or are significantly reduced. (3-17-22)

~~17~~06. **Director**. The Director of the Idaho Department of Health and Welfare or their designee. (3-17-22)

~~**18. Emergency**. Emergency, as defined in Section 16-2403(6), Idaho Code, means a situation in which the child's condition, as evidenced by recent behavior, poses a significant threat to the health or safety of the child, their family or others, or poses a serious risk of substantial deterioration in the child's condition that cannot be eliminated by the use of supportive services or intervention by the child's parents, or mental health professionals, and treatment in the community while the child remains in their family home. (3-17-22)~~

~~**19. Extended Family Member of an Indian Child**. As defined by the law or custom of an Indian child's tribe or, in the absence of such law or custom, a person who has reached the age of eighteen (18) and who is an Indian child's grandparent, aunt or uncle, brother or sister, brother-in-law or sister-in-law, niece or nephew, first or second cousin, or stepparent. (3-17-22)~~

07. **Eligibility Screening**. The collection and review of information directly related to the applicant's mental health and level of functioning, which the Department uses to determine whether an applicant is eligible for children's mental health services available through the Department's Division of Behavioral Health. ( )

~~**011. DEFINITIONS AND ABBREVIATIONS F THROUGH K.**~~
~~For the purposes of these rules, the following terms apply: (3-17-22)~~

~~**01. Face-to-Face Contact**. An interaction between Department staff and another individual. The interaction may occur in person or by electronic means that includes both audio and visual technology that comply with HIPAA and 42 CFR Part 2. (3-17-22)~~

~~**02.** **Family**. A family is two (2) or more persons related by blood, marriage, or adoption. (3-17-22)~~

~~**03.** **Family Support Services**. Assistance provided to a family to assist them in caring for a child eligible for services under Section 107 of these rules. The purpose of family support services is to strengthen adults in their role as parents through the provision of services including: assistance with transportation, family counseling services, training, education, and emergency assistance funds in accordance with IDAPA 16.06.13, "Emergency Assistance for Families and Children." Family support services must be on the treatment plan. (3-17-22)~~

~~**04.** **Federal Poverty Guidelines**. Guidelines issued annually by the Federal Department of Health and Human Services establishing the poverty income limits. The federal poverty guidelines for the current year may be found online at http://aspe.hhs.gov/poverty/. (3-17-22)~~

~~**05.** **Guardian**. (3-17-22)~~

~~**a.** As set forth under Title 15, Chapter 5, Part 2, Idaho Code, an individual who has been appointed by a court of law to have and exercise the powers and responsibilities of a parent who has not been deprived of custody of their minor and unemancipated child; or (3-17-22)~~

~~**b.** The Department, an agency, or an individual, other than a parent, who is acting in the place of a parent (in loco parentis) or, has assumed legal responsibility for, legal custody of, or control of a child. (3-17-22)~~

~~**06.** **Indian**. Any person who is a member of an Indian tribe or who is an Alaska Native and a member of a Regional Corporation as defined in 43 USC 1606. (3-17-22)~~

~~**07.** **Indian Child**. Any unmarried person who is under the age of eighteen (18) who is: (3-17-22)~~

~~**a.** A member of an Indian tribe; or (3-17-22)~~

~~**b.** Eligible for membership in an Indian tribe and the biological child of a member of an Indian tribe. (3-17-22)~~

~~**08.** **Indian Child Welfare Act (ICWA)**. The Indian Child Welfare Act, 25 USC 1901, et seq. (3-17-22)~~

~~**09.** **Indian Child's Tribe**. (3-17-22)~~

~~**a.** The Indian tribe in which an Indian child is a member or eligible for membership; or (3-17-22)~~

~~**b.** In the case of an Indian child who is a member of or eligible for membership in more than one (1) tribe, the Indian tribe with which the Indian child has the more significant contacts. (3-17-22)~~

~~**10.** **Indian Tribe**. Any Indian Tribe, band, nation, or other organized group or community of Indians recognized as eligible for the services provided to Indians by the Secretary because of their status as Indians, including any Alaska Native village as defined in 43 USC 1602(c). (3-17-22)~~

~~**11.** **Inpatient Services**. Mental health and medical services provided to a child admitted to a psychiatric hospital. (3-17-22)~~

011. (RESERVED)

012. DEFINITIONS AND ABBREVIATIONS L THROUGH R.
For the purposes of these rules, the following terms apply: (3-17-22)

~~**01.** **Licensed**. Facilities or programs that are licensed in accordance with the provisions of IDAPA 16.06.02, "Child Care Licensing," or hospitals licensed in accordance with IDAPA 16.03.14, "Hospitals." (3-17-22)~~

~~**02. Medicaid**. Idaho's Medical Assistance Program administered under Title XIX of the Social Security Act. (3-17-22)~~

~~**03. Outpatient Services**. Mental health services provided to a child who is not admitted to a psychiatric hospital or in a residential treatment setting. (3-17-22)~~

041. Parent. A person who, by birth or through adoption, is considered legally responsible for a child. The term "guardian" is not included in the definition of parent. (3-17-22)

052. Placement Agreement. A standardized, written agreement, signed by the Department and a parent or guardian, that outlines specific responsibilities of each party regarding the child's placement in alternate care. (3-17-22)

~~**06. Residential Treatment**. A treatment facility licensed as a children's residential care facility that provides twenty-four (24) hour care in a highly-structured setting delivering substitute parental care and mental health services. (3-17-22)~~

~~**07. Respite Care**. Time-limited care provided to children. Respite care is utilized in circumstances that require short term, temporary care of a child by a caregiver different from the child's usual caregiver. The duration of an episode of respite care ranges from one (1) partial day up to fourteen (14) consecutive days. (3-17-22)~~

~~**013. DEFINITIONS AND ABBREVIATIONS S THROUGH Z.**~~
~~For the purposes of these rules, the following terms apply: (3-17-22)~~

~~**01. Sliding Fee Scale**. A scale used to determine an individual's cost for services based on Federal Poverty Guidelines and found in IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules." (3-17-22)~~

~~**02. Teens at Risk**. Individuals attending Idaho secondary public schools who have been identified by school personnel or their designee as expressing or exhibiting indications of depression, suicidal inclination, emotional trauma, substance use, or other behaviors or symptoms that indicate the existence of, or that may lead to, the development of mental illness or a substance use disorder. (3-17-22)~~

~~**03. Teen Early Intervention Specialist**. A person with a master's degree in social work, psychology, marriage and family therapy, counseling, chemical dependency, addictive studies, psychiatric nursing, or very closely related field of study contracted to work with teens at risk. (3-17-22)~~

~~**04. Title XIX (Medicaid)**. 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. (3-17-22)~~

~~**05. Treatment Foster Care**. A service that provides clinical intervention for children eligible for services under Section 107 of these rules within the private homes of trained, licensed foster families. (3-17-22)~~

~~**06. Treatment Plan**. The individualized treatment plan describes the child's strengths and needs, short and long-term treatment goals, desired outcomes, and the roles, strategies, resources, and timeframes for coordinated implementation of services and supports. The plan is developed with the child, when possible, and the child's parent or guardian. The treatment plan includes a crisis plan and plans for transitioning out of services or to adult services. The treatment plan also includes the alternate care plan, if the child is in alternate care. (3-17-22)~~

~~**07. Wraparound**. Wraparound is a planning process that brings together a team of professionals and citizens working together to support children eligible for services under Section 107 of these rules and their families. Members of the team include the child, family members, representatives of public and private agencies, civic groups, and other community members. The services and supports focus on the strengths of the child and family, are provided in the local community, and are customized to fit the individual culture of the family. (3-17-22)~~

0143. -- 099. (RESERVED)

CHILDREN'S MENTAL HEALTH SERVICES
(Sections 100-199)

100. CHILDREN'S MENTAL HEALTH SERVICES.
The Department is the lead agency in establishing and coordinating community supports, services, and treatment for children eligible for services under Section 107 of these rules and their families. The following services, as defined under Sections 010 through 013 of these rules, are provided by or through Children's Mental Health field offices in each region: (3-17-22)

01. Assessment. (3-17-22)

02. Case Management. (3-17-22)

03. Crisis Response. (3-17-22)

04. Day Treatment Services. (3-17-22)

05. Family Support Services. (3-17-22)

06. Inpatient Services. (3-17-22)

07. Outpatient Services. (3-17-22)

08. Residential Treatment. (3-17-22)

09. Respite Care. (3-17-22)

10. Treatment Foster Care. (3-17-22)

11. Wraparound. (3-17-22)

101. TEENS AT RISK PROGRAM.
The Teens at Risk program is for individuals attending Idaho secondary public schools who have been identified by school personnel or their designee as expressing or exhibiting indications of depression, suicidal inclination, emotional trauma, substance use, or other behaviors or symptoms that indicate the existence of, or that may lead to, the development of mental illness or a substance use disorder. The Department may enter into contracts for Teens at Risk programs in cooperation with Idaho public school districts subject to Department appropriations and available funding for this program. The Department reserves the right to make the final determination to award a school district a Teens at Risk contract. (3-17-22)

01. Application. School districts may apply to the Department through a competitive application process. The Department will provide written information to the State Department of Education and interested school districts on the amount of funding available, closing date for submission of applications, and information on how to obtain application forms and instructions by July 1 of each year that funding is available. Only applications submitted on the prescribed forms and consistent with Department instructions will be considered for evaluation. (3-17-22)

02. Contracting Process. (3-17-22)

a. A team comprised of at least one (1) Department staff person, a representative from the state Department of Education, a representative from the local school district, and a parent, will evaluate the applications from school districts for contracts for Teens at Risk programs. The evaluation criteria will include the demonstrated need for the program in the school district and the contribution the school district is providing to the program, with a preference for rural school districts. The Department will consider the team recommendations and make the final determination of contracts for Teens at Risk programs. (3-17-22)

b. The number of school districts awarded a Teens at Risk program will depend upon the amount of specific funding appropriated by the legislature for this program. (3-17-22)

~~c. The Department will enter into a written contract with each school district awarded a Teens at Risk program. The contract will set forth the terms, services, data collecting, funding, and other activities prior to the implementation of the program. (3-17-22)~~

~~03. Services. Teen early intervention specialists hired or under contract with the school district will be available to serve teens at risk within the school setting and offer group counseling, recovery support, suicide prevention and other mental health and substance use disorder counseling services as needed. Teens at risk who are not enrolled in public schools may only participate in services if assigned by a judge and with the permission of the local school administrator who administers the Teens at Risk program. Parents of teens participating in the Teens at Risk program will not incur a financial obligation for services provided by the program. (3-17-22)~~

~~04. Outcomes. The Department will gather data and evaluate the effectiveness of the Teens at Risk program. In accordance with Section 16-2404A(7), Idaho Code, the Department may contract with state universities or colleges to assist in the identification of appropriate data elements, data collection, and evaluation. Data elements used to evaluate the program may include: (3-17-22)~~

~~a. Teen arrests, detention, and commitments to state custody; (3-17-22)~~

~~b. Teen suicide rates; (3-17-22)~~

~~c. Impacts on juvenile mental health and drug courts; (3-17-22)~~

~~d. Access to mental health services; and (3-17-22)~~

~~e. Academic achievement and school disciplinary actions. (3-17-22)~~

10~~2~~0. -- 104. (RESERVED)

105. ACCESSING CHILDREN'S MENTAL HEALTH SERVICES.
Children's mental health services administered by the Department's Division of Behavioral Health may be accessed either through an eligibility screening ~~application for services~~ or through a court order for services. ~~An application for services must be signed by a child's parent or guardian. (3-17-22)~~( )

106. ELIGIBILITY SCREENING AND MENTAL HEALTH ASSESSMENT.
~~Once an application has been signed or a court order has been received for children's mental health services, the Department will schedule and conduct a mental health assessment. Each mental health assessment will be documented using the Department's Idaho Standard Mental Health Assessment Report at http://www.healthandwelfare.idaho.gov. A Department clinician will either complete a mental health assessment, or, at the Department's discretion, accept an assessment completed by another mental health professional. In order to be considered, assessments completed by other mental health professionals must have occurred within ninety (90) days prior to the date of application or court order. The Department clinician will gather additional information, as needed, in order to complete the assessment process~~The eligibility screening must be directly related to the individual's mental illness and level of functioning and is based on the eligibility criteria under section 107 of this rule. Once an individual is found eligible for children's mental health services, the individual will be authorized for a clinical assessment from a treatment provider in the Division of Behavioral Health's network to determine level of care.
~~(3-17-22)~~( )

107. ELIGIBILITY DETERMINATION.

01. ~~The Department Determines~~ Determination of 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. ~~(3-17-22)~~( )

02. Eligibility Requirements. To be eligible for voluntary children's mental health services ~~through a~~

~~voluntary application to the Department,~~ the ~~applicant~~ individual must: ~~(3-17-22)~~( )

a. Be under eighteen (18) years of age; (3-17-22)

b. Reside within the state of Idaho; (3-17-22)

c. Have a DSM-5-TR mental health diagnosis. A substance use disorder alone, or developmental disorder alone, does not constitute an eligible mental health diagnosis, although one (1) or more of these conditions may co-exist with an eligible mental health diagnosis; and ~~(3-17-22)~~( )

d. Have a substantial functional impairment as assessed by using the Department's approved tool. (3-17-22)

03. 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. Parents or guardians retain custody of the child. ~~(3-17-22)~~( )

04. Ineligible Conditions. A child who does not meet the requirements under Subsections 107.02 or 107.03 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, "Substance Use Disorders Services" or IDAPA 16.04.11, "Developmental Disabilities Agencies," for substance use or developmental disability services. (3-17-22)

108. -- 109. (RESERVED)

110. NOTICE OF DECISION ON ELIGIBILITY.

01. Notification of Eligibility Determination. The Department will determine the child's eligibility for children's mental health services, in accordance with Section 107 of these rules, within thirty (30) calendar days of receipt of a signed application for services. Within five (5) working days of the determination of eligibility, the Department will send written notification to the child's parent or guardian of the eligibility determination. The written notice will include: (3-17-22)

a. The child's name and identifying information; (3-17-22)

b. A statement of the decision; (3-17-22)

c. A concise statement of the reasons for the decision; and (3-17-22)

d. The process for pursuing an administrative appeal regarding eligibility determinations. (3-17-22)

02. Parental Rights. If the Department determines that an applicant is eligible for children's mental health services through the Department, the Department clinician must inform the child's parent or guardian that they have the right to reject the services offered by the Department, unless imposed by court order. (3-17-22)

03. Other Information that Must be Provided to the Parent. The clinician must also inform the parent that fees may be incurred for certain services, in accordance with IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules," and that a parent has financial responsibility for the child. (3-17-22)

~~**04. Reapplication for Mental Health Services**. If the Department determines that a child is not eligible for children's mental health services through the Department, the child's parent or guardian may reapply after six (6) months or at any time upon a showing of a substantial, material change in circumstances.~~ ~~(3-17-22)~~

~~**111. -- 114. (RESERVED)**~~

~~**115. TREATMENT PLAN.**~~

~~A treatment plan will be developed by the Department, a parent or guardian, and the child, if appropriate, and may include the service provider or service providers. This plan will be specific, measurable, and realistic in the identification of the goal(s), relevant areas of concern, and desired results.~~ ~~(3-17-22)~~

~~**01. Development of Treatment Plan**. A treatment plan will be completed within fifteen (15) days of the date the child was determined eligible for children's mental health services. The parent or guardian must be given the opportunity to participate in the development of the treatment plan and sign it. The parent or guardian must sign the treatment plan indicating their agreement with service needs identified and their participation in its development. If these signatures, indicating participation in the development of the treatment plan are not obtained, the reason the signatures were not obtained must be documented in the record, including the reason for the parent's or guardian's refusal to sign. If the services are court-ordered and the parent or guardian refuses to sign the plan, the refusal must also be documented on the plan. If the services are voluntary and the parent or guardian refuses to sign the plan, the Department may close the case.~~ ~~(3-17-22)~~

~~**02. Annual Development of Treatment Plan**. The Department will develop a plan at least annually. The parent or guardian will be given the opportunity to participate in the annual development of the treatment plan and to sign it.~~ ~~(3-17-22)~~

~~**03. One Hundred Twenty Day Review**. Treatment plans are to be reviewed with the family at least once every one hundred twenty (120) days.~~ ~~(3-17-22)~~

~~**04. Goals and Tasks**. Treatment plans must include a long term goal that identifies specific behavior changes, have measurable desired results, and have specific tasks that identify by whom, how, and when the tasks will be completed.~~ ~~(3-17-22)~~

111. -- 115. (RESERVED)

116. OUTCOMES FOR CHILDREN'S MENTAL HEALTH SERVICES.

Outcomes for children's mental health services are measured through the administration of a satisfaction survey and the Department-approved standardized functional assessment tool. (3-17-22)

~~**117. CASE RECORDS.**~~

~~**01. Electronic and Physical Files**. The Department must maintain an electronic file and a physical file containing information on each child receiving children's mental health services. The physical file may include non-electronic documentation such as originals or copies of all court orders, birth certificates, social security cards, and assessment information that originates outside the Department.~~ ~~(3-17-22)~~

~~**02. Storage of Records**. All physical case records must be stored in a secure file storage area away from public access, and retained not less than five (5) years after the case is closed, after which they may be destroyed.~~ ~~(3-17-22)~~

~~**a.** Exception for Adoption Records. Complete family case records involving adoptive placements must be forwarded to the Department's central adoption unit for permanent storage.~~ ~~(3-17-22)~~

~~**b.** Exception for Case Records Involving an Indian Child. A case record involving an Indian child must be available at any time at the request of an Indian child's tribe or the Secretary of the Interior.~~ ~~(3-17-22)~~

~~**118. USE OF PUBLIC FUNDS AND BENEFITS.**~~

~~Public funds and benefits will be used to provide services for children eligible for services under Section 107 of these rules and their families. Services should be planned and implemented to maximize the support of the family's ability to provide adequate safety and well-being for the child at home. If the child cannot receive adequate services within the family home, the Department will arrange services to minimize the need for institutional or alternate care placement. Services will be individually planned with the family to meet the unique needs of each child and family. The Department will not require a parent or guardian to relinquish custody of the child in order to receive Department funded services.~~ ~~(3-17-22)~~

117. -- 118. (RESERVED)

119. FINANCIAL RESPONSIBILITY OF PARENT(S).
Parent(s) of a child eligible for services under Section 107 of these rules who is receiving outpatient services either directly from the Department, or through Department contracts with private providers, are financially responsible for services provided to their child and to their family, including court-ordered children's mental health services. The financial responsibility for each service will be in accordance with the ability of parent(s) to pay as determined under IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules." Parent(s) will not incur a financial obligation for services provided to their child through a Teens at Risk program. (3-17-22)

~~**120. SLIDING FEE SCHEDULE FOR CHILDREN'S MENTAL HEALTH OUTPATIENT SERVICES.**~~
~~The fee charged to parents for outpatient children's mental health services is determined using the sliding fee schedule under IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules," Section 300.~~ ~~(3-17-22)~~

~~**121. FEE DETERMINATION FOR CHILDREN'S MENTAL HEALTH OUTPATIENT SERVICES.**~~
~~Prior to the delivery of outpatient services, a "Fee Determination" form must be completed by a child's parent when requesting children's mental health services. The fee determination process includes the considerations found under IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules," Section 400.~~ ~~(3-17-22)~~

12~~2~~0. -- 199. (RESERVED)

ALTERNATE CARE PLACEMENT
(Sections 200-299)

200. AUTHORITY FOR ALTERNATE CARE PLACEMENT.
The Department may place a child into alternate care under either of the following conditions in Subsection 200.01 or 200.02 of this rule: (3-17-22)

01. Court Order. The Department may place a child into alternate care when the Department has been ordered by the Court to provide alternate care for a child and the services are medically necessary. ~~(3-17-22)~~( )

~~**a.** A placement agreement must be developed by the Department and the parent or guardian prior to the child's placement in alternate care.~~ ~~(3-17-22)~~

~~**b.** The treatment plan will identify areas of concern, goals, desired outcomes, time frames, tasks, and task responsibilities.~~ ~~(3-17-22)~~

~~**c.** The placement agreement entered into between the Department and a parent or guardian may be revoked with a twenty-four (24) hour notice by the child's parent or guardian. If notice is given by the parent or guardian, the Department will notify the court.~~ ~~(3-17-22)~~

02. Voluntary Placement. The Department may place a child into alternate care with the Department when a parent or guardian is no longer able to maintain a child eligible for services under Section 107 of these rules in the child's home and the Department or its representative/contractor determines that ~~the child would benefit from alternate care and treatment~~ services are medically necessary. ~~(3-17-22)~~( )

~~**a.** A treatment plan, alternate care plan, and a placement agreement must be developed by the Department and the parent or guardian prior to the child's placement in alternate care. The treatment plan will identify areas of concern, goals, desired outcomes, time frames, tasks and task responsibilities.~~ ~~(3-17-22)~~

~~**b.** The placement agreement entered into between the Department and a parent or guardian may be revoked with a twenty-four (24) hour notice by the child's parent or guardian.~~ ~~(3-17-22)~~

201. PROTECTIONS FOR CHILDREN IN ALTERNATE CARE.

~~**01. Statutory Requirements**. The Department must arrange alternate care in accordance with the protections established in:~~ ~~(3-17-22)~~

~~a. The Children's Mental Health Services Act, Title 16, Chapter 24, Idaho Code; (3-17-22)~~

~~b. The Child Protective Act, Title 16, Chapter 16, Idaho Code; and (3-17-22)~~

~~c. The Indian Child Welfare Act, 25 USC 1901, et seq. (3-17-22)~~

0~~2~~1. **Requirement for Licensure**. A child that is placed in alternate care must be placed in a licensed foster home, licensed residential care facility, or in a licensed hospital. (3-17-22)

~~03. Out-of-State Placement. Placement of a child in an alternate care setting outside the state of Idaho requires that the Department comply with the Interstate Compact on the Placement of Children, in accordance with Section 16-2102, Idaho Code. (3-17-22)~~

0~~4~~2. **Least Restrictive Setting**. Whenever possible, the Department will arrange placement: (3-17-22)

a. In the least restrictive setting available that will meet the child's mental health treatment needs; and (3-17-22)

b. That is in close proximity to the parent or guardian. (3-17-22)

c. If the placement does not meet the requirements of Subsections 201.04.a. and 201.04.b. of this rule, the Department or its representative/contractor will provide written justification to the child's parent or guardian by way of the Alternate Care Plan that the placement is in the best interests of the child. ~~(3-17-22)~~( )

0~~5~~3. **Visitation for Child's Parent or Guardian**. Visitation arrangements ~~will be documented in the alternate care plan~~ must be documented in their member record and documented in the Department or their representative/contractor's care management system. ~~(3-17-22)~~( )

~~06. Notification to Parents or Guardians of Change in Placement. (3-17-22)~~

~~a. The Department will provide written notification to the child's parent or guardian no later than seven (7) days after a child's change of placement. (3-17-22)~~

~~b. If an Indian child under jurisdiction of the court is relocated to another alternate care setting, similar notice must be sent to the child's Indian custodian, and the child's tribe. Wherever these rules require notice to the parent or custodian and tribe of an Indian child, notice must also be provided to the Secretary of the Interior by certified mail with return receipt requested to Department of the Interior, Bureau of Indian Services, Division of Social Services, Code 450, Mail Stop 310-SIB, 1849 C Street, N.W., Washington, D.C. 20240. In addition, under 25 CFR Section 23.11, copies of such notices must be sent by certified mail with return receipt requested to the Portland Area Director, Bureau of Indian Affairs, 911 NE 11th Avenue, Portland, OR 97232. If the identity or location of the parent or Indian custodian and the tribe cannot be determined, notice of the proceeding must be given to the Secretary, who will provide notice to the parent or Indian custodian and tribe. (3-17-22)~~

202. (RESERVED)

203. DATE A CHILD ENTERED ALTERNATE CARE.
A child is considered to have entered alternate care on the date the child is actually placed in an alternate care setting. All alternate care benefits, eligibility determinations, and required reviews are based on the date the child entered alternate care. (3-17-22)

~~**204. TITLE XIX ELIGIBILITY.**~~
~~Children placed in alternate care through the Department are eligible for Title XIX, if they meet the eligibility requirements as defined in IDAPA 16.06.01, "Child and Family Services." Application for these programs will be made by Department clinicians on the forms and in the manner prescribed by the Department's Division of Family and Community Services. (3-17-22)~~

204. (RESERVED)

205. ALTERNATE CARE LICENSURE.
All private homes and facilities in Idaho providing alternate care for children under these rules must be licensed in accordance with IDAPA 16.06.02, "Child Care Licensing," unless foster care placement of an Indian child is made with a foster home licensed, approved, or specified by the Indian child's tribe, or an institution for children approved by an Indian tribe or operated by an Indian organization. (3-17-22)( )

206. ALTERNATE CARE CASE MANAGEMENT.
Case management must continue while the child is in alternate care and include the following: (3-17-22)

01. Preparation for Placement. Preparing a child for placement in alternate care is the joint responsibility of the child's parent or guardian, the child (when appropriate), the clinician and the alternate care provider. (3-17-22)

02. Information for Alternate Care Provider. The Department and the child's parent or guardian must inform the alternate care provider of the alternate care provider's roles and responsibilities in meeting the needs of the child and provide the following information to the alternate care provider: (3-17-22)

a. Any medical, health, and dental needs of the child including the names and addresses of the child's doctor, dentist, and other health providers, a record of the child's immunizations, the child's current medications, the child's known medical problems, and any other pertinent health information concerning the child; (3-17-22)

b. The child's current functioning and behaviors; (3-17-22)

c. The child's history, past experiences, and reasons for placement into alternate care; (3-17-22)

d. The child's cultural and racial identity; (3-17-22)

e. Any educational, developmental, or special needs of the child; (3-17-22)

f. Names and addresses of the child's current or last school attended, including homeschool or alternate school, if applicable; (3-17-22)

g. The child's interests and talents; (3-17-22)

h. The child's attachment to current caretakers; (3-17-22)

i. The individualized and unique needs of the child; (3-17-22)

j. Procedures to follow in case of emergency; and (3-17-22)

k. Any additional information that may be required to meet the needs of the child. (3-17-22)

03. Consent for Medical Care. A parent or guardian must sign a Departmental form of consent for medical care and keep the clinician advised of where they can be reached in case of an emergency. Any refusal to give medical consent must be documented in the case record. (3-17-22)

04. Financial Arrangements. The Department is responsible for explaining the financial and payment arrangements to the alternate care provider and must complete the documentation required for payment to the alternate care provider. (3-17-22)

05. Contact Requirements. The child's parent or guardian, the clinician, the alternate care provider, and the child, if of appropriate developmental age, must establish a schedule for frequent and regular visits between the child and the family and the clinician or their designee. (3-17-22)

a. Face-to-face contact between the child and the clinician must occur at least monthly. An in-person

visit must occur within the first thirty (30) days of placement and then the in-person visits must occur at a minimum of quarterly thereafter. (3-17-22)

b. Face-to-face contact between the child's parent or guardian and the clinician must occur at least monthly. (3-17-22)

c. Face-to-face contact between the alternate care provider and the clinician must occur at least monthly. (3-17-22)

d. Frequent and regular contact between the child, the child's parent or guardian, and other family members will be encouraged and facilitated unless it is specifically determined by the Department not to be in the best interest of the child. Such contact will be face-to-face if possible, with this contact augmented by telephone calls, written correspondence, pictures, and the use of video and other technology as may be relevant and available. (3-17-22)

e. When a child is placed in alternate care in another state, a Department clinician must maintain at least monthly contact with the child, the child's family, and the alternate care provider with whom they have been placed as long as the state of Idaho has the placement responsibility for the child, in accordance with Section 200 of these rules. The supervising agency in the state where the child is living will be requested to maintain monthly, face-to-face contact with the child and make quarterly reports to the Department in accordance with arrangements made through the Interstate Compact on the Placement of Children. (3-17-22)

06. Transition Planning. Planning for transition from alternate care will be developed with all concerned parties. Transition planning will be initiated at the time of placement and completed prior to the child's return home or to another living arrangement. A written Transition Plan is part of the Alternate Care Plan and the Treatment Plan. As part of transition planning, efforts are coordinated by the Department and the parents or guardians to expedite access to community and Department services. (3-17-22)

207. – 221. (RESERVED)

222. ALTERNATE CARE PLANNING.
Alternate care planning is mandated by the provisions of Sections 471(a)(15) and 475, P.L. 96-272. (3-17-22)

01. Alternate Care Plan Required. Each child receiving alternate care under the supervision of the state must have a standardized written alternate care plan. (3-17-22)

a. The purpose of the plan is to facilitate the provision of mental health treatment services and the safe return of the child to their own home as expeditiously as possible, or to make other permanent arrangements for the child if such return is not feasible. (3-17-22)

b. The alternate care plan must be included as part of the treatment plan. (3-17-22)

02. Written Alternate Care Plan. The Department must have completed a written alternate care plan within thirty (30) days after a child has been placed in alternate care. (3-17-22)

a. A parent or guardian and the child, to the extent possible, are to be involved in planning, selecting, and arranging the alternate care placement and any subsequent changes in placement. (3-17-22)

b. The alternate care plan must include documentation that a parent or guardian has been provided written notification of: (3-17-22)

i. Visitation arrangements made with the alternate care provider, including any changes in their visitation schedule; (3-17-22)

ii. Any change of placement, when the child is relocated to another alternate care or institutional setting as soon as possible, but no later than seven (7) days after placement; and (3-17-22)

~~iii. Their right to discuss any changes and to seek recourse if they disagree with any changes in visitation or other alternate care arrangements.~~ (3-17-22)

~~**c.** All parties involved in developing the alternate care plan, including the alternate care provider, parent or guardian, and the child, if of appropriate developmental age:~~ (3-17-22)

~~i. Will be asked by the Department to sign the alternate care plan that includes a statement indicating that they have read and understood the alternate care plan; and~~ (3-17-22)

~~ii. Will receive a copy of the alternate care plan from the Department.~~ (3-17-22)

2~~23~~06. -- 235. (RESERVED)

236. PARENTAL FINANCIAL SUPPORT FOR CHILDREN IN ALTERNATE CARE.
In accordance with Sections 56-203B and 16-2406, Idaho Code, parent(s) are responsible for costs associated with the care of their child in alternate care. (3-17-22)

~~**01. Notice of Parental Responsibility**. The Department will provide the parent(s) with written notification of their responsibility to contribute toward the cost of their child's support, treatment, and care, including clothing, medical, incidental, and educational costs.~~ (3-17-22)

~~**02. Financial Arrangements with Parent(s)**. Parent(s) are responsible to reimburse the Department for the costs of alternate care when their child is placed in alternate care in accordance with a court order or voluntary placement agreement. Parents are expected to contribute to the cost of their child's care, but parents will not be asked to pay more than the actual cost of care, including clothing, medical, incidental, and educational costs.~~ (3-17-22)

~~**237. SUPPORT AGREEMENTS AND SUPPORT ORDERS.**~~

~~**01. Support Agreement for Voluntary Placement**. If the placement is voluntary, a parent must sign a support agreement that specifies the amount of support to be paid to the Department, when it is to be paid, and the address to which it is to be paid.~~ (3-17-22)

~~**02. Support Order for Payment of Involuntary Placement Costs**. In the case of a court-ordered placement, if no support agreement has been reached with a parent prior to the court hearing, the Department may request the Court hold a support hearing to establish a support order for payment of involuntary placement costs.~~ (3-17-22)

~~**238. -- 239. (RESERVED)**~~

~~**240. INSURANCE COVERAGE.**~~
~~The parent or guardian must inform the Department of all insurance policies covering the child, including names of carriers, and policy or subscriber numbers. If medical, health, and dental insurance coverage is available for the child, the parent must acquire and maintain such insurance.~~ (3-17-22)

~~**241. MEDICAL CARD FOR CHILDREN IN ALTERNATE CARE.**~~
~~The Department will issue a medical card to cover medical expenses for each child placed in alternate care.~~ (3-17-22)

~~**242. -- 243. (RESERVED)**~~

~~**244. MEDICAL EMERGENCIES.**~~
~~In case of serious illness, the alternate care provider must immediately seek medical attention for the child and notify the Department as soon as possible. A parent or guardian, the court in an emergency, or the Department, if it is the guardian of the child, has the authority to consent to major medical care or hospitalization in accordance with Section 39-4504, Idaho Code.~~ (3-17-22)

~~**245. DENTAL CARE.**~~

Each child age three (3) years or older, who is placed in alternate care, must receive a dental examination as soon as possible after placement, but not later than ninety (90) days, and thereafter according to a schedule prescribed by the dentist. (3-17-22)

01. Costs Paid by Medicaid. If dental care not included in the state medical assistance program is recommended, a request for payment will be submitted to the state Medicaid dental consultant. (3-17-22)

02. Emergencies. Emergency dental services will be provided for children in alternate care and paid for by the Department, if there are no other financial resources available. (3-17-22)

246. COSTS OF PRESCRIPTION DRUGS.
The Department will purchase prescribed drugs, at the Medicaid rate, for a child in alternate care through participating pharmacies. (3-17-22)

247. MEDICAL EXAMINATION UPON ENTERING ALTERNATE CARE.
Within thirty (30) days of entering alternate care, each child will receive a medical examination to assess the child's health status, and thereafter according to a schedule prescribed by the child's physician or other health care professional. (3-17-22)

248. – 250. (RESERVED)

251. DRIVERS' TRAINING AND LICENSES FOR CHILDREN IN ALTERNATE CARE.
Only a parent or guardian of a child in alternate care may authorize drivers' training, provide payment, and sign for drivers' licenses and permits. (3-17-22)

252. – 282. (RESERVED)

283. PAYMENT TO FAMILY ALTERNATE CARE PROVIDERS.
Monthly payments for care provided by family alternate care providers are paid according to IDAPA 16.06.01, "Child and Family Services." (3-17-22)

01. Gifts. Additional payments for Christmas gifts and birthday gifts will be paid in the appropriate months. (3-17-22)

02. Clothing. Costs for clothing will be paid, based upon the Department's determination of each child's needs. All clothing purchased for a child in alternate care becomes the property of the child. (3-17-22)

03. School Fees. School fees due upon enrollment will be paid directly to the school or to the foster parents, based upon the Department's determination of the child's needs. (3-17-22)

284. ADDITIONAL PAYMENTS TO FAMILY ALTERNATE CARE PROVIDERS.
For those children who, as determined by the Department, require additional care above room, board, shelter, daily supervision, school supplies, and personal incidentals, the Department may pay the family alternate care provider an additional amount to that paid according to IDAPA 16.06.01, "Child and Family Services." The family alternate care rate is based upon a continuous ongoing assessment of the child's circumstances that necessitate special rates as well as the care provider's ability, activities, and involvement in addressing those special needs. (3-17-22)

01. Lowest Level of Need. A child requiring a mild degree of care for documented conditions receives the lowest level of additional payments for the following: (3-17-22)

a. Chronic medical problems; (3-17-22)

b. Frequent, time-consuming transportation needs; (3-17-22)

c. Behaviors requiring extra supervision and control; and (3-17-22)

d. Need for preparation for independent living. (3-17-22)

02. **Moderate Level of Need**. A child requiring a moderate degree of care for documented conditions receives the moderate level of additional payments for the following: (3-17-22)

a. Ongoing major medical problems; (3-17-22)

b. Behaviors that require immediate action or control; and (3-17-22)

c. Alcohol or other substance use disorder. (3-17-22)

03. **Highest Level of Need**. A child requiring an extraordinary degree of care for documented conditions receives the highest level of additional payments for the following: (3-17-22)

a. Serious emotional or behavioral disorder that requires continuous supervision; (3-17-22)

b. Severe developmental disability; and (3-17-22)

c. Severe physical disability such as quadriplegia. (3-17-22)

04. **Reportable Income**. Additional payments for more than ten (10) qualified children received during any calendar year must be reported as income to the Internal Revenue Service. (3-17-22)

285. – 599. **(RESERVED)**

600. **TREATMENT FOSTER CARE.**
A family home setting in which treatment foster parents provide twenty four (24) hour room and board as well as therapeutic services and a high level of supervision. Services provided in treatment foster care are at a more intense level than provided in foster care and at a lower level than provided in residential care. Services may include the following: participation in the development and implementation of the child's treatment plan, behavior modification, community supports, crisis intervention, documentation of services and the child's behavior, participation as a member of a multi-disciplinary team, and transportation. Placement into a treatment foster home for children eligible for services under Section 107 of these rules is based on the documented needs of the child, the inability of less restrictive settings to meet the child's needs, and the clinical judgment of the Department. (3-17-22)

01. **Qualifications**. Prior to being considered for designation and reimbursement as a treatment foster parent, each prospective treatment foster parent must accomplish the following: (3-17-22)

a. Meet all foster family licensure requirements as set forth in IDAPA 16.06.02, "Child Care Licensing"; (3-17-22)

b. Complete Department approved treatment foster care initial training; and (3-17-22)

c. Provide a minimum of two (2) references in addition to those provided to be licensed to provide foster care. The additional references must be from individuals who have worked with the prospective treatment foster parent. The additional references must verify that the prospective treatment foster parent has: (3-17-22)

i. Training related to, or experience working with, children or youth with mental illness or behavior disorders; and (3-17-22)

ii. Demonstrated cooperation and a positive working relationship with families and providers of mental health services. (3-17-22)

02. **Continuing Education**. Following designation as a treatment foster home, each treatment foster home parent must complete fourteen (14) hours of additional training per year as specified in an agreement developed between the treatment foster parents and the Department. (3-17-22)

03. **Availability**. At least one (1) treatment foster parent in each treatment family home must be

available twenty-four (24) hours a day, seven (7) days a week to respond to the needs of the foster child. (3-17-22)

04. Payment. The Department will pay treatment foster parents up to one thousand eight hundred ($1,800) dollars per month per child, which includes the monthly payment rate specified in Sections 283 and 284 of these rules. The payment will be made to treatment foster parents in accordance with a contract with the Department. The purpose of the contract is to make clear that the treatment foster parents must fulfill the requirements for treatment foster parents under the treatment plan referenced in Subsection 600.06 of this rule. (3-17-22)

05. Payment to Contractors. The Department may also provide treatment foster care through a contract with an agency that is a private provider of treatment foster care. The Department will specify the rate of payment in the contract with the agency. (3-17-22)

06. Treatment Plan. The treatment foster parent(s) must implement the portions of the Department-approved treatment plan for which they are designated as responsible for each child in their care. This plan is incorporated as part of the treatment plan identified in Section 115 of these rules. (3-17-22)

601. – 699. (RESERVED)

700. RESIDENTIAL CARE FACILITIES.
Residential care facilities provide a more intensive setting than treatment foster care. Residential care facilities in Idaho are licensed under IDAPA 16.06.02, "Child Care Licensing" to provide residential care for children and staffed by employees who cover assigned shifts. Children placed in residential care facilities receive services that may include the following: assessment, supervision, treatment plan development and implementation, documentation, behaviorally focused skill building, service coordination or clinical case management, consultation, psychotherapy, psychiatric care, and twenty-four (24) hour crisis intervention. Placement into a residential care facility for children eligible for services under Section 107 of these rules is based on the documented needs of the child and the inability of less restrictive settings to meet the child's needs. (3-17-22)

01. Prior Authorization. Prior authorization must be obtained from an authorized representative in the Department's Division of Behavioral Health for placement of a child in a residential care facility where the Division of Behavioral Health is making full or partial payment. (3-17-22)

02. Payment. When care is purchased from private providers, payment will be made in accordance with a contract authorized by the Department, based on the needs of each child being placed and the services to be provided. (3-17-22)

701. – 799. (RESERVED)

800. SIX MONTH REVIEWS FOR CHILDREN IN ALTERNATE CARE PLACEMENTS.
A review is to occur at the end of a six (6) month period for any child in an alternate care placement. The Department will conduct a case review to assure compliance with all applicable state and federal laws, and to ensure the treatment plan focuses on the goals of safety, permanency, effectiveness of treatment, and well-being of the child. The Department may request the court hold a review hearing for the child in accordance with Section 16-2407(3), Idaho Code. (3-17-22)

01. Notice of Six Month Review. The parent or guardian, foster parent of a child, or relative providing care for the child is to be provided with notice of their right to be heard in the six (6) month review. In the case of an Indian child, the child's tribe and any Indian custodian must also be provided with notice. This must not be construed to require that any foster parent, or relative providing care for the child be made a party to the review solely on the basis of the receipt of such notice. Participants have the right to be represented by the individual of their choice. (3-17-22)

02. Procedure in the Six Month Review. The parties who received notice will be given the opportunity to participate in the case review. (3-17-22)

03. Members of Six Month Review Panel. The six (6) month review panel must include a Department employee who is not in the direct line of supervision in the delivery of services to the child or parent or guardian. The

~~review panel may include agency staff, staff of other agencies, officers of the court, members of Indian tribes, and citizens qualified by experience, professional background, or training. Members of the panel will be chosen by and receive instructions from an authorized representative in the Department's Division of Behavioral Health, to enable them to understand the review process and their roles as participants.~~ ~~(3-17-22)~~

~~**04. Considerations in Six Month Review**. Whether conducted by the court in a review hearing or a Department review panel, under state law, federal law and regulation, each of the following must be addressed in a six (6) month review:~~ ~~(3-17-22)~~

~~**a.** Determine the extent of compliance with the treatment plan;~~ ~~(3-17-22)~~

~~**b.** Determine the extent of progress made toward alleviating or mitigating the causes necessitating the placement;~~ ~~(3-17-22)~~

~~**c.** Review compliance with the Indian Child Welfare Act, when applicable;~~ ~~(3-17-22)~~

~~**d.** Determine the safety of the child, the continuing need for and appropriateness of the child's placement; and~~ ~~(3-17-22)~~

~~**e.** Project a date by which the child may be returned and safely maintained at home or placed for adoption, guardianship, or other permanent placement.~~ ~~(3-17-22)~~

~~**05. Recommendations and Conclusions of Six Month Review Panel**. Following the six (6) month review, written conclusions and recommendations will be provided to all participants, subject to Department safeguards for confidentiality. The document containing the written conclusions and recommendations must also include appeal rights.~~ ~~(3-17-22)~~

~~801~~237. -- 999. (RESERVED)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.03.01 – RULES OF THE STATE BOARD OF CHIROPRACTIC PHYSICIANS

DOCKET NO. 24-0301-2401 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1, 2025, in the year of the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

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 67-2604, Idaho Code, Sections 67-9404, 67-9405, 67-9406, 67-9409, and 67-9413, Idaho Code, and Sections 54-701 through 54- 717, 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 under Executive Order 2020-01, Zero Based Regulation. Text amended since these rules were published as proposed are purely administrative in nature. No substantive changes are made. The change can be found in Appendix A, Section 2 where the reference to Rule 450 was removed as it no longer exists.

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 July 3, 2024 Idaho Administrative Bulletin, Vol. 24-7, pages 187-204.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

As authorized in Section 54-707A, Idaho Code, the fee(s) in this rulemaking are established in Rule 400. None of these fees are being changed as a result of this rulemaking or since being previously reviewed by the Idaho Legislature.

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 is not anticipated to have any negative fiscal impact on the State General Fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Krissy Veseth, Bureau Chief, at (208) 577-2491. Materials pertaining to the pending rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

DATED this 30th day of August, 2024.

Krissy Veseth
Bureau Chief
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 577-2491
Email: krissy.veseth@dopl.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. This rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, Sections 67-9404, 67-9405, 67- 9406, 67-9409, and 67-9413, Idaho Code, and Sections 54-701 through 54-717, Idaho Code.

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

24.03.01 – Rules of the State Board of Chiropractic Physicians

Tuesday, July 16, 2024 – 9 a.m. (MT)
Division of Occupational and Professional Licenses
Coolwater Room, Chinden Campus Building 4
11341 W. Chinden Blvd.,
Boise, ID 83714

Virtual Meeting Link

Telephone and web conferencing information will be posted on https://dopl.idaho.gov/calendar/ and https://townhall.idaho.gov/.

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

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

Under Executive Order 2020-01, Zero-Based Regulation, the Idaho State Board of Chiropractic Physicians is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the proposed rule changes reflect a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. This proposed rulemaking updates the rules to comply with governing statute and Executive Order 2020-01.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A. The fees did not change.

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:

This rulemaking is not anticipated to have any negative fiscal impact on the State General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted under Docket No. 24-ZBRR-2401. The Omnibus Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 3, 2024, Idaho Administrative Bulletin, Vol. 24-4, p.41.

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. No materials have been incorporated by reference into the proposed rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this proposed rule, contact Krissy Veseth, Bureau Chief, at (208) 577-2491. Materials pertaining to the proposed rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 24, 2024.

DATED June 7, 2024.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 24-0301-2401

***Italicized text* indicates amendments to the proposed text as adopted in the pending rule.**

24.03.01 – RULES OF THE STATE BOARD OF CHIROPRACTIC PHYSICIANS

000. LEGAL AUTHORITY.
These rules are promulgated pursuant to Section 54-707, Idaho Code. (3-28-23)

001. SCOPE.
These rules govern the practice of chiropractic in Idaho. (3-28-23)

002. -- 009. (RESERVED)

010. DEFINITION.

01. Chiropractic Assistant. A chiropractic assistant is an individual functioning in a dependent relationship with a supervising chiropractic physician in the performance of any chiropractic practice. (3-28-23)

02. Chiropractic Intern. A chiropractic intern is defined as any individual who is presently enrolled in a school of chiropractic and is qualified to practice as an intern as established by the approved chiropractic ~~college~~ program that the individual attends and who will function in a dependent relationship with a supervising chiropractic physician in the performance of chiropractic practice. ~~(3-28-23)~~( )

03. Direct Personal Supervision. Direct Personal Supervision means that the licensed chiropractic physician is physically present in the clinic, is monitoring the activities of the supervisee, and is available to intervene, if necessary. (3-28-23)

~~**04. Inactive Retired**. The status of a licensee who is over sixty-five (65) years of age, has paid the inactive retired fee and is permanently retired from the practice of chiropractic. The holder of an inactive retired license may not practice chiropractic in Idaho.~~ ~~(3-28-23)~~

04. Clinical Nutritional Practice. Clinical nutritional methods, without clinical nutrition certification, is defined as the clinical use, administration, recommendation, prescribing, selling, and distributing over-the-counter vitamins, minerals, botanical medicine, herbals, homeopathic, phytonutrients, antioxidants, enzymes, glandular extracts, peptides, amino acids, and durable and non-durable medical goods and devices. ( )

011. -- 099. (RESERVED)

100. ~~APPLICATIONS~~LICENSURE.

01. Qualifications. (3-28-23)

a. New applicants will meet the following requirements: (3-28-23)

i. Successful passage of all ~~N~~national ~~B~~boards ~~Parts I, II, III, and IV~~ administered at the time of application, or other examinations approved by the Board; ~~(3-28-23)~~( )

ii. ~~Graduation from a Council on Chiropractic Education (CCE) approved college or university; and~~Graduation from a chiropractic school, college, or, or other programs as approved by the Board. ~~(3-28-23)~~( )

~~iii. Applicants will be required to sign an affidavit swearing under oath that they have fully reviewed and understand and will abide by the Chiropractic Act, Title 54, Chapter 7, Idaho Code, and the Board's Rules, IDAPA 24, Title 03, Chapter 01, "Rules of the State Board of Chiropractic Physicians." (3-28-23)~~

b. Endorsement applicants will meet the following requirements: (3-28-23)

i. Successful passage of the ~~N~~national ~~B~~boards ~~Parts~~ which were in effect at the time of graduation from chiropractic college ~~and physiotherapy~~, or other examinations approved by the Board; ~~(3-28-23)~~( )

ii. ~~If licensed prior to January, 1980, CCE approved college or university not required. If licensed after January, 1980, applicant must have graduated from a CCE approved college or university~~Graduation from a program accredited by agency recognized by the U.S. Department of Education or other program approved by the Board; ~~(3-28-23)~~( )

iii. Five (5) years of consecutive practice without discipline immediately prior to application and holds a current, valid license to practice in a state, territory, or district of the United States or Canada; (3-28-23)

~~iv. Applicants demonstrate that they possess the requisite qualifications to provide the same standard of chiropractic care as provided by physicians in this state. The Board may, in its sole discretion, require further examination to establish such qualifications, such as passage of the National Board Special Purposes Examination for Chiropractors (SPEC); and (3-28-23)~~

~~v. Applicants sign an affidavit swearing under oath that they have fully reviewed and understand and will abide by the Chiropractic Act, Title 54, Chapter 7, Idaho Code, and the Board's Rules, IDAPA 24, Title 03, Chapter 01, "Rules of the State Board of Chiropractic Physicians." (3-28-23)~~

02. Continuing Education. All licensees must comply with the following continuing education requirements: ( )

a. Applicants for renewal are required to complete a minimum of thirty-six (36) hours of continuing education within the preceding twenty-four (24) months, as approved by the Board. ( )

b. Each licensee is responsible for maintaining documentation verifying continuing education compliance. ( )

c. The Board may waive the requirements of this rule for reasons of individual hardship including health or other good cause. The licensee should request the waiver in advance of renewal and must provide any information requested by the Board to assist in substantiating hardship cases. This waiver is granted at the sole discretion of the Board. ( )

d. Continuing education hours not claimed in the current renewal cycle may be claimed in the next renewal cycle. Hours may be carried forward from the immediately preceding cycle, and may not be carried forward more than one renewal cycle. ( )

e. A licensee is exempt from the continuing education requirements under this section for the period between the initial issuance of the original license and the first expiration date of that license. ( )

f. Approved continuing education courses are those courses, programs, and activities that are germane to the practice of chiropractic, as defined in Sections 54-704(1) and (2), Idaho Code, and meet the general requirements and content requirements of these rules, and are approved, sponsored, or provided by the following entities or organizations, or otherwise approved by the Board: ( )

i. A college or university accredited by a nationally recognized accrediting agency as recognized by the United States Department of Education; ( )

ii. American Medical Association Physicians Recognition Award (AMA PRA) certified continuing education activities as certified by the American Medical Association (AMA) or other accreditors; ( )

iii. Providers of Approved Continuing Education (PACE); ( )

iv. Other courses may be approved by the Board based upon documentation submitted by the licensee on a board approved form. ( )

03. Inactive License Status Renewal. ( )

a. An inactive license must be renewed biennially by submitting the established fee and renewal application. Inactive licenses not renewed will be canceled. ( )

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 in Idaho. ( )

04. Return to Active Status of License Inactive for Six (6) or Fewer Years. An inactive license holder whose license has been inactive for six (6) or fewer years may convert from inactive to active license status by: ( )

a. Making written application to the Board on a form prescribed by the Board; ( )

b. Providing documentation to the Board showing successful completion within the previous twenty-four (24) months of the continuing education requirements for renewal of an active license; and ( )

c. Paying a fee equivalent to the difference between the current inactive fee and the active renewal fee. ( )

05. Return to Active Status of License Inactive for More Than Six (6) Years. An inactive license holder whose license has been inactive for more than six (6) years may convert from inactive to active license status by: ( )

a. Making written application to the Board on a form prescribed by the Board. ( )

b. Providing an account to the Board for that period of time during which the license was inactive and fulfilling requirements that demonstrate competency to resume practice. Those requirements may include, but are not limited to, education, supervised practice, and examination as determined by the Board. The Board may consider practice in another jurisdiction in determining competency. ( )

c. Paying a fee equivalent to the difference between the current inactive fee and the active renewal fee. ( )

06. Practice Permits. Only one (1) permit may be issued under any circumstances to any individual. Such permit will be valid for a period not to exceed twelve (12) months: ( )

a. Temporary permits will be invalidated when an applicant has failed any attempted examination for licensure in this or any other state, territory, possession, or country more than once. Failure to sit for the next scheduled examination will invalidate the temporary permit and no further permits will be issued. ( )

b. Intern permits expire upon graduation. ( )

101. -- 149. (RESERVED)

~~150. FEES.~~
~~All fees are non-refundable.~~

~~Fee Type~~	~~Amount (Not to Exceed)~~
~~Application~~	~~$200~~
~~Original license~~	~~$200~~
~~Annual renewal~~	~~$200~~
~~Inactive license~~	~~$150~~
~~Reinstatement of expired license~~	~~$35~~
~~Reinstatement of inactive license~~	~~$150~~
~~Temporary permit~~	~~$150~~
~~Intern permit~~	~~$150~~
~~Application for clinical nutrition certification~~	~~$175~~
~~Original for clinical nutrition certification~~	~~$175~~
~~Clinical nutrition certification renewal~~	~~$175~~

~~(3-28-23)~~

150. EDUCATION.
Requirement for Approval. The Board will consider any college, domestic or foreign, which meets standards as determined by the Board and teaches accredited courses in all the subjects set forth in Sections 54-704(1) and 54-709(1)(b), Idaho Code. ( )

151. -- 199. (RESERVED)

200. ~~EXAMINATIONS~~PRACTICE STANDARDS.
~~It is the applicant's duty to take and successfully pass the National Board Examinations administered by the National Board of Chiropractic Examiners as specified in these rules.~~ ~~(3-28-23)~~

01. Code of Ethics. Chiropractic physicians are responsible for maintaining and promoting ethical practice in accordance with the ethical principles set forth in Appendix A in these rules. ( )

02. Chiropractic Assistants. The chiropractic physician is responsible and liable for: ( )

a. Direct personal supervision; ( )

b. Any acts of the assistant in the performance of chiropractic practice; ( )

c. Proper training and capabilities of the chiropractic assistant before authorization is given to perform any chiropractic practice or patient education. ( )

03. Chiropractic Assistant Limitations. A chiropractic assistant must not: ( )

a. Manipulate articulations; ( )

b. Interpret diagnostic results for the patient; ( )

c. Provide treatment advice to any patient. ( )

04. **Chiropractic Interns**. The chiropractic physician is responsible and liable for: ( )

a. Direct personal supervision of the intern; ( )

b. Any acts of the intern in the performance of chiropractic practice; ( )

c. Determining that the intern possesses sufficient training and capabilities before authorization is given to perform any chiropractic practice. ( )

05. **Chiropractic Intern Limitations**. A chiropractic intern must not: ( )

a. Perform any chiropractic practice independently, but must perform all such practice under the direct personal supervision of a licensed Chiropractic Physician; ( )

b. Provide diagnostic results or interpretations to the patient prior to consultation with the supervising Chiropractic Physician; ( )

c. Provide treatment advice to any patient without instructions from the supervising Chiropractic Physician. ( )

201. -- ~~299~~399. (RESERVED)

~~**300. INACTIVE LICENSE.**~~
~~A licensee holding a current active license in this state who is not practicing chiropractic in this state may be issued an inactive license in accordance with Section 54-708(2), Idaho Code, as follows:~~ ~~(3-28-23)~~

~~**01. Inactive Status**. Each application for an Inactive status license must be accompanied by:~~ ~~(3-28-23)~~

~~**a.** The established fee; and~~ ~~(3-28-23)~~

~~**b.** A written application to change a current active license to an inactive license.~~ ~~(3-28-23)~~

~~**c.** An inactive license is issued for one (1) year.~~ ~~(3-28-23)~~

~~**02. Inactive License Status Renewal**.~~ ~~(3-28-23)~~

~~**a.** An inactive license must be renewed annually by submitting the established fee and renewal application. Inactive licenses not renewed will be canceled.~~ ~~(3-28-23)~~

~~**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.~~ ~~(3-28-23)~~

~~**03. Return to Active Status of License Inactive for Five (5) or Fewer Years**. An inactive license holder whose license has been inactive for five (5) or fewer years may convert from inactive to active license status by:~~ ~~(3-28-23)~~

~~**a.** Making written application to the Board on a form prescribed by the Board;~~ ~~(3-28-23)~~

~~**b.** Providing documentation to the Board showing successful completion within the previous twelve (12) months of the continuing education requirements for renewal of an active license; and~~ ~~(3-28-23)~~

c. Paying a fee equivalent to the difference between the current inactive fee and the active renewal fee. (3-28-23)

04. Return to Active Status of License Inactive for More Than Five (5) Years. An inactive license holder whose license has been inactive for more than five (5) years may convert from inactive to active license status by: (3-28-23)

a. Making written application to the Board on a form prescribed by the Board. (3-28-23)

b. Providing an account to the Board for that period of time during which the license was inactive and fulfilling requirements that demonstrate competency to resume practice. Those requirements may include, but are not limited to, education, supervised practice, and examination as determined by the Board. The Board may consider practice in another jurisdiction in determining competency. (3-28-23)

c. Paying a fee equivalent to the difference between the current inactive fee and the active renewal fee. (3-28-23)

05. Clinical Nutrition Certificate Expires. If a licensee holds a clinical nutrition certificate and places their license on inactive status, the clinical nutrition certificate is immediately canceled as though the license was not timely renewed as provided in Section 703 of these rules. (3-28-23)

06. Reissuance of Clinical Nutrition Certificate. An inactive license holder who held a clinical nutrition certificate at the time their license was placed on inactive status who returns to active license status pursuant to this rule may be reissued a clinical nutrition certificate by showing proof of compliance with the provisions of Sections 704, 705, and 706 that apply to their situation. (3-28-23)

301. – 349. (RESERVED)

350. CONTINUING EDUCATION.
All licensees must comply with the following continuing education requirements: (3-28-23)

01. Requirement. Applicants for renewal are required to complete a minimum of eighteen (18) hours of continuing education within the preceding twelve (12) months, as approved by the Board. (3-28-23)

a. Continuing education credit will only be given for actual time in attendance or for the time spent participating in the educational activity. (3-28-23)

b. The educational setting may include a classroom, conference/seminar, on line, or a virtual classroom. (3-28-23)

c. If the licensee completes two (2) or more courses having substantially the same content during any one (1) renewal period, the licensee only will receive continuing education credit for one (1) of the courses. (3-28-23)

02. Documentation. Each licensee maintains documentation verifying continuing education attendance and curriculum for a period of five (5) years from the date of completion. This documentation will be subject to audit by the Board. (3-28-23)

a. Documented evidence of meeting the continuing education requirement will be in the form of a certificate or letter from the sponsoring entity that includes verification of attendance by the licensee, the title of the activity, the subject material covered, the dates and number of hours credited, and the presenter's full name and professional credentials. (3-28-23)

b. A licensee must submit the verification documentation to the Board if requested by the Board. In the event a licensee fails to provide the Board with acceptable documentation of the hours attested to on the renewal application, the licensee may be subject to disciplinary action. (3-28-23)

03. Waiver. The Board may waive the requirements of this rule for reasons of individual hardship including health or other good cause. The licensee should request the waiver in advance of renewal and must provide any information requested by the Board to assist in substantiating hardship cases. This waiver is granted at the sole discretion of the Board. (3-28-23)

04. Carryover of Continuing Education Hours. Continuing education hours not claimed in the current renewal year may be claimed in the next renewal year. Hours may be carried forward from the immediately preceding year, and may not be carried forward more than one renewal year. (3-28-23)

05. Exemption. A licensee is exempt from the continuing education requirements under this section for the period between the initial issuance or the original license and the first expiration date of that license. (3-28-23)

06. Continuing Education Activities. The following educational activities qualify for continuing education: (3-28-23)

a. Post-graduate education courses, germane to chiropractic practice as approved by the Board. (3-28-23)

b. Attendance at Board meetings. (3-28-23)

351. APPROVAL OF CONTINUING EDUCATION COURSES.

01. Approved Continuing Education Courses. Approved continuing education courses are those courses, programs, and activities that are germane to the practice of chiropractic, as defined in Sections 54-704(1) and (2), Idaho Code, and meet the general requirements and content requirements of these rules, and are approved, sponsored, or provided by the following entities or organizations, or otherwise approved by the Board: (3-28-23)

a. Council of Chiropractic Education (CCE) approved chiropractic college or university, a college or university accredited by a nationally recognized accrediting agency as recognized by the United States Secretary of Education or an educational program approved by the Board; (3-28-23)

b. Providers of Approved Continuing Education (PACE); (3-28-23)

c. National and state chiropractic associations; and (3-28-23)

d. Provider Course Approval. Other courses that may be approved by the Board based upon documentation submitted by a continuing education provider. Requests for approval of courses made by the provider must be submitted on a form approved by the Board that includes: (3-28-23)

i. The nature and subject of the course and how it is germane to the practice of chiropractic; (3-28-23)

ii. The name of the instructor(s) and their qualifications; (3-28-23)

iii. The date, time, and location of the course; (3-28-23)

iv. The specific agenda for the course; (3-28-23)

v. The number of continuing education hours requested; (3-28-23)

vi. The procedures for verification of attendance; and (3-28-23)

vii. Other information as may be requested by the Board. (3-28-23)

viii. Upon review of all information requested, the Board may deny any request for a course that does not meet the requirements of Idaho law or rule. Board approval of a course will be granted for a period not to exceed

~~two (2) years or until the course materials or instructors are changed, whichever may occur first.~~ ~~(3-28-23)~~

~~**02. Licensee Course Approval**. Other courses that may be approved by the Board based upon documentation submitted by the licensee. All requests for approval must be made to the Board in writing and include the nature and subject of the course and its relevancy to the practice of chiropractic, name of instructor(s) and their qualifications, date, time and location of the course, and procedures for verification of attendance.~~ ~~(3-28-23)~~

~~**352. -- 399. (RESERVED)**~~

~~**400. APPROVED SCHOOLS OF CHIROPRACTIC.**~~

~~**01. Requirement for Approval**.~~ ~~(3-28-23)~~

~~**a.** The Board will consider a school, college, or university in good standing only if such school, college, or university conforms to the requirements of "recognized candidate for accreditation," or "accredited" of the Council of Chiropractic Education or any foreign country college which meets equivalent standards as determined by the Board and teaches accredited courses in all the subjects set forth in Section 54-709(1)(b), Idaho Code.~~ ~~(3-28-23)~~

~~**b.** Regardless of the Council on Chiropractic Education status, the Board may make additional requirements for approval as a reputable school, college or university of Chiropractic.~~ ~~(3-28-23)~~

~~**02. New Schools**. Those graduates of new schools of chiropractic will only be accepted for licensure application provided the school reaches "recognized candidate for accreditation" status with the Council on Chiropractic Education within one year following the first graduating class.~~ ~~(3-28-23)~~

400. FEES.
All fees are non-refundable.

Fee Type	Amount (Not to Exceed)
Application	$200
Original license	$200
Annual renewal	$200
Inactive license	$150
Reinstatement of expired license	$35
Reinstatement of inactive license	$150
Temporary permit	$150
Intern permit	$150
Application for clinical nutrition certification	$175
Original for clinical nutrition certification	$175
Clinical nutrition certification renewal	$175

( )

401. -- ~~449~~699. (RESERVED)

~~**450. ADVERTISEMENTS.**~~

~~**01. Prohibited Advertising**. A chiropractor must not disseminate or cause the dissemination of any advertisement or advertising which is any way fraudulent, false, deceptive or misleading. Any advertisement or advertising will be deemed by the Board to be fraudulent, false, deceptive, or misleading if it:~~ ~~(3-28-23)~~

~~a. Is likely to deceive, defraud, or harm the public; or (3-28-23)~~

~~b. Uses false or misleading statement(s) regarding a chiropractor's skill or the efficacy or value of the chiropractic medicine, treatment, or remedy prescribed by a chiropractor or at a chiropractor's direction in the treatment of any disease or other condition of the body or mind. (3-28-23)~~

~~451. -- 549. (RESERVED)~~

~~550. CHIROPRACTIC ASSISTANTS.~~

~~01. Chiropractic Physician Responsible and Liable. The chiropractic physician is responsible and liable for: (3-28-23)~~

~~a. Direct personal supervision; (3-28-23)~~

~~b. Any acts of the assistant in the performance of chiropractic practice; (3-28-23)~~

~~c. Proper training and capabilities of the chiropractic assistant before authorization is given to perform any chiropractic practice. (3-28-23)~~

~~02. Chiropractic Assistant Limitations. A chiropractic assistant must not: (3-28-23)~~

~~a. Manipulate articulations; (3-28-23)~~

~~b. Provide diagnostic results or interpretations to the patient; (3-28-23)~~

~~c. Provide treatment advice to any patient without instructions from the supervising Chiropractic Physician. (3-28-23)~~

~~551. CHIROPRACTIC INTERN.~~

~~01. Chiropractic Physician Responsible and Liable. The chiropractic physician is responsible and liable for: (3-28-23)~~

~~a. Direct personal supervision of the intern; (3-28-23)~~

~~b. Any acts of the intern in the performance of chiropractic practice; (3-28-23)~~

~~c. Determining that the intern possesses sufficient training and capabilities before authorization is given to perform any chiropractic practice. (3-28-23)~~

~~02. Chiropractic Intern Limitations. A chiropractic intern must not: (3-28-23)~~

~~a. Perform any chiropractic practice independently, but must perform all such practice under the direct personal supervision of a licensed Chiropractic Physician; (3-28-23)~~

~~b. Provide diagnostic results or interpretations to the patient prior to consultation with the supervising Chiropractic Physician; (3-28-23)~~

~~c. Provide treatment advice to any patient without instructions from the supervising Chiropractic Physician. (3-28-23)~~

~~552. TEMPORARY PRACTICE PERMITS.~~
~~When an original application for license or internship is accepted by the board as being fully completed, in accordance with the requirements of the Idaho Chiropractic Physician Law and these Rules, a temporary permit to practice may be issued. (3-28-23)~~

01. Supervision Required. A permit holder may work only when under the direct personal supervision of a chiropractic physician currently licensed in Idaho. The name, address, and signature of the supervising chiropractic physician will appear on the application. (3-28-23)

02. Only One Permit May Be Issued. Only one (1) permit may be issued under any circumstances to any individual. (3-28-23)

03. Validity of Temporary Permits. Temporary permit to practice will be valid for a period not to exceed twelve (12) months and only: (3-28-23)

a. In the case of an applicant for Idaho licensure, until the results of the next scheduled examination have been released. No work permit will be issued to an applicant who has previously failed an examination for licensure in this or any other state, territory, possession, or country more than once. Failure to sit for the next scheduled examination will invalidate the work permit and no further permits will be issued. (3-28-23)

b. In the case of an intern, until the scheduled date of graduation from an approved school of chiropractic. Upon original application for licensure in Idaho, the intern permit may be extended by the board until the results of the next scheduled examination have been released. No work permit will be issued to an applicant who has previously failed an examination for licensure in this or any other state, territory, possession, or country more than once. Failure to sit for the next scheduled examination will invalidate the work permit and no further permits will be issued. (3-28-23)

553. – 604. (RESERVED)

605. CODE OF ETHICS.
Chiropractic physicians are responsible for maintaining and promoting ethical practice in accordance with the ethical principles set forth in Appendix A in these rules. (3-28-23)

606. – 699. (RESERVED)

700. CLINICAL NUTRITION CERTIFICATION AND PRACTICE.

01. Non-Certified Clinical Nutritional Practice. Clinical nutritional methods as referenced in Section 54-704(1), Idaho Code, include, but are not limited to, the clinical use, administration, recommendation, compounding, prescribing, selling, and distributing non-prescription vitamins, minerals, botanical medicine, herbals, homeopathic, phytonutrients, antioxidants, enzymes and glandular extracts, and durable and non-durable medical goods and devices. Nothing herein shall allow any deviation from Section 54-704(3), Idaho Code. (3-28-23)

02. Certified Clinical Nutritional Practice.The Board may issue clinical nutrition certification to a chiropractic physician licensed by the Board who successfully completes the minimum education and complies with requirements in Chapter 7, Title 54, Idaho Code governing clinical nutrition certification and the requirements of Sections 700 through 706. (3-28-23)

701. (RESERVED)

702. REQUIREMENTS FOR CLINICAL NUTRITION CERTIFICATION.
The Board may grant clinical nutrition certification to a licensee who completes an application, pays the applicable fees and meets the following requirements: (3-28-23)

01. General. (3-28-23)

a. Hold and maintain a current, active, unrestricted license as a chiropractic physician issued by the Board. (3-28-23)

b. Not have been on probation or otherwise disciplined by the Board or by any other licensing board or regulatory entity; provided the applicant may make written request to the Board for an exemption review to determine the applicant's suitability for certification, which the Board shall determine in accordance with the

~~following:~~ ~~(3-28-23)~~

~~i. The exemption review shall consist of a review of any documents relating to the probation or discipline and any supplemental information provided by the applicant bearing upon the applicant's suitability for certification. The Board may, at its discretion, grant an interview of the applicant. During the review, the Board shall consider the following factors or evidence:~~ ~~(3-28-23)~~

~~(1) The severity or nature of the violation(s) resulting in probation or discipline;~~ ~~(3-28-23)~~

~~(2) The period of time that has passed since the violation(s) under review;~~ ~~(3-28-23)~~

~~(3) The number or pattern of violations or other similar incidents;~~ ~~(3-28-23)~~

~~(4) The circumstances surrounding the violation(s) that would help determine the risk of repetition;~~ ~~(3-28-23)~~

~~(5) The relationship of the violation(s) to the practice of chiropractic or any health care profession, including but not limited to, whether the violation(s) related to clinical practice, involved patient care, a violation of any state or federal law, rule or regulation relating to controlled substances or to a drug, substance or product identified in Section 54-704(3)(b), Idaho Code;~~ ~~(3-28-23)~~

~~(6) The applicant's activities since the violation(s) under review, such as employment, education, participation in treatment, payment of restitution, or any other factors that may be evidence of current rehabilitation; and~~ ~~(3-28-23)~~

~~(7) Any other mitigating or aggravating circumstances.~~ ~~(3-28-23)~~

~~ii. The applicant shall bear the burden of establishing current suitability for certification.~~ ~~(3-28-23)~~

~~**e.** Successfully complete the requirements of Section 54-717, Idaho Code, and Section 702.~~ ~~(3-28-23)~~

~~**d.** Written verification of current health care provider cardiopulmonary resuscitation (CPR) certification. Health care provider CPR certification must be from a course that includes a hands-on skill component as provided by the American Heart Association, American Red Cross, American Health and Safety Institute or similar provider approved by the Board. Written verification of current basic life support (BLS) certification. All chiropractic physicians holding clinical nutrition certification must maintain current health care provider CPR and BLS certification as provided in this Section.~~ ~~(3-28-23)~~

~~**e.** Certify that the chiropractic physician has BLS equipment on the premises where clinical nutrition treatment is being performed. BLS equipment shall include at a minimum:~~ ~~(3-28-23)~~

~~i. Rescue breathing equipment.~~ ~~(3-28-23)~~

~~ii. Oxygen.~~ ~~(3-28-23)~~

~~iii. Epinephrine.~~ ~~(3-28-23)~~

~~**f.** Certify that the chiropractic physician possesses and will provide to patients informed consent documentation that explains the benefits and potential risks of the specific course of intravenous or injectable nutrition therapy that is being proposed and that the physician will in advance obtain from the patient written voluntary permission to perform the proposed therapy in accordance with Section 54-717(7), Idaho Code.~~ ~~(3-28-23)~~

~~**g.** Payment of all fines, costs, fees or other amounts that are due and owing to the Board or in compliance with a payment arrangement with the Board is required to be eligible for clinical nutrition certification pursuant to Sections 700 through 706.~~ ~~(3-28-23)~~

~~**02. Didactic Education Requirement**. Provide a certificate or other evidence acceptable to the Board~~

~~of successful completion of a minimum of seven (7) credits (seventy-seven (77) hours) of didactic human nutrition, nutrition biochemistry, and nutritional pharmacology courses. The certificate or other evidence of successful completion must be provided directly to the Board by the educational institution.~~ ~~(3-28-23)~~

~~**a.** Chiropractic physicians licensed by the Board who apply for clinical nutrition certification may be determined to have satisfied the didactic education requirements only if they present a certificate or other evidence acceptable to the Board pursuant to this Section demonstrating they commenced obtaining the didactic education required by this Section no earlier than three (3) years prior to applying for clinical nutrition certification and thereafter successfully completed the requirements.~~ ~~(3-28-23)~~

~~**03. Practicum Requirement**. Provide a certificate or other evidence acceptable to the Board of successful completion of a minimum of twenty-four (24) hours of practicum in intravenous and injectable nutrient therapy, which must include: sterile needle practices, phlebotomy, proper injection techniques, intravenous therapy techniques, intramuscular injection techniques, safety practices, and use and expected outcomes utilizing micronutrients, response to adverse effects, lab testing, and blood chemistry interpretation.~~ ~~(3-28-23)~~

~~**a.** After July 1, 2019, the practicum of any applicant for clinical nutrition certification required by this Section must not have commenced more than two (2) years prior to the date of application for clinical nutrition certification and be successfully completed thereafter.~~ ~~(3-28-23)~~

~~**04. Accredited Institution and Program Requirement**. The courses and practicum required by Subsections 702.02 and 702.03 must be taken from an accredited chiropractic college or other accredited institution of higher education. In addition the courses and practicum must be from an accredited program at the college or institution or be a program approved by the Board.~~ ~~(3-28-23)~~

~~**a.** For purposes of this Section "accredited" means accredited by an accrediting agency recognized by the United States Department of Education.~~ ~~(3-28-23)~~

~~**b.** For purposes of this Section "approved by the Board" means a program that is a "recognized candidate for accreditation," has "initial accreditation" status or "preaccreditation" status by an accrediting body recognized by the United States Department of Education, or is substantially equivalent to a program having that status.~~ ~~(3-28-23)~~

~~**c.** An applicant for clinical nutrition certification bears the burden to demonstrate their education and training in clinical nutrition meets the requirements of this Section, including both the accredited institution and accredited program requirements.~~ ~~(3-28-23)~~

~~**05. Audit of Compliance with Clinical Nutrition Certification and Recertification Requirements**. The Board may conduct audits to confirm that licensees meet the requirements to maintain clinical nutrition certification and recertification. In the event a licensee audited by the Board fails to provide documentation or other evidence acceptable to the Board of meeting the clinical nutrition certification or recertification requirements as verified to the Board as part of their annual license renewal or the recertification process the matter will be referred to Division's investigative unit for investigation and potential disciplinary proceedings by the Board.~~ ~~(3-28-23)~~

~~**06. Requirement to Maintain Supporting Documentation**. A licensee need not submit documentation to the Board with a chiropractic license renewal application verifying qualifications for annual issuance of clinical nutrition certification pursuant to Section 703, or verifying qualifications to recertify clinical nutrition certification pursuant to Section 706. However, a licensee must maintain documentation for a period of five (5) years verifying the licensee has satisfied the requirements. A licensee must submit the documentation to the Board if the annual reissuance or the recertification is audited. All documentation must include the licensee's name, and as applicable, the date the course or other required activity commenced and was completed, provider name, course title and description, length of the course/activity, and other information required by the Board.~~ ~~(3-28-23)~~

703~~0~~. ~~ANNUAL ISSUANCE OF~~ CLINICAL NUTRITION CERTIFICATION ~~WITH LICENSE RENEWAL~~.

01. Expiration Date. Chiropractic physicians' clinical nutrition certification expires on the expiration

date of their chiropractic license and must be issued ~~annually~~ biennially with the renewal of their license ~~pursuant to Section 350~~. The Board will waive the clinical nutrition certification fee in conjunction with the first timely renewal of the chiropractic license after initial clinical nutrition certification. ~~(3-28-23)~~( )

~~**02. Issuance**. Clinical nutrition certification is issued annually by timely submission of a chiropractic license renewal application, payment of the chiropractic license renewal fee, the clinical nutrition certification fee, any amounts owing pursuant to Subsection 702.01.g., and verifying to the Board that the licensee is in compliance with the requirements for clinical nutrition certification as provided in the Board's laws and rules. (3-28-23)~~

~~**03. Failure to Comply with Issuance Requirements**. (3-28-23)~~

~~**a.** If a licensee with clinical nutrition certification fails to verify meeting clinical nutrition certification annual issuance requirements when renewing their chiropractic physician license the clinical nutrition certification is canceled and the chiropractic physician license will be renewed without clinical nutrition certification. (3-28-23)~~

~~**b.** If a licensee with clinical nutrition certification fails to timely renew their chiropractic physician license their clinical nutrition certification is canceled. (3-28-23)~~

~~**c.** Clinical nutrition certification canceled pursuant to this Section may be reissued within three (3) years in accordance with Section 704. (3-28-23)~~

~~**704. REISSUANCE OF CANCELLED CLINICAL NUTRITION CERTIFICATION.**~~

~~**01. Reissuance**. Clinical nutrition certification canceled pursuant to Subsection 703.03 may be reissued within three (3) years of cancellation as follows: (3-28-23)~~

~~**a.** Submission of a reissuance application and payment of the current clinical nutrition certification fee. (3-28-23)~~

~~**b.** Submission of any other documents required by the Board for reissuance including but not limited to: (3-28-23)~~

~~i. Documentation of holding current licensure as a chiropractic physician from the Board meeting the requirements of Section 702. (3-28-23)~~

~~ii. Documentation of compliance with clinical recertification requirements in accordance with Section 706. (3-28-23)~~

~~iii. Documentation of current health care provider CPR and BLS certification and certification that the chiropractic physician has BLS equipment on the premises where clinical nutrition treatment is performed and that informed consent and voluntary permission to perform the proposed therapy are being used in accordance with Section 702. (3-28-23)~~

~~**705. CLINICAL NUTRITION CERTIFICATION CANCELLED FOR OVER THREE (3) YEARS.**~~
~~Clinical nutrition certification canceled for a period of more than three (3) years may not be reissued. The chiropractic physician so affected is required to make application to the Board in compliance with Section 701 and Section 702 and pay the application and other fees for new clinical nutrition certification. The applicant will be reviewed by the Board and considered as follows: (3-28-23)~~

~~**01. Current Competency and Training**. The chiropractic physician must fulfill requirements as determined by the Board that demonstrate the chiropractic physician's competency to regain clinical nutrition certification in this state. Such requirements may include, but are not limited to, education, supervised practice, and examination, including some or all education, training and other requirements for original clinical nutrition certification as set forth in Section 54-717, Idaho Code, and Section 702. (3-28-23)~~

~~**02. New Clinical Nutrition Certification**. Chiropractic Physicians who fulfill the conditions and requirements of this Section may be granted a new clinical nutrition certification. (3-28-23)~~

~~706. CLINICAL NUTRITION RECERTIFICATION REQUIREMENT.~~

0~~1~~2. **Recertification in Clinical Nutrition Every ~~Three~~ Four (4~~3~~) Years**. After Initial certification in clinical nutrition, chiropractic physicians must recertify in clinical nutrition every ~~three~~ four (3~~4~~) years in order to maintain clinical nutrition certification. ~~(3-28-23)~~( )

~~02. Annual Verification of Meeting Requirements. In order to maintain clinical nutrition certification pursuant to Section 54-717, Idaho Code, and Section 700, chiropractic physicians having clinical nutrition certification must annually verify, along with their chiropractic license renewal, pursuant to Subsection 706.01 by attesting to the Board they are in compliance with the requirements to recertify in clinical nutrition the following:~~ ~~(3-28-23)~~

~~a. Completion within the three (3) years prior to recertification of a twelve (12) hour in person face to face classroom course from an institution and program meeting Section 702.04 accreditation requirements. The course must include both didactic education and practical review and practice of contemporary developments and best practices to maintain core competency in the practice of clinical nutrition as set forth in Section 54-716, Idaho Code, and Section 54-717, Idaho Code.~~ ~~(3-28-23)~~

~~b. Current licensure as a chiropractic physician issued by the Board meeting the requirements of Section 702.~~ ~~(3-28-23)~~

~~c. Current health care provider CPR and BLS certification and that BLS equipment is maintained on the premises where clinical nutrition treatment is performed pursuant to Section 702.~~ ~~(3-28-23)~~

~~d. They possess and will provide to patients informed consent documentation that explains the benefits and potential risks of the specific course of intravenous or injectable nutrition therapy that is being proposed and that the physician will in advance obtain from the patient written voluntary permission to perform the proposed therapy in accordance with Section 54-717(7), Idaho Code.~~ ~~(3-28-23)~~

03. **Recertification is in Addition to Required ~~Annual~~ Biennial Continuing Education**. ~~The~~ A twelve (12) hour recertification course ~~requirement is~~ which includes both didactic education and practical review and practice of contemporary developments and best practices to maintain core competency in the practice of clinical nutrition as set forth in Section 54-716, Idaho Code, and Section 54-717, Idaho Code must be completed in addition to the ~~annual eighteen~~ biennial thirty-six (1~~8~~36) hours of continuing education required under Section ~~350~~ 100.02.a prior to recertification. This recertification course must be approved by the board. ~~(3-28-23)~~( )

04. **Failure to Timely Recertify in Clinical Nutrition**. Clinical nutrition certification not timely recertified in accordance with Section 706 expires and is canceled. ~~Clinical nutrition certification canceled for failure to recertify may be reissued within three (3) years in accordance with Section 704~~. ~~(3-28-23)~~( )

70~~7~~1. OBTAINING AND INDEPENDENTLY ADMINISTERING CLINICAL NUTRITION PRESCRIPTION DRUG PRODUCTS.
A chiropractic physician with clinical nutrition certification as defined by Sections 54-704(4), 54-716 and 54-717, Idaho Code, may obtain and independently administer prescription drug products in the practice of chiropractic subject to the conditions below. (3-28-23)

01. **Current Certification in Clinical Nutrition Required**. Only chiropractic physicians who hold current certification in clinical nutrition by the Board may obtain and independently administer prescription drug products during chiropractic practice. To hold a current certification in clinical nutrition, a chiropractic physician must have an active unrestricted license to practice chiropractic. ~~(3-28-23)~~( )

02. **~~Obtain~~ Prescription Drugs Products from the Formulary**. A chiropractic physician with clinical nutrition certification may not obtain or administer a prescription drug product that is not listed in the chiropractic clinical nutrition formulary or otherwise prescribe, dispense, distribute, or direct a patient to use a prescription drug product except as allowed in Section 54-704(5), Idaho Code. ~~(3-28-23)~~( )

~~**03. Only Administer Prescription Drug Products from the Formulary**. Chiropractic physicians with clinical nutrition certification may only administer those prescription drug products listed in the chiropractic clinical nutrition formulary.~~ ~~(3-28-23)~~

~~**a.** Chiropractic physicians with clinical nutrition certification may not prescribe, dispense, distribute, or direct to a patient the use of a prescription drug product except as allowed in Section 54-704(5), Idaho Code.~~ ~~(3-28-23)~~

~~**04. Routes of Administration and Dosing of Prescription Drug Products**. Prescription drug products listed in the chiropractic clinical nutrition formulary may be administered through oral, topical, intravenous, intramuscular or subcutaneous routes by a chiropractic physician with clinical nutrition certification. The route of administration and dosing are in accordance with the product's labeling as approved by the federal food and drug administration or with the manufacturer's instructions.~~ ~~(3-28-23)~~

0~~5~~3. **Practice Limited to Chiropractic Physicians with Clinical Nutrition Certification**. Chiropractic interns, chiropractic assistants, holders of chiropractic temporary practice permits and others working under the authority or direction of a chiropractic physician may not perform any practice or function requiring clinical nutrition certification. (3-28-23)

~~**06. Sale, Transfer, or Other Distribution of Prescription Drugs Prohibited**. Chiropractic physicians with clinical nutrition certification may obtain and administer prescription drug products to a patient only in accordance with this Section 707. Chiropractic physicians may not prescribe, sell, transfer, dispense, or otherwise distribute prescription drug products to any person or entity. Prescription drug products not administered to a patient are handled in accordance with Subsections 708.05, 708.06, and 708.07.~~ ~~(3-28-23)~~

708~~7~~2. CLINICAL NUTRITION FORMULARY.
Chiropractic physicians certified in clinical nutrition may obtain and independently administer, during chiropractic practice, only the prescription drug products listed in this chiropractic clinical nutrition formulary and subject to the provisions hereof. (3-28-23)

01. Chiropractic Clinical Nutrition Prescription Drug Formulary. Prescription drug products that may be used by chiropractic physicians with clinical nutrition certification are limited to the following: (3-28-23)

a. Vitamins: vitamin A, all B vitamins and vitamin C; (3-28-23)

b. Minerals: ammonium molybdate, calcium, chromium, copper, iodine, magnesium, manganese, potassium, selenium, sodium, and zinc; (3-28-23)

c. Fluids: dextrose, lactated ringers, ~~p~~Plasma ~~l~~Lyte, saline, and sterile water; ~~(3-28-23)~~( )

d. Epinephrine; and (3-28-23)

e. Oxygen for use during an emergency or allergic reaction. (3-28-23)

02. Sources of Clinical Nutrition Prescription Drug Products. Prescription drug products listed in the chiropractic clinical nutrition formulary may be obtained only by a chiropractic physician with clinical nutrition certification and only from a source licensed under Chapter 17, Title 54, Idaho Code, that is a wholesale distributor, a manufacturer, a pharmacy, compounding pharmacy, or an outsourcing facility and from no other source. (3-28-23)

03. No Compounding of Prescription Drug Products. ~~No vitamin or mineral may be compounded, as defined in Section 54-1705, Idaho Code, by a chiropractic physician. A compounded drug product containing two (2) or more of the vitamins or minerals approved in the chiropractic clinical nutrition formulary may be obtained for office use by a chiropractic physician with clinical nutrition certification only from an outsourcing facility licensed under Chapter 17, Title 54, Idaho Code or compounding pharmacy and from no other source.~~ A chiropractic physician may not obtain or use in chiropractic practice a compounded drug product containing a prescription drug product that is not included in the chiropractic clinical nutrition formulary. ~~(3-28-23)~~( )

~~**04. Limitations on Possession of Prescription Drug Products**. Possession of prescription drug products without a valid prescription drug order by chiropractic physicians licensed pursuant to Chapter 7, Title 54, Idaho Code, and certified pursuant to Sections 54-708, and 54-717, Idaho Code, or their agents or employees are limited to:~~ ~~(3-28-23)~~

~~**a.** Only those prescription drug products listed in Sections 54-716, Idaho Code, and in the chiropractic clinical nutrition formulary;~~ ~~(3-28-23)~~

~~**b.** Only those quantities reasonably required for use in the usual and lawful course of the chiropractic physician's clinical nutrition practice based on the patient panel size and history of orders.~~ ~~(3-28-23)~~

~~**05. Prescription Drug Product Storage**. Clinical nutrition prescription drugs must be stored in accordance with United States Pharmacopeia-National Formulary requirements in an area maintained and secured appropriately to safeguard product integrity and protect against product theft or diversion.~~ ~~(3-28-23)~~

~~**06. Expired, Deteriorated, Adulterated, Damaged, or Contaminated Prescription Drug Products**. Expired, deteriorated, adulterated, damaged, or contaminated prescription drug products must be removed from stock and isolated for return, reclamation or destruction.~~ ~~(3-28-23)~~

0~~7~~4. **Compliance with Federal and State Requirements**. In addition to the requirements of the Idaho Chiropractic Practice Act and rules of the Board, chiropractic physicians must comply with all federal and state laws, rules and policies governing possession, storage, record keeping, use, and disposal of prescription drug products.
(3-28-23)

~~**709. MEDICAL WASTE.**~~
~~Chiropractic physicians certified in clinical nutrition must dispose of medical waste during the practice of chiropractic clinical nutrition according to the following protocol:~~ ~~(3-28-23)~~

~~**01. Containers for Non-Sharp, Medical Waste**. Medical waste, except for sharps, must be placed in disposable containers/bags that are impervious to moisture and strong enough to preclude ripping, tearing, or bursting under normal conditions of use. The bags must be securely tied so as to prevent leakage or expulsion of solid or liquid waste during storage, handling, or transport. The containment system must have a tight fitting cover and be kept clean and in good repair. All bags used for containment of medical waste must be clearly identified by label or color, or both.~~ ~~(3-28-23)~~

~~**02. Containers for Sharps**. Sharps must be placed in impervious, rigid, puncture-resistant containers immediately after use. After use, needles must not be bent, clipped or broken by hand. Rigid containers of discarded sharps must either be labeled or colored like the disposable bags used for other medical waste, or placed in such labeled or colored bags and disposed of according to container guidelines.~~ ~~(3-28-23)~~

7~~10~~03. -- 999. (RESERVED)

Appendix A – Chiropractic Physicians Code of Ethics

PREAMBLE

This code of ethics sets 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 must act in the best interest of the patient. This code of ethics is binding on all chiropractic physicians.

1. Duty to Report

A. It is the duty of every licensee to notify the Board through the Division of Occupational and Professional Licenses of any violation of the Chiropractic Act or Board Rules, if the licensee has personal knowledge of the conduct.

B. 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 must 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.

C. If convicted of a felony or a crime involving dishonesty, theft, violence, habitual use of drugs or alcohol, or sexual misconduct, the licensee must 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~~ for the purpose of clinical research. Any willful failure to comply with these requirements will be deemed false and deceptive advertising ~~*under rule 450*~~. Licensees must comply with all state and federal laws and regulations governing research projects on humans, and will 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~~ 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.

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. Prepaid Funds

A chiropractic physician shall promptly refund any unearned fees within thirty (30) days upon request and cancellation of the prepaid 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 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.09.01 – RULES OF THE BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS

DOCKET NO. 24-0901-2401 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1, 2025, in the year of the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

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 67-2604, Idaho Code, Sections 67-9404, 67-9405, 67-9406, 67-9409, and 67-9413, Idaho Code, and Sections 54-1601 through 54-1616, 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:

Under Executive Order 2020-01, Zero-Based Regulation, the Idaho Board of Examiners of Nursing Home Administrators is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the July 3, 2024, Idaho Administrative Bulletin, Vol. 24-7, pages 205-210.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

As authorized in Section 54-1604, Idaho Code, the fee(s) in this rulemaking are established in Rule 600. None of these fees are being changed as a result of this rulemaking or since being previously reviewed by the Idaho Legislature.

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 is not anticipated to have any negative fiscal impact on the state General Fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Krissy Veseth, Bureau Chief, at (208) 577-2491. Materials pertaining to the pending rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

DATED this 30th day of August, 2024.

Krissy Veseth
Bureau Chief
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 577-2491
Email: krissy.veseth@dopl.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. This rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, Sections 67-9404, 67-9405, 67- 9406, 67-9409, and 67-9413, Idaho Code, and Sections 54-1601 through 54-1616, Idaho Code.

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

24.09.01 – Rules of the Board of Examiners of Nursing Home Administrators

Tuesday, July 16, 2024 – 9:00 a.m. (MT)
Division of Occupational and Professional Licenses
Coolwater Room, Chinden Campus Building 4
11341 W. Chinden Blvd.
Boise, ID 83714

Virtual Meeting Link

Telephone and web conferencing information will be posted on https://dopl.idaho.gov/calendar/ and https://townhall.idaho.gov/.

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

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

Under Executive Order 2020-01, Zero-Based Regulation, the Idaho State Board of Examiners of Nursing Home Administrators is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the proposed rule changes reflect a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. This proposed rulemaking updates the rules to comply with governing statute and Executive Order 2020-01.

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

N/A. The fees did not increase, but the fee for a temporary permit was removed.

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:

This rulemaking is not anticipated to have any negative fiscal impact on the state General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted under Docket No. 24-ZBRR-2401. The Omnibus Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 3, 2024, Idaho Administrative Bulletin, Vol. 24-4, p.42.

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. No materials have been incorporated by reference into the proposed rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this proposed rule, contact Krissy Veseth, Bureau Chief, at (208) 577-2491. Materials pertaining to the proposed rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 24, 2024.

DATED this 7th day of June, 2024.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 24-0901-2401

24.09.01 – RULES OF THE BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS

000. LEGAL AUTHORITY.
These rules promulgated pursuant to Section 54-1604, Idaho Code. (3-28-23)

001. SCOPE.
These rules govern the practice of nursing home administration in Idaho. (3-28-23)

002. -- 099. (RESERVED)

100. ~~EXAMINATION FOR~~ LICENSURE.

~~01. Examination Fee~~. ~~The examination fee for the national examination will be in the amount as determined by the National Association of Long Term Care Administration Boards and is paid to the entity administering said examination. The examination fee is in addition to the license fee provided for in Section 54-1604, sub-paragraph (g), Idaho Code.~~ ~~(3-28-23)~~

01. Exam. All applicants must pass the approved NAB Nursing Home Administrator exam and Core exam, or other examination as approved by the Board. ( )

02. Applicant History. An applicant who has a conviction, finding of guilt, withheld judgment, or suspended sentence for any felony or any crime related to an applicant's fitness for licensure, or whose license has been subject to discipline in any state, territory, or country must submit with the application a written statement and any supplemental information establishing the applicant's current suitability for licensure. ~~The Board may consider~~ The written statement should include the factors set forth in Section 67-9411, Idaho Code. ~~(3-28-23)~~( )

~~03. Contents of Exam, Passing Scores~~. ~~An applicant must pass an examination issued by NAB, and an examination pertaining to Idaho law and rules governing nursing homes administered by the Board. The passing score of the Idaho Laws and Rules Examination is seventy-five percent (75%).~~ ~~(3-28-23)~~

~~**04. Date and Location of Exam**. Examinations are held at the location and at the times determined by the entity administering the national examination. The state examination is a take-home examination and is returned to the Board.~~ ~~(3-28-23)~~

03. Additional Requirements. Applicants for original licensure must also demonstrate completion of a specialized course of study in nursing home long-term health care administration approved by the Board. Any applicant holding a Health Services Executive (HSE) credential issued by NAB has met all educational and training requirements for licensure in Idaho. ( )

~~**101. -- 199. (RESERVED)**~~

~~200~~101. CONTINUING EDUCATION REQUIREMENTS.

01. Educational Requirements. In order to qualify as continuing education, a seminar or course of study ~~will be relevant to nursing home administration as determined by the Board and~~ must be sponsored by an accredited ~~universities~~ university or college~~s~~, State or National health related associations, and/or approved by NCERS (National Continuing Education Review Service), or as otherwise approved by the Board. ~~(3-28-23)~~( )

02. Renewal of License. ~~Applicants for renewal of license are required to complete a minimum of twenty (20) clock hours of approved courses within the preceding twelve month (12) period. Licensees are not required to comply with this requirement during the first year in which they become licensed under this chapter~~ Applicants for renewal of license are required to complete, in a twenty-four (24) month renewal cycle, twelve (12) continuing education hours relevant to nursing home administration. ~~(3-28-23)~~( )

~~**03. Carryover of Continuing Education Hours**. Continuing education hours not claimed in the current renewal year may be claimed in the next renewal year. A maximum of twenty (20) hours may be carried forward from the immediately preceding year, and may not be carried forward more than one (1) renewal year.~~ ~~(3-28-23)~~

0~~4~~3. Waiver. The Board may waive the requirements of this rule for reasons of individual hardship including health or other good cause. The licensee should request the waiver in advance of renewal and will provide any information requested by the Board to assist in substantiating hardship cases. This waiver is granted at the sole discretion of the Board. (3-28-23)

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

~~**300. ENDORSEMENT.**~~
~~Each applicant for licensure by endorsement is required to document compliance with each of the following requirements.~~ ~~(3-28-23)~~

~~**01. A Valid License**. Hold a valid and current nursing home administrator license issued in another state or jurisdiction with substantially equivalent licensing standards.~~ ~~(3-28-23)~~

~~**02. Experience/Education**.~~ ~~(3-28-23)~~

~~**a.** One thousand (1,000) hours of experience as an administrator in training in another state; or~~ ~~(3-28-23)~~

~~**b.** A total of one thousand (1,000) hours of combined experience obtained in an administrator in training program and from practical experience as an administrator in another state; or~~ ~~(3-28-23)~~

~~**c.** A master's degree in health administration related to long-term care from an accredited institution; or~~ ~~(3-28-23)~~

~~**d.** A master's degree in health administration or business administration with a healthcare emphasis from an accredited institution and one (1) year management experience in long-term care.~~ ~~(3-28-23)~~

~~03. National Examination. Has taken and successfully passed the NAB examination. (3-28-23)~~

~~04. State Examination. Has taken and successfully completed the state of Idaho examination. (3-28-23)~~

~~05. Criminal History. Applicant is subject to Section 100.02 of these rules. (3-28-23)~~

~~301. -- 399. (RESERVED)~~

~~400~~102. NURSING HOME ADMINISTRATORS-IN-TRAINING.

~~01. Supervised Hour Requirements. An individual must successfully complete one thousand (1,000) hours under the direct supervision of a licensed nursing home administrator in compliance with Section 54-1610, Idaho Code, and these rules in order to be eligible to take the examination. (3-28-23)~~

0~~2~~1. Trainees. A trainee must work on a full time basis ~~in any capacity~~ in an Idaho licensed nursing home setting. Full time shall be at least a thirty-two (32) hour per week work schedule with consideration for normal leave taken. ~~(3-28-23)~~( )

~~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. (3-28-23)~~

a. Trainees shall submit with their application a declaration signed by the supervising Nursing Home Administrator who shall serve as the preceptor. This declaration shall certify that the supervising administrator has: ( )

i. Licensure in good standing with the State of Idaho; and ( )

ii. Two (2) or more years of consecutive employment as a nursing home administrator. ( )

b. Reports for those trainees employed in a nursing home must be submitted to the Board after completion of each five hundred (500) hour increment and reflect that the preceptor of the trainee has instructed, assisted, and given assignments as deemed necessary to fulfill the requirements ~~of Subsection 400.03~~ set forth herein. ~~(3-28-23)~~( )

0~~3~~2. Nursing Home Administrator-in-Training Requirements. A Nursing Home Administrator-in-Training shall be required to train in all domains of nursing home administration including the following: (3-28-23)

a. ~~Customer care, support, and services~~Care, services, and supports. ~~(3-28-23)~~( )

b. ~~Human resources~~Operations. ~~(3-28-23)~~( )

c. ~~Finance~~Environment and quality. ~~(3-28-23)~~( )

d. ~~Environment~~Leadership and strategy. ~~(3-28-23)~~( )

~~e. Management and leadership. (3-28-23)~~

~~f. Completion of a specialized course of study in nursing home long-term health care administration approved by NAB or otherwise approved by the Board. (3-28-23)~~

0~~4~~3. Facility Administrator. The trainee must spend no less than thirty-two (32) hours ~~a~~ per month with the preceptor in ~~a~~ training, duties as assigned, and ~~/or observational situation~~ observation in the ~~five~~ four (~~5~~4) domains of nursing home administration as outlined in ~~Subsection 400.03~~ herein. 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, during the training period, reports must

reflect particular emphasis on all ~~five~~ four (~~5~~4) domains of nursing home administration during the time spent in the nursing home. ~~(3-28-23)~~( )

~~**05. Preceptor Certification.** (3-28-23)~~

~~**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: (3-28-23)~~

~~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 (3-28-23)~~

~~ii. Who successfully completes a six (6) clock hour preceptor orientation course approved by the Board. (3-28-23)~~

~~**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. (3-28-23)~~

~~**c.** The preceptor must be re-certified by the Board every ten (10) years. (3-28-23)~~

~~**401. -- 449. (RESERVED)**~~

~~450~~103. ADMINISTRATOR DESIGNEE QUALIFICATION.
In order to practice as an administrator designee, an individual shall register with the Board as an Administrator Designee by submitting an application and providing documentation of ~~each~~ the following requirements. ~~(3-28-23)~~( )

~~**01. Criminal History.** Applicant is subject to Section 67-9411, Idaho Code. (3-28-23)~~

~~**02. Education.** Provide proof of either: (3-28-23)~~

~~**a.** A bachelors degree from an approved college or university, or (3-28-23)~~

~~**b.** Two (2) years of satisfactory practical experience in nursing home administration or a related health administration area for each year of the required education as set forth in Section 54-1605(3), Idaho Code; (3-28-23)~~

0~~4~~1. Experience. Provide proof of having one (1) year of management experience in a skilled nursing facility. ~~Experience documented in Subsection 450.03.b. may also be used to meet this requirement.~~ ~~(3-28-23)~~( )

0~~5~~2. Authorization. Submit an agreement signed by an Idaho Licensed Nursing Home Administrator, in good standing with the State of Idaho, who will act as a consultant to assist the designee in administrating the facility. ~~(3-28-23)~~( )

~~451~~104. -- ~~499~~599.(RESERVED)

~~**500. PERMITS.**~~

~~**01. Requirements for Issuance.** A temporary permit may be issued upon submission of an endorsement application evidencing a license in good standing in another state and payment of fees. The permit shall be valid until the Board acts upon their endorsement application. No more than one (1) temporary permit may be granted to any applicant for any reason. (3-28-23)~~

~~**02. Issuance of a Temporary Permit Does Not Obligate the Board.** Issuance of a temporary permit does not obligate the board to subsequently issue a license. Issuance of a subsequent license depends upon a successful application to the Board. (3-28-23)~~

~~501. -- 599. (RESERVED)~~

600. FEES.

FEE	AMOUNT (Not to Exceed)
Original Application	$200
Original License	$200
Annual Renewal	$200
Endorsement Application	$200
~~Temporary Permit~~Administrator-in-training	$100
~~Administrator-in-training~~License Reinstatement	$100
~~License Reinstatement~~	~~$100~~

~~(3-28-23)~~( )

601. -- 999. (RESERVED)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.19.01 – RULES OF THE BOARD OF EXAMINERS OF RESIDENTIAL CARE FACILITY ADMINISTRATORS

DOCKET NO. 24-1901-2401 (ZBR CHAPTER REWRITE, FEE RULE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo and Cost/Benefit Analysis (CBA)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1, 2025, in the year of the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

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 67-2604, Idaho Code, Sections 67-9404, 67-9405, 67-9406, 67-9409, and 67-9413, Idaho Code, and Sections 54-4201 through 54- 4216, 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:

Under Executive Order 2020-01, Zero-Based Regulation, the Idaho Board of Examiners of Residential Care Facility Administrators is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the July 3, 2024, Idaho Administrative Bulletin, Vol. 24-7, pages 211-216.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

As authorized in Sections 54-4205 and 54-4209, Idaho Code, the fee(s) in this rulemaking are established in Rule 400. The application fee, annual renewal fee, provisional permit fee, and reissuance of lost license fee has been increased from $150 to $200.

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 is not anticipated to have any negative fiscal impact on the state General Fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Krissy Veseth, Bureau Chief, at (208) 577-2491. Materials pertaining to the pending rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

DATED this 30th day of August, 2024.

Krissy Veseth
Bureau Chief
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 577-2491
Email: krissy.veseth@dopl.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. This rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, Sections 67-9404, 67-9405, 67- 9406, 67-9409, and 67-9413, Idaho Code, and Sections 54-4201 through 54-4216, Idaho Code.

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

24.19.01 – Rules of the Board of Examiners of Residential Care Facility Administrators

Tuesday, July 16, 2024 – 9:00 a.m. (MT)
Division of Occupational and Professional Licenses
Coolwater Room, Chinden Campus Building 4
11341 W. Chinden Blvd.
Boise, ID 83714

Virtual Meeting Link

Telephone and web conferencing information will be posted on https://dopl.idaho.gov/calendar/ and https://townhall.idaho.gov/.

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

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

Under Executive Order 2020-01, Zero-Based Regulation, the Idaho State Board of Examiners of Residential Care Facility Administrators is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the proposed rule changes reflect a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. This proposed rulemaking updates the rules to comply with governing statute and Executive Order 2020-01.

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

The application fee, annual renewal fee, provisional permit fee, and reissuance of lost license fee has been increased from $150 to $200.

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:

This rulemaking is not anticipated to have any negative fiscal impact on the state General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted under Docket No. 24-ZBRR-2401-2401. The Omnibus Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 3, 2024, Idaho Administrative Bulletin, Vol. 24-4, p.42.

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

The American College of Health Care Administrators (ACHA) Code of Ethics was incorporated by reference in the administrative rules effective March 28, 2023. That incorporation by reference remains in these proposed rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this proposed rule, contact Krissy Veseth, Bureau Chief, at (208) 577-2491. Materials pertaining to the proposed rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 24, 2024.

DATED this 7th day of June, 2024.

THE FOLLOWING IS THE TEXT OF ZBR FEE DOCKET NO. 24-1901-2401

24.19.01 – RULES OF THE BOARD OF EXAMINERS OF RESIDENTIAL CARE FACILITY ADMINISTRATORS

000. LEGAL AUTHORITY.
These rules are promulgated pursuant to Section 54-4205, Idaho Code. (3-28-23)

001. SCOPE.
These rules govern the practice of residential care facility administration in Idaho. (3-28-23)

002. – 003. (RESERVED)

004. INCORPORATION BY REFERENCE.
The document titled "ACHCA Code of Ethics," published by the American College of Health Care Administrators (ACHCA), current as of May, 2024, ~~as referenced in Section 650,~~ is herein adopted and incorporated by reference and is available from the Board's office and on the Board web site. ~~(3-28-23)~~( )

005. -- 099. (RESERVED)

100. ~~APPLICATIONS~~LICENSURE.

01. Applications. Applications will be on forms approved by the Board. No application will be considered for any action unless accompanied by the appropriate fees and until the required supporting documentation is received by the Division. ~~If an applicant fails to respond to a Board request or an application has lacked activity for twelve (12) consecutive months, the application on file with the Board will be deemed denied and will be terminated upon thirty (30) days written notice, unless good cause is established to the Board.~~
~~(3-28-23)~~( )

02. Qualifications for Administrator License. To be granted an Administrator License the applicant must: ( )

a. Submit a criminal background check by an entity approved by the Board; ( )

b. Document completion of a specialized course or program of study as set forth in Subsection 150 of these rules; ( )

c. Submit proof that the applicant has passed the Residential Care Facility Administrators examination developed and administered by the National Association of Boards of Examiners of Long Term Care Administrators (NAB), or other examinations as approved by the Board; and ( )

d. Any applicant holding a Health Services Executive (HSE) credential issued by NAB has met all educational and training requirements for licensure in Idaho. ( )

03. Nursing Home Administrator Qualifications for License. Applicants must take and pass the Board-approved residential care administrator examination. This requirement may be waived if the applicant submits evidence satisfactory to the Board showing at least one (1) year of leadership or management experience working in a residential care facility or nursing home facility within the five (5) years preceding the application. ( )

101. CONTINUING EDUCATION.

01. Educational Requirements. In order to qualify as continuing education, a seminar or course of study must be sponsored by accredited universities or colleges, State or National health related associations, and/or approved by NCERS (National Continuing Education Review Service), or as otherwise approved by the Board. ( )

02. Renewal of License. Applicants for renewal of license are required to complete, in a twenty-four (24) month renewal cycle, twelve (12) job-related continuing education hours relevant to residential care administration. ( )

03. Waiver. The Board may waive the requirements of this rule for reasons of individual hardship including health or other good cause. The licensee should request the waiver in advance of renewal and will provide any information requested by the Board to assist in substantiating hardship cases. This waiver is granted at the sole discretion of the Board. ( )

10~~1~~2. -- 149. (RESERVED)

~~150. QUALIFICATIONS FOR ADMINISTRATOR LICENSE.~~
~~Each applicant for an administrator's license must submit proof, along with their application, that said individual is at least twenty-one (21) years of age and meets all the following qualifications for the issuance of a license:~~ ~~(3-28-23)~~

~~01. Criminal Background Check~~~~. The applicant must submit a criminal background check by an entity approved by the Board establishing that the applicant has not been convicted, pled guilty or nolo contendere or received a withheld judgment for a felony or any crime involving dishonesty or the health or safety of a person.~~
~~(3-28-23)~~

~~02. Education and Experience~~~~. The applicant must document one (1) of the combinations of education and experience in accordance with Section 54-4206, Idaho Code, and Subsection 400 of these rules.~~
~~(3-28-23)~~

~~03. Coursework~~~~. The applicant must document completion of a specialized course or program of study as set forth in Subsection 400 of these rules.~~ ~~(3-28-23)~~

~~04. Examination~~~~. The applicant must submit proof of successful passage of a relevant examination as approved by the Board and defined in Subsection 300 of these rules.~~ ~~(3-28-23)~~

~~151. -- 159. (RESERVED)~~

~~160. NURSING HOME ADMINISTRATOR QUALIFICATIONS FOR LICENSE.~~
~~Any applicant who holds a valid Idaho nursing home administrator license must meet the requirements provided in Section 54-4211(2), Idaho Code, and must take and pass the Board-approved residential care administrator examination. This requirement may be waived if the applicant submits evidence satisfactory to the Board that he has at least one (1) year of leadership or management experience working in a residential care facility or nursing home facility within the five (5) years preceding the application.~~ ~~(3-28-23)~~

~~161. -- 299. (RESERVED)~~

~~300. EXAMINATIONS.~~

~~01. Examination. The Board approves the following examinations for licensure:~~ ~~(3-28-23)~~

~~a. The Residential Care Facility Administrators examination developed and administered by the National Association of Boards of Examiners of Long Term Care Administrators (NAB) and an open book examination of law and rules governing residential care administrators in Idaho. The passing score for the NAB examination is determined by NAB. An applicant for examination is required to register with NAB and pay any required examination fees directly to NAB. The passing score for the open book examination is seventy-five percent (75%).~~ ~~(3-28-23)~~

~~b. Other examinations as approved by the Board.~~ ~~(3-28-23)~~

~~301. -- 399. (RESERVED)~~

~~400~~150. **EDUCATIONAL AND TRAINING REQUIREMENTS.**

01. Approved Course. ~~(3-28-23)~~

~~a.~~ The Certification Program for Residential Care Facility Administrators course, administered by the Idaho Health Care Association (IHCA)~~, Idaho Center for Assisted Living (ICAL), are~~ is the approved course~~s~~ of study to qualify for licensure. ~~(3-28-23)~~( )

~~b. Any Certification Program for Residential Care Facility Administrators provided by a state or national Residential Care Facility Administrator organization or a nationally or regionally accredited college or university must be an approved course of study to qualify for licensure.~~ ~~(3-28-23)~~

02. Approval of Other Courses. Applicants may, in lieu of completion of the Certification Program for Residential Care Facility Administrators, submit official documentation of successful completion of relevant courses. These courses must be approved by the Board before equivalency will be given. (3-28-23)

151. -- 299. (RESERVED)

300. DISCIPLINE.

01. Costs and Fees. The Board may order a licensed residential care facility administrator to pay the costs and fees incurred by the Board in the investigation or prosecution of the licensee for violation of Section 54-4213(1), Idaho Code. ( )

~~401. CONTINUING EDUCATION.~~

~~01. Minimum Hours Required. Applicants for annual renewal or reinstatement are required to complete a minimum of twelve (12) hours of continuing education courses within the preceding twelve-month (12) period. Basic First Aid, Cardio Pulmonary Resuscitation, medication assistance, or fire safety courses will not be considered for continuing education credit.~~ ~~(3-28-23)~~

~~02. Course Approval. Courses of study relevant to residential care facility administration and sponsored or provided by the following entities or organizations are approved for continuing education credits:~~

~~(3-28-23)~~

~~**a.** Accredited colleges or universities.~~ ~~(3-28-23)~~

~~**b.** Federal, state or local government entities.~~ ~~(3-28-23)~~

~~**c.** National or state associations.~~ ~~(3-28-23)~~

~~**d.** Otherwise approved by the Board based upon documentation submitted by the licensee or course provider reviewing the nature and subject of the course and its relevancy to residential care administration, name of instructor(s) and their qualifications, date, time and location of the course and procedures for verification of attendance.~~ ~~(3-28-23)~~

~~**03. Credit**. Continuing education credit will only be given for actual time in attendance or for the time spent participating in the educational activity. One (1) hour of continuing education is equal to sixty (60) minutes. Courses taken by correspondence or by computer on-line may be approved for continuing education if the courses require an exam or other proof of successful completion. Each licensee must maintain proof of attendance or successful completion documentation of all continuing education courses for a period of three (3) years.~~ ~~(3-28-23)~~

~~**04. Special Exemption**. The Board has authority to make exceptions for reasons of individual hardship, including health, when certified by a medical doctor, or other good cause. The licensee must provide any information requested by the Board to assist in substantiating hardship cases. This exemption is granted at the sole discretion of the Board.~~ ~~(3-28-23)~~

~~**402. -- 449. (RESERVED)**~~

~~**450. SCOPE OF PRACTICE.**~~
~~A residential care facility administrator must possess the education, training, and experience necessary to insure that appropriate services and care are provided for each facility resident within any facility under the licensee's administration. Information contained within the application together with supporting documentation maintained by the licensee is prima facie evidence of the licensee's education and experience. It is the responsibility of the individual licensee to maintain adequate documentation of education and experience appropriate to the planning, organizing, directing and control of the operation of a residential care facility.~~ ~~(3-28-23)~~

~~451~~301. -- ~~599~~399.(RESERVED)

~~600~~400. FEES.

FEE TYPE	AMOUNT (Not to Exceed)
Application	$~~150~~200
Annual Renewal	$~~150~~200
Provisional Permit	$~~150~~200
Reissuance of Lost License	$10
Reinstatement	As provided in Section 67-2614, Idaho Code

~~(3-28-23)~~( )

~~601~~401. -- ~~649~~999.(RESERVED)

~~**650. DISCIPLINE.**~~

~~**01. Civil Fine**. The Board may impose a civil fine not to exceed one thousand dollars ($1,000) upon a licensed residential care facility administrator for each violation of Section 54-4213(1), Idaho Code.~~ ~~(3-28-23)~~

~~**02. Costs and Fees**. The Board may order a licensed residential care facility administrator to pay the costs and fees incurred by the Board in the investigation or prosecution of the licensee for violation of Section 54-4213(1), Idaho Code. (3-28-23)~~

~~**03. Code of Ethics**. The Board has adopted (ACHCA) Code of Ethics. Violations of the code of ethics is considered grounds for disciplinary action. (3-28-23)~~

~~**651. – 999. (RESERVED)**~~

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.24.01 – RULES OF THE GENETIC COUNSELORS LICENSING BOARD

DOCKET NO. 24-2401-2401 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1, 2025, in the year of the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

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 67-2604, Idaho Code, Sections 67-9404, 67-9405, 67-9406, 67-9409, and 67-9413, Idaho Code, and Sections 54-5601 through 54- 5616, 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:

Under Executive Order 2020-01, Zero-Based Regulation, the Idaho Board of Genetic Counselors is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the July 3, 2024, Idaho Administrative Bulletin, Vol. 24-7, pages 219-223.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

As authorized in Section 54-5613, Idaho Code, the fees in this rulemaking are established in Rule 400. None of these fees are being changed as a result of this rulemaking or since being previously reviewed by the Idaho Legislature.

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 is not anticipated to have any negative fiscal impact on the state General Fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Krissy Veseth, Bureau Chief, at (208) 577-2491. Materials pertaining to the pending rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

DATED this 30th day of August, 2024.

Krissy Veseth
Bureau Chief
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 577-2491
Email: krissy.veseth@dopl.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. This rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, Sections 67-9404, 67-9405, 67- 9406, 67-9409, and 67-9413, Idaho Code, and Sections 54-5601 through 54-5616, Idaho Code.

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

24.24.01 – Rules of the Genetic Counselors Licensing Board

Tuesday, July 16, 2024 – 9:00 a.m. (MT)
Division of Occupational and Professional Licenses
Chinden Campus Building 4
11341 W. Chinden Blvd.
Boise, ID 83714

Virtual Meeting Link

Telephone and web conferencing information will be posted on https://dopl.idaho.gov/calendar/ and https://townhall.idaho.gov/.

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

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

Under Executive Order 2020-01, Zero-Based Regulation, the Idaho Genetic Counselors Licensing Board is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the proposed rule changes reflect a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. This proposed rulemaking updates the rules to comply with governing statute and Executive Order 2020-01.

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

The fees did not change.

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:

This rulemaking is not anticipated to have any negative fiscal impact on the state General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted under Docket No. 24-ZBRR-2401. The Omnibus Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 3, 2024, Idaho Administrative Bulletin, Vol. 24-4, p.42.

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

The National Society of Genetic Counselors Code of Ethics April 2017 edition was incorporated by reference in the administrative rules effective March 28, 2023. That incorporation by reference remains in these proposed rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this proposed rule, contact Krissy Veseth, Bureau Chief, at (208) 577-2491. Materials pertaining to the proposed rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 24, 2024.

DATED this 7th day of June, 2024.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 24-2401-2401

24.24.01 – RULES OF THE GENETIC COUNSELORS LICENSING BOARD

000. LEGAL AUTHORITY.
These rules are promulgated pursuant to Title 54, Chapter 56, Idaho Code. (3-28-23)

001. SCOPE.
These rules regulate the profession of genetic counseling in the interest of the public health, safety, and welfare. (3-28-23)

002. INCORPORATION BY REFERENCE.
The document titled "National Society of Genetic Counselors Code of Ethics," ~~adopted January 1992 and revised December 2004, January 2006, and~~ dated April 2017, is incorporated by reference into this rule and is available at the Board's office and on the Board's web site. ~~(3-28-23)~~( )

003. -- ~~249~~099. (RESERVED)

100. LICENSURE.

01. General. An applicant who in any state, territory, or country has had a license revoked or suspended or has been otherwise disciplined by a Board, a government agency, or any other disciplinary body, or has been found guilty, convicted, received a withheld judgment or suspended sentence for a felony must submit with his application a written statement and any supplemental information establishing his current suitability for licensure. ( )

02. Education. An applicant must hold a master's degree or higher in genetics from an American Board of Genetic Counseling (ABGC), American Board of Medical Genetics (ABMG), Accreditation Council for Genetic Counseling (ACGC), or National Society of Genetic Counselors (NSGC) accredited program or master's degree or higher in a related field of study as approved by the Board. ( )

03. Examination. An applicant must pass an ABGC or ABMG administered genetic counselor certification exam, or another exam approved by the board. ( )

04. Certification. An applicant must provide proof of current certification from the ABGC or ABMG. ( )

101. -- 199. (RESERVED)

200. PRACTICE STANDARDS.

01. Unprofessional and Unethical Conduct. Unprofessional and unethical conduct is conduct that does not conform to the guidelines for genetic counseling contained within the (NSGC) Code of Ethics, incorporated by reference into Section 002 of these rules and approved by the Board as the Idaho Code of Ethics. ( )

201. -- 399. (RESERVED)

~~250~~400. FEES.
All fees are non-refundable except that, if a license fee is tendered but the Board does not issue a license, the respective license fee will be returned. Fees are established in accord with Section 54-5613, Idaho Code as follows:

FEE TYPE	AMOUNT (Not to Exceed)
Application	$200
Original License	$200
Annual Renewal	$200
Provisional License	$200
License by Endorsement	$200
~~Examination~~Reinstatement	~~Determined by third-party examination administrator~~As provided in Section 67-2614, Idaho Code
~~Reinstatement~~	~~As provided in Section 67-2614, Idaho Code~~

~~(3-28-23)~~( )

~~251~~401. -- ~~299~~999.(RESERVED)

~~300. REQUIREMENTS FOR ORIGINAL LICENSURE.~~

~~01. General~~. ~~An applicant who in any state, territory or country has had a license revoked or suspended or has been otherwise disciplined by a Board, a government agency, or any other disciplinary body, or has been found guilty, convicted, received a withheld judgment or suspended sentence for a felony or a lesser crime conviction must submit with his application a written statement and any supplemental information establishing his current suitability for licensure.~~ ~~(3-28-23)~~

~~02. Consideration of Factors and Evidence~~. ~~The Board will consider the factors set forth in Section 67-9411, Idaho Code.~~ ~~(3-28-23)~~

~~03. Interview~~. ~~The Board may, at its discretion, grant an interview of the applicant.~~ ~~(3-28-23)~~

~~04. Applicant Bears the Burden~~. ~~The applicant will bear the burden of establishing his current suitability for licensure.~~ ~~(3-28-23)~~

~~05. Education~~. ~~An applicant must hold a master's degree or higher in genetics from an American~~

~~Board of Genetic Counseling (ABGC), American Board of Medical Genetics (ABMG), Accreditation Council for Genetic Counseling (ACGC), or National Society of Genetic Counselors (NSGC) accredited program or master's degree or higher in a related field of study as approved by the Board.~~ ~~(3-28-23)~~

~~**06. Examination**. An applicant must pass an ABGC or ABMG administered genetic counselor certification exam. The passage of the exam may have occurred prior to the effective date of these rules.~~ ~~(3-28-23)~~

~~**07. Certification**. An applicant must provide proof of current certification from the ABGC or ABMG.~~ ~~(3-28-23)~~

~~**301. – 309. (RESERVED)**~~

~~**310. REQUIREMENTS FOR LICENSURE BY ENDORSEMENT.**~~
~~The Board may grant a license to an applicant for licensure by endorsement who meets the following requirements:~~ ~~(3-28-23)~~

~~**01. General**. Meets the requirements prescribed in Subsection 300.01 of these rules; and~~ ~~(3-28-23)~~

~~**02. Holds a Current License**. The applicant must be the holder of a current active license in the profession and at the level for which a license is being sought, issued by the authorized regulatory entity of another state, territory, or jurisdiction. The state, territory, or jurisdiction must have licensing requirements substantially equivalent to or higher than those required for new applicants in Idaho. The certification of licensure must be received by the Board from the issuing agency.~~ ~~(3-28-23)~~

~~**311. REQUIREMENTS FOR PROVISIONAL LICENSE.**~~
~~The Board may issue a provisional license to allow a person who has been granted active candidate status to engage in the practice of genetic counseling. The holder of a provisional license may only practice under the general supervision of a person fully licensed under this chapter or a physician licensed in this state.~~ ~~(3-28-23)~~

~~**01. General**. Meets the requirements prescribed in Subsection 300.01 of these rules; and~~ ~~(3-28-23)~~

~~**02. Supervision**. While the provisional licensee is providing genetic counseling services, the licensee's supervisor need not be physically present; however, the supervisor must be readily accessible to the provisional licensee by telephone or by electronic means for consultation and assistance.~~ ~~(3-28-23)~~

~~**312. INACTIVE STATUS.**~~

~~**01. Request for Inactive Status**. Licensees requesting an inactive status during the renewal of their active license must submit a written request and pay the established fee.~~ ~~(3-28-23)~~

~~**02. Inactive License Status**. 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 in Idaho.~~ ~~(3-28-23)~~

~~**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, provide proof of ABGC certification and one (1) year of continuing education immediately preceding application.~~ ~~(3-28-23)~~

~~**313. – 499. (RESERVED)**~~

~~**500. CONTINUING EDUCATION.**~~
~~All licensees must comply with the following continuing education requirements:~~ ~~(3-28-23)~~

~~**01. Requirement**. Beginning with the second renewal of their license, a licensee will be required to complete a minimum of two (2) Continuing Education Units (CEUs) within the preceding twelve (12) months or one (1) CEU and one (1) Professional Activity Credit (PAC) within the preceding twelve (12) months.~~ ~~(3-28-23)~~

~~**02. Documentation**. Each licensee will maintain documentation verifying continuing education course~~

~~attendance and curriculum, or completion of the educational activity for a period of five (5) years from the date of completion. This documentation will be subject to audit by the Board.~~ ~~(3-28-23)~~

~~**a.** Documented evidence of meeting the continuing education course requirement must be in the form of a certificate or letter from the sponsoring entity that includes verification of attendance by the licensee, the title of the activity, the subject material covered, the dates and number of hours credited, and the presenter's full name and professional credentials. Documented evidence of completing a continuing education activity must be in such form as to document both completion and date of the activity.~~ ~~(3-28-23)~~

~~**b.** A licensee must submit the verification documentation to the Board, if requested by the Board. If a licensee fails to provide the Board with acceptable documentation of the hours attested to on the renewal application, the licensee may be subject to disciplinary action.~~ ~~(3-28-23)~~

~~**03. Waiver**. The Board may for good cause waive the requirements of this rule. The licensee should request the waiver in advance of renewal and must provide any information requested by the Board to assist in substantiating hardship cases. This waiver is granted at the sole discretion of the Board.~~ ~~(3-28-23)~~

~~**04. Carryover of Continuing Education Hours**. CEUs and PACs not claimed in the current renewal year may be claimed in the next renewal year. A maximum of two (2) CEUs or one (1) PAC and one (1) CEU may be carried forward from the immediately preceding year, and may not be carried forward more than one renewal year.~~ ~~(3-28-23)~~

~~**501. – 699. (RESERVED)**~~

~~**700. UNPROFESSIONAL AND UNETHICAL CONDUCT.**~~
~~Unprofessional and unethical conduct is conduct that does not conform to the guidelines for genetic counseling contained within the (NSGC) Code of Ethics, incorporated by reference into Section 002 of these rules and approved by the Board as the Idaho Code of Ethics.~~ ~~(3-28-23)~~

~~**701. – 899. (RESERVED)**~~

~~**900. DISCIPLINE.**~~

~~**01. Disciplinary Action**. If the Board determines that grounds for discipline exist for violations of Title 54, Chapter 56, Idaho Code, violations of these rules, or both, it may impose disciplinary sanctions against the licensee.~~ ~~(3-28-23)~~

~~**901. – 999. (RESERVED)**~~

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.33.01 – RULES OF THE BOARD OF MEDICINE FOR THE PRACTICE OF MEDICINE AND OSTEOPATHIC MEDICINE IN IDAHO

DOCKET NO. 24-3301-2401 (ZBR CHAPTER REWRITE, FEE RULE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo and Cost/Benefit Analysis (CBA)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1, 2025, in the year of the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. This rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 67-1002, 54-1806, 54-1806A, 54-1807, 54-1812, 54-1813, 54-1814, 54-1841, 54-1867, 67-2614, 67-9406 and 67-9409, 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:

Under Executive Order 2020-01, Zero-Based Regulation, the Idaho State Board of Medicine is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the pending rule reflects a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. It also amends the rules in response to recent statutes passed by the Idaho Legislature: HB542a (2024) and HB153 (2023). There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the July 3, 2024, Idaho Administrative Bulletin, Vol. 24-7, pages 224-235.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

As authorized in Sections 54-1807, 54-1808, 54-1813, 54-1867, Idaho Code, the fees in this rulemaking are established in Rule 400. The pending rules create new license types of a three-year provisional license for international physicians, pursuant to HB542a (2024), and a single-year license for bridge year physicians, pursuant to HB153 (2023), and impose new fees of up to $300 for each license type, consistent with the statutes.

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 is not anticipated to have any negative fiscal impact on the State General Fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Krissy Veseth, Bureau Chief, at (208) 577-2491. Materials pertaining to the pending rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

DATED this 30th day of August, 2024.

Krissy Veseth
Bureau Chief
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 577-2491
Email: krissy.veseth@dopl.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. This rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 6-1002, 54-1806, 54-1806A, 54-1807, 54-1812, 54-1813, 54-1814, 54-1841, 54-1867, 67-2614, 67-9406 and 67-9409, Idaho Code.

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

24.33.01 – Rules of the Board of Medicine for the Practice of Medicine and Osteopathic Medicine in Idaho

Monday, July 15, 2024 – 3:00 p.m. (MT)
Division of Occupational and Professional Licenses
Chinden Campus Building 4
11341 W. Chinden Blvd.
Boise, ID 83714

Virtual Meeting Link

Telephone and web conferencing information will be posted on https://dopl.idaho.gov/calendar/ and https://townhall.idaho.gov/.

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

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

Under Executive Order 2020-01, Zero-Based Regulation, the Idaho State Board of Medicine is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the proposed rule changes reflect a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. This proposed rulemaking updates the rules to comply with governing statute and Executive Order 2020-01. It also amended the rules in response to recent statutes passed by the Idaho legislature: H0542a (2024) and H0062 (2023).

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

The proposed rules create new license types of a three-year provisional license for international physicians, pursuant to H0542a (2024), and a single-year license for bridge year physicians, pursuant to H0062 (2023), and impose new fees of up to $300 for each license type, consistent with the statutes.

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:

This rulemaking is not anticipated to have any negative fiscal impact on the state General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted under Docket No. 24-ZBRR-2401. The Omnibus Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 3, 2024, Idaho Administrative Bulletin, Vol. 24-4, p.43.

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. No materials have been incorporated by reference into the proposed rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this proposed rule, contact Krissy Veseth, Bureau Chief, at (208) 577-2491. Materials pertaining to the proposed rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 24, 2024.

DATED this 7th day of June, 2024.

THE FOLLOWING IS THE TEXT OF ZBR FEE DOCKET NO. 24-3301-2401

24.33.01 – RULES OF THE BOARD OF MEDICINE FOR THE ~~LICENSURE TO~~ PRACTICE OF MEDICINE AND OSTEOPATHIC MEDICINE IN IDAHO

000. LEGAL AUTHORITY.
These rules are promulgated pursuant to Sections 6-1002, 54-1806~~(2), 54-1806(4), 54-1806(11),~~ 54-1806A, 54-1807, 54-1812, 54-1813, 54-1814~~, and~~ 54-1841, and 54-1867 Idaho Code. ~~(3-28-23)~~( )

001. SCOPE.
These rules govern the ~~licensure to~~ practice of medicine and osteopathic medicine in Idaho. Nothing in this rule chapter authorizes the practice of medicine or any of its branches by a person not so licensed by the Board.
~~(3-28-23)~~( )

~~**002. – 009. (RESERVED)**~~

0~~10~~02. DEFINITIONS.

01. **Ablative**. The separation, eradication, removal, or destruction of human tissue. ( )

012. **Acceptable International School of Medicine**. An international medical school located outside the United States or Canada that meets the standards for medical educational facilities set forth in Subsection 051 100.02 and is accredited by the ECFMG. (3-28-23)( )

~~**02.** **Medical Practice Act**. Title 54, Chapter 18, Idaho Code.~~ (3-28-23)

~~**242. DEFINITIONS RELATED TO INTERNS AND RESIDENTS.**~~

013. **Acceptable Intern or Resident Training Program**. A medical training program or course of medical study that has been approved by the LCME, Council on Medical Education or COCA of the AOA. (3-28-23)( )

024. **Acceptable PostGgraduate Training Program**. A post graduate medical training program or course of medical study that has been approved by the ACGME or AOA. (3-28-23)( )

~~**151. DEFINITIONS RELATING TO SUPERVISING AND DIRECTING PHYSICIANS.**~~

~~**01.** **Athletic Trainer**. A person who has met the qualifications for licensure as set forth in Title 54, Chapter 39, Idaho Code, is licensed under that chapter, and carries out the practice of athletic training under the direction of a designated Idaho licensed physician, registered with the Board.~~ (3-28-23)

05. **Cosmetic Treatment**. An aesthetic treatment prescribed by a physician for a patient that uses prescriptive medical/cosmetic devices or products to penetrate or alter human tissue. ( )

026. **Directing Physician**. A designated Idaho licensed physician, registered with the Board pursuant to this chapter and Title 54, Chapter 39, Idaho Code, who oversees the practice of athletic training and is responsible for the athletic training services provided by the athletic trainer. ~~This chapter does not authorize the practice of medicine or any of its branches by a person not so licensed by the Board.~~ (3-28-23)( )

07. **Incisive**. The power and quality of cutting of human tissue. ( )

038. **Medical Personnel**. An individual who, under the direction and supervision of a supervising physician, pursuant to the applicable Idaho statutes and the applicable rules promulgated by the Board, provides ~~cosmetic~~ treatments ~~using prescriptive medical/cosmetic devices and products that are exclusively non-incisive or non-ablative under the direction and supervision of a supervising physician, pursuant to the applicable Idaho statutes and the applicable rules promulgated by the Board~~ to patients. (7-1-24)( )

09. **Parenteral Admixture**. A preparation of sterile products intended for administration by injection. ( )

10. **Prescriptive Medical/Cosmetic Device**. An FDA-approved prescriptive device that uses waveform energy including, but not limited to, intense pulsed light or lasers, to cosmetically alter human tissue. ( )

11. **Prescriptive Medical/Cosmetic Product**. An FDA-approved prescriptive product whose primary intended use of the product is achieved through chemical action and cosmetically alters human tissue including, but not limited to, filler substances such as collagen or fat; lipo transfer; muscle immobilizers or sclerosing agents. ( )

0412. **Supervising Physician of Interns or Residents**. Any person approved by the Board who is licensed to practice medicine and surgery or osteopathic medicine and surgery in Idaho, who signs the application for registration of an intern or resident, and who is responsible for the direction and supervision of their activities. (7-1-24)

~~05~~13. **Supervising Physician of Medical Personnel**. An Idaho licensed physician who supervises and has full responsibility for ~~cosmetic~~ treatments ~~using prescriptive medical/cosmetic devices and products~~ provided by medical personnel. ~~(7-1-24)~~( )

0~~1~~103. ABBREVIATIONS.

01. **ACGME**. Accreditation Council for Graduate Medical Education. (3-28-23)

02. **AOA**. American Osteopathic Association. (3-28-23)

03. **COCA**. Commission on Osteopathic College Accreditation. (3-28-23)

04. **ECFMG**. Educational Commission for Foreign Medical Graduates. (3-28-23)

05. **FAIMER**. Foundation for Advancement of International Medical Education. (3-28-23)

06. **FDA**. United States Food and Drug Administration. ( )

0~~6~~7. **FSMB**. Federation of State Medical Boards. (3-28-23)

0~~7~~8. **LCME**. Liaison Committee on Medical Education. (3-28-23)

0~~8~~9. **USMLE**. United States Medical Licensing Exam. (3-28-23)

~~09~~10. **WFME**. World Federation for Medical Education. (3-28-23)

0~~12~~04. -- 0~~49~~99. (RESERVED)

100. LICENSURE.

~~050~~01. General Qualifications for Licensure and Renewal. ( )
~~Requirements for licensure and renewal are found in Title 54, Chapter 18, Idaho Code, IDAPA 24.33.03, and on Board approved forms.~~ ~~(3-28-23)~~

~~01. Additional Circumstances~~. ~~The Board may require further inquiry when in its judgment the need is apparent as outlined in Board policy.~~ ~~(3-28-23)~~

a. Residence. No period of residence in Idaho is required of any applicant, however, each applicant for licensure must be legally able to work and live in the United States. Original documentation of lawful presence in the United States must be provided upon request. The Board may refuse licensure or to renew a license if the applicant is not lawfully present in the United States. ( )

~~02~~b. Special Purpose Examination. Upon inquiry, if further examination is required, the Board may require passage of the Special Purpose Examination (SPEX) administered by the FSMB, a post licensure assessment conducted by the FSMB, or an evaluation by an independent agency accepted by the Board to evaluate physician competence. (3-28-23)

~~03~~c. Board Determinations. ~~Where~~ When the Board deems necessary, it may limit, condition, or restrict a newly issued license based on the Board's determination and the recommendation of the assessment or evaluation. ~~(3-28-23)~~( )

~~04~~d. Postgraduate Training Program. Successful completion of one year of a medical residency or internship program constitutes successful completion of a postgraduate training program acceptable to the Board. (3-28-23)

~~051~~02. Licensure for Graduates of International Medical Schools Located Outside of the United States and Canada. ( )

01a. International Medical Graduate. In addition to meeting the ~~requirements of Section 050~~ General Qualifications for Licensure and Renewal, graduates of international medical schools located outside of the United States and Canada, who do not meet the requirements set forth in Section 54-1812, Idaho Code, must submit to the Board: ~~(3-28-23)~~( )

~~a~~i. Original certificate from the ECFMG or original documentation that the applicant has passed the examination either administered or recognized by the ECFMG and passed an examination acceptable to the Board that demonstrates qualification for licensure or successfully completed the USMLE; (3-28-23)

~~b~~ii. Original documentation directly from the international medical school that establishes to the satisfaction of the Board that the international medical school meets the standards for medical educational facilities set forth in Subsection ~~051.02~~ 100.02.b. of this Rule; ~~(3-28-23)~~( )

~~c~~iii. A transcript from the international medical school showing successful completion of all the courses taken and grades received and original documentation of successful completion of all clinical coursework; and (3-28-23)

~~d~~iv. Original documentation of successful completion of two (2) years of progressive postgraduate training at one (1) training program accredited for internship, residency, or fellowship training by the ACGME, AOA or the Royal College of Physicians and Surgeons of Canada or its successor organization, provided however, a resident who is attending an Idaho based residency program may be licensed after successful completion of one (1) years of progressive post graduate training, if the following conditions are met: (3-28-23)

~~i.~~(1) Written approval of the residency program director; (3-28-23)

~~ii.~~(2) Signed written contract with the Idaho residency program to complete the entire residency program; (3-28-23)

~~iii.~~(3) Remained in good standing at the Idaho-based residency program; (3-28-23)

~~iv.~~(4) Notified the Board within thirty (30) days if there is a change in circumstances or affiliation with the program; and (3-28-23)

~~v.~~(5) Received an MD or DO degree from an approved school that is eligible for Idaho licensure after graduation. ~~(3-28-23)~~( )

02b. International Medical School Requirements. An international medical school must be listed in the World Directory of Medical Schools, a joint venture of WFME and FAIMER. Graduates of schools not listed in WFME or FAIMER must submit to the Board original documentation of three (3) of the four (4) requirements listed below: (3-28-23)

~~a~~i. A valid ECFMG Certificate. (3-28-23)

~~b~~ii. Successful completion of three (3) years of progressive post graduate training at one (1) training program accredited for internship, residency or fellowship training in an ACGME or AOA or Royal College of Physicians and Surgeons of Canada or its successor organization's approved program. (3-28-23)

~~c~~iii. Current board certification by a specialty board approved by the American Board of Medical Specialties or the AOA. (3-28-23)

~~d~~iv. Evidence of five (5) years of unrestricted practice as a licensee of any United States or Canadian jurisdiction. (3-28-23)

~~243~~03. **Temporary Registration**. ( )

01a. Eligibility. Any person ~~identified in Section 54-1813(2), Idaho Code~~ practicing under the

supervision of an Idaho-licensed physician as part of a postgraduate medical training program. ~~(7-1-24)~~( )

~~02~~b. Registration Certificate. Each registration will be issued for a period of one (1) year and will identify the supervising physician. Each registrant will notify the Board in writing of any change of the supervising physician or the program or course of study fourteen (14) days prior to any such change. If the Board deems the applicant qualified, and if the course of study requires, the Board may additionally certify on the registration certificate that the registrant is qualified to write prescriptions for Class III through Class V scheduled medications. (7-1-24)

~~03~~c. Discipline. Registrations may be terminated, suspended, or made conditional by the Board on the grounds set forth in Section 54-1814, Idaho Code. (7-1-24)

~~04~~d. Annual Renewal. Registration may be renewed annually and, if not renewed by the expiration date, will be canceled. (7-1-24)

~~05~~e. Notification of Changes.Registrants must notify the Board in writing of any adverse action or termination, whatever the outcome, from any post graduate training program and any name changes within fourteen (14) days of such event. (7-1-24)

~~06~~f. Disclosure. A registrant must ensure patients are informed that the registrant is currently enrolled in a post graduate training program and working under the supervision of a licensed physician. (7-1-24)

~~052. -- 078. (RESERVED)~~

~~079~~04. **Continuing Medical Education (CME) ~~Required~~ Requirements**. ( )

~~01~~a. Renewal. ~~Each person licensed to practice medicine and surgery or osteopathic medicine or surgery in Idaho shall complete no less than forty (40) hours of practice relevant, Category 1, CME every two (2) years. (3-28-23)~~

~~02.~~ ~~**Verification of Compliance**. Licensees will, at~~ Prior to license renewal, each licensee shall provide an attestation ~~to the Board~~ indicating ~~compliance. The Board, in its discretion, may require such additional evidence as is necessary to verify compliance.~~ that they have either: ~~(3-28-23)~~( )

i. Completed no less than forty (40) hours of practice-relevant CME during the prior two (2) years; ( )

~~03~~ii. ~~**Alternate Compliance**. The Board may accept~~Maintained current board certification ~~or recertification by a member of~~ from the American Board of Medical Specialties, the AOA, or the Royal College of Physicians and Surgeons of Canada or its successor organization; or ( )

iii. ~~in lieu of compliance with continuing education requirements during the cycle in which the certification or recertification is granted. The Board may also grant an exemption for~~Participated full time ~~participation~~ in a residency or fellowship training program at a professionally accredited institution. ~~(3-28-23)~~( )

b. Verification of Compliance. The Board, in its discretion, may require such additional evidence as is necessary to verify compliance. ( )

~~04. **Penalties for Noncompliance**. The Board may condition, limit, suspend, or refuse to renew the license of any person whom the Board determines has failed to comply with the continuing education requirements of this chapter. (3-28-23)~~

101. -- 1~~50~~99. (RESERVED)

200. PRACTICE STANDARDS.

~~162~~01. **Duties of Collaborating Physicians**. ( )

~~01~~a. Responsibilities. A collaborating physician is responsible for complying with the requirements set forth in Title 54, Chapter 18 and IDAPA 24.33.02 when collaborating and consulting in the medical services provided by any physician assistant or graduate physician assistant either through a collaborative practice agreement or through the facility bylaws or procedures of any facility with credentialing and privileging systems. (3-28-23)

~~161~~02. **Duties ~~O~~of Directing Physicians**. ( )

~~01~~a. Responsibilities. The directing physician accepts full responsibility for the acts and athletic training services provided by the athletic trainer and oversees the practice of athletic training of the athletic trainer, and for the supervision of such acts which include, but are not limited to: (3-28-23)

~~a~~i. An on-site visit at least semiannually to personally observe the quality of athletic training services provided; and (3-28-23)

~~b~~ii. Recording of a periodic review of a representative sample of the records, including, but not limited to, records made from the past six (6) months of the review to evaluate the athletic training services that were provided. (3-28-23)

~~02~~b. Scope of Practice. The directing physician must ensure the scope of practice of the athletic trainer, as set forth in IDAPA 24.33.05, and Section 54-3903, Idaho Code, will be limited to and consistent with the scope of practice of the directing physician and exclude any independent practice of athletic training by an athletic trainer. (3-28-23)

~~03~~c. Directing Responsibility. The responsibilities and duties of a directing physician may not be transferred to a business entity, professional corporation, or partnership, nor may they be assigned to another physician without prior notification and Board approval. (3-28-23)

~~04~~d. Available Supervision. The directing physician will oversee the activities of the athletic trainer and must be available either in person or by telephone to supervise, direct, and counsel the athletic trainer. The scope and nature of the direction of the athletic trainer will be outlined in an athletic training service plan or protocol, as set forth in IDAPA 24.33.05. (3-28-23)

~~05~~e. Disclosure. It is the responsibility of each directing physician to ensure that each athlete who receives athletic training services is aware of the fact that said person is not a licensed physician. (3-28-23)

~~163~~03. **Duties ~~O~~of Supervising Physicians ~~O~~of Interns ~~A~~and Residents**. ( )

~~01~~a. Responsibilities. The supervising physician is responsible for the direction and supervision of the medical acts and patient services provided by an intern or resident. The direction and supervision of such activities include, but are not limited to: (3-28-23)

~~a~~i. Synchronous direct communication at least monthly with intern or resident to ensure the quality of care provided; (3-28-23)

~~b~~ii. Recording of a periodic review of a representative sample of medical records to evaluate the medical services that are provided; and (3-28-23)

~~c~~iii. Regularly scheduled conferences between the supervising physician and the intern or resident. (3-28-23)

~~02~~b. Available Supervision. The supervising physician will oversee the activities of the intern or resident, and must always be available either in person or by telephone to supervise, direct and counsel the intern or resident. (3-28-23)

~~03~~c. Disclosure. It is the responsibility of each supervising physician to ensure that each patient who receives the services of an intern or resident is notified of the fact that said person is not a licensed physician.

(3-28-23)

~~164~~04. Duties of Supervising Physicians ~~O~~of Medical Personnel. ( )

a. Purpose. The "practice of medicine," as defined in Section 54-1803(1), Idaho Code, includes the administration of parenteral admixtures and the performance of cosmetic treatments using prescriptive medical/cosmetic devices and products which penetrate ~~and~~ or alter human tissue. Such ~~cosmetic~~ treatments can ~~result in~~ lead to significant complications ~~such as visual impairment, blindness, inflammation, burns, scarring, hypopigmentation, and hyperpigmentation~~ that may result in permanent injury or death and, therefore, can only be performed as set forth herein. ~~This chapter does not authorize the practice of medicine or any of its branches by a person not so licensed by the Board.~~ ~~(3-28-23)~~( )

~~**01. Definitions.**~~ ~~(3-28-23)~~

~~**a.** Ablative. Ablative is the separation, eradication, removal, or destruction of human tissue.~~ ~~(3-28-23)~~

~~**b.** Incisive. Incisive is the power and quality of cutting of human tissue.~~ ~~(3-28-23)~~

~~**c.** Cosmetic Treatment. An aesthetic treatment prescribed by a physician for a patient that uses prescriptive medical/cosmetic devices and/or products to penetrate or alter human tissue.~~ ~~(3-28-23)~~

~~**d.** Prescriptive Medical/Cosmetic Device. A federal food and drug administration approved prescriptive device that uses waveform energy including, but not limited to, intense pulsed light or lasers, to cosmetically alter human tissue.~~ ~~(3-28-23)~~

~~**e.** Prescriptive Medical/Cosmetic Product. A federal food and drug administration approved prescriptive product whose primary intended use of the product is achieved through chemical action and cosmetically alters human tissue including, but not limited to, filler substances such as collagen or fat; lipo transfer; muscle immobilizers or sclerosing agents.~~ ~~(3-28-23)~~

~~02~~b. ~~Duties and~~ Responsibilities ~~of Supervising Physicians~~. The supervising physician accepts full responsibility for ~~cosmetic~~ all treatments provided by medical personnel and for the supervision of such treatments. ~~The supervising physician must be trained in the safety and use of prescriptive medical/cosmetic devices and products.~~ ~~(3-28-23)~~( )

~~a~~i. Patient Record. The supervising physician must document an adequate legible patient record of his evaluation, assessment, and plan for the patient prior to the initial ~~cosmetic~~ treatment. ~~(3-28-23)~~( )

~~**b.** Supervisory Responsibility. A supervising physician of medical personnel may not supervise more than three (3) such medical personnel contemporaneously. The Board, however, may authorize a supervising physician to supervise a total of six (6) such medical personnel contemporaneously if necessary to provide adequate cosmetic treatments and upon prior petition documenting adequate safeguards to protect the public health and safety.~~ ~~(3-28-23)~~

~~c~~ii. Available Supervision. The supervising physician will be on-site or immediately available to respond promptly to any questions or problems that may occur while a ~~cosmetic~~ treatment is being performed by medical personnel. Such supervision includes, but is not limited to: ~~(3-28-23)~~( )

~~i.~~(1) Periodic review of the medical records to evaluate the prescribed ~~cosmetic~~ treatments that are provided by such medical personnel including any adverse outcomes or changes in the treatment protocol; and ~~(3-28-23)~~( )

~~ii.~~(2) Regularly scheduled conferences between the supervising physician and such medical personnel. (3-28-23)

~~c~~iii. Verification of Training. The supervising physician is responsible to ensure that, with respect to any treatment performed, the medical personnel possess the proper training to perform the treatment, the indications for

the prescribed treatment, and the pre- and post-procedure care involved. The supervising physician will verify the training of medical personnel upon the board-approved Medical Personnel Supervising Physician Registration form. The Medical Personnel Supervising Physician Registration Form will be maintained on file at each practice location and at the address of record of the supervising physician. ~~(3-28-23)~~( )

~~d~~iv. ~~Scope of~~ Cosmetic Treatments.~ ( )

(1) Scope. Cosmetic treatments can only be performed by a physician or by medical personnel under the supervision of a physician. Physicians who supervise cosmetic treatments must be trained in the safety and use of prescriptive medical/cosmetic devices and products. Medical personnel providing cosmetic treatments are limited to using prescriptive medical/cosmetic devices and products that are exclusively non-incisive and non-ablative. The supervising physician will ensure cosmetic treatments provided by medical personnel are limited to and consistent with the scope of practice of the supervising physician. ~~The supervising physician will ensure that, with respect to each procedure performed, the medical personnel possess the proper training in cutaneous medicine, the indications for the prescribed treatment, and the pre- and post-procedure care involved.~~ ~~(3-28-23)~~( )

(2) Supervision. A supervising physician of medical personnel may not supervise more than three (3) medical personnel providing cosmetic treatments contemporaneously. The Board, however, may authorize a supervising physician to supervise a total of six (6) such medical personnel contemporaneously if necessary to provide adequate treatments and upon prior petition documenting adequate safeguards to protect the public health and safety. ( )

~~f~~v. Disclosure. It is the responsibility of each supervising physician to ensure that every patient receiving ~~a cosmetic~~ treatment from medical personnel is advised of the education and training of the medical personnel rendering the treatment and that such medical personnel are not licensed physicians. ~~(3-28-23)~~( )

~~g~~vi. Patient Complaints. The supervising physician will report to the Board of Medicine all patient complaints received against medical personnel that relate to the quality and nature of ~~cosmetic~~ treatments rendered. ~~(3-28-23)~~( )

~~h~~vii. Duties and Responsibilities Nontransferable. The responsibilities and duties of a supervising physician may not be transferred to a business entity, professional corporation, or partnership, nor may they be assigned to another physician or person. (3-28-23)

~~165~~201. -- 2~~41~~99.(RESERVED)

300. DISCIPLINE.
In addition to the grounds for discipline set forth in Idaho Code, every person licensed or permitted by the Board is subject to discipline upon any of the following grounds: ( )

01. Unethical Advertising. Advertising the licensee or permittee's practice in any unethical or unprofessional manner, including but not limited to: ( )

a. Using advertising or representations likely to deceive, defraud, or harm the public. ( )

b. Making a false or misleading statement regarding the licensee or permittee's skill or the efficacy or value of the treatment, remedy, or service offered, performed, or prescribed by the licensee or permittee. ( )

03. Standard of Care. Providing health care that fails to meet the standard of health care provided by other qualified licensees or permittees of the same profession, in the same community or similar communities, including but not limited to: ( )

a. Being found mentally incompetent or insane by any court of competent jurisdiction. ( )

b. Engaging in practice or behavior that demonstrates a manifest incapacity or incompetence to practice his or her profession. ( )

c. Allowing another person or organization to use his or her license or permit to practice his or her profession. ( )

d. Prescribing, selling, administering, distributing or giving any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug to himself or herself or to a spouse, child, or stepchild. ( )

e. Using any controlled substance or alcohol to an extent that use impairs the licensee or permittee's ability to practice his or her profession competently. ( )

f. Violating any state or federal law or regulation relating to controlled substances. ( )

g. Directly promoting surgical procedures or laboratory tests that are unnecessary and not medically indicated. ( )

h. Failure to transfer pertinent and necessary medical records to another provider when requested to do so by the subject patient or client or by his or her legally designated representative. ( )

i. Failing to maintain adequate records. Adequate patient or client records means legible records that contain, at a minimum, subjective information, an evaluation and report of objective findings, assessment or diagnosis, and the plan of care. ( )

j. Providing care or performing any service outside the licensee or permittee's scope of practice as set forth in Idaho Code, including providing care or performing a service without supervision, if such is required by Idaho Code or Board rule. ( )

k. Failing to have a supervising or directing physician who is licensed by the Board, if such supervision is required by Idaho Code or Board rule. ( )

04. Conduct. Engaging in any conduct that constitutes an abuse or exploitation of a patient or client arising out of the trust and confidence placed in the licensee or permittee by the patient or client, including but not limited to: ( )

a. Obtaining any fee by fraud, deceit, or misrepresentation. ( )

b. Employing abusive billing practices. ( )

c. Commission of any act of sexual contact, misconduct, exploitation, or intercourse with a patient or client or former patient or client or related to the licensee's practice. ( )

i. Consent of the patient or client shall not be a defense. ( )

ii. This section does not apply to sexual contact between a licensee or permittee and the licensee or permittee's spouse or a person in a domestic relationship who is also a patient or client. ( )

iii. A former patient or client includes a patient or client for whom the licensee or permittee has provided services related to the licensee or permittee's practice, including prescriptions, within the last twelve (12) months; sexual or romantic relationships with former patients or clients beyond that period of time may also be a violation if the licensee or permittee uses or exploits the trust, knowledge, emotions, or influence derived from the prior professional relationship with the patient or client. ( )

d. Accepting any reimbursement for service, beyond actual expenses, while providing services under a volunteer license. ( )

e. Employing, supervising, directing, aiding, or abetting a person not licensed or permitted in this state who directly or indirectly performs activities or provides services requiring a license or permit. ( )

f. Failing to report to the Board any known act or omission of a Board licensee or permittee that violates any provision of these rules. ( )

g. Interfering with an investigation or disciplinary proceeding by willful misrepresentation of facts or by use of threats or harassment against any patient or client, Board or Advisory Board or Committee member, Board staff, hearing officer, or witness in an attempt to influence the outcome of a disciplinary proceeding, investigation, or other legal action. ( )

h. Failing to obey any and all state and local laws and rules related to the licensee or permittee's practice or profession. ( )

05. Failure to Cooperate. Failing to cooperate with the Board during any investigation or disciplinary proceeding, even if such investigation or disciplinary proceeding does not personally concern the particular licensee. ( )

06. On-Site Review. The Board, by and through its designated agents, is authorized to conduct on-site reviews of the activities of its licensees at the locations and facilities in which the licensees practice at such times as the Board deems necessary. ( )

301. -- 399. (RESERVED)

~~1~~400. FEES~~ – TABLE~~.

~~01. Fees – Table.~~ Nonrefundable fees are as follows:

Fees – Table ~~(Non-Refundable)~~		
Licensure Fee	-	Not more than $600
Provisional License	-	Not more than $300
Temporary License	-	Not more than $300
Reinstatement License Fee plus total of renewal fees not paid by applicant	-	Not more than $300
~~Inactive License Renewal Fee~~	~~-~~	~~Not more than $100~~
Renewal of License to Practice Medicine Fee	-	Not more than $300
~~Duplicate Wallet License~~	~~-~~	~~Not more than $20~~
~~Duplicate Wall Certificate~~	~~-~~	~~Not more than $50~~
Volunteer License Application Fee	-	$0
Volunteer License Renewal Fee	-	$0
Limited License for Bridge Year Physicians	-	Not more than $300
Temporary Registration	-	Not more than $25

~~(3-28-23)~~( )

~~02. Administrative Fees for Services.~~ ~~Administrative fees for services shall be billed on the basis of time and cost.~~ ~~(3-28-23)~~

[existing Section 151 has been moved under proposed Section 002]

~~152. -- 160. (RESERVED)~~

[existing Sections 161-164 have been moved under proposed Section 200]

~~**165. -- 241. (RESERVED)**~~

[existing Sections 242-243 have been moved under proposed Sections 002 & 100, respectively]

~~**244. FEES - TABLE.**~~
~~Nonrefundable fees are as follows:~~

~~Fees~~	
~~Temporary Registration~~	~~- $25 annually~~

~~(7-1-24)~~

~~245~~401. -- ~~9~~799. (RESERVED)

~~0~~800. PHYSICIAN PANEL~~IST~~ FOR PRELITIGATION CONSIDERATION OF ~~MEDICAL~~ MALPRACTICE CLAIMS.

01. **~~Eligibility~~Obligation**. A physician licensed to practice medicine or osteopathic medicine in Idaho must be available to serve in any two (2) year period, or a longer period not to exceed five (5) years, as determined by the panel chairman, as a physician panelist for prelitigation consideration of a medical malpractice claim.
~~(3-28-23)~~( )

02. **Excusing Physicians from Serving**. A physician panelist so selected must serve unless he had served on a prelitigation panel during any previous two (2) year period, or a longer period not to exceed five (5) years, as determined by the panel chairman or for good cause shown, is excused by the panel chairman. To show good cause for relief from serving, the selected physician panelist must present an affidavit to the panel chairman which shall set out the facts showing that service would constitute an unreasonable burden or undue hardship. The panel chairman has the sole authority to excuse a selected physician from serving on a prelitigation panel. (3-28-23)

03. **Penalties for Noncompliance**. The Board may condition, limit, suspend, or refuse to renew the license of any physician whom the Board determines has failed to serve as a physician panelist for the prelitigation consideration of a medical malpractice claim. (3-28-23)

~~0~~801. -- ~~0~~999. (RESERVED)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.33.02 – RULES FOR THE LICENSURE OF PHYSICIAN ASSISTANTS

DOCKET NO. 24-3302-2401 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1, 2025, in the year of the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. This rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 54-1806, 54-1807A, 67-2614, 67-9406, and 67-9409, 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:

Under Executive Order 2020-01, Zero-Based Regulation, the Idaho State Board of Medicine is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the pending rule reflects a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the July 3, 2024, Idaho Administrative Bulletin, Vol. 24-7, pages 236-239.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

As authorized in Sections 54-1807, 54-1808, 54-1813, 54-1867, Idaho Code, the fees in this rulemaking are established in Rule 400. The pending rules do not impose any new or increased fees.

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 is not anticipated to have any negative fiscal impact on the state General Fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Krissy Veseth, Bureau Chief, at (208) 577-2491. Materials pertaining to the pending rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

DATED this 30th day of August, 2024.

Krissy Veseth
Bureau Chief
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 577-2491
Email: krissy.veseth@dopl.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. This rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 6-1002, 54-1806, 54-1807A, 67-2614, 67-9406 and 67-9409, Idaho Code.

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

24.33.02 – Rules for the Licensure of Physician Assistants

Monday, July 15, 2024 – 3:00 p.m. (MT)
Division of Occupational and Professional Licenses
Coolwater Room, Chinden Campus Building 4
11341 W. Chinden Blvd.
Boise, ID 83714

Virtual Meeting Link

Telephone and web conferencing information will be posted on https://dopl.idaho.gov/calendar/ and https://townhall.idaho.gov/.

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

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

Under Executive Order 2020-01, Zero-Based Regulation, the Idaho State Board of Medicine is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the proposed rule changes reflect a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. This proposed rulemaking updates the rules to comply with governing statute and Executive Order 2020-01.

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

N/A. The proposed amendments to the rules do not impose any new or increased fees.

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:

This rulemaking is not anticipated to have any negative fiscal impact on the state General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted under Docket No. 24-ZBRR-2401. The Omnibus Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 3, 2024, Idaho Administrative Bulletin, Vol. 24-4, p.43.

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. No materials have been incorporated by reference into the proposed rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this proposed rule, contact Krissy Veseth, Bureau Chief, at (208) 577-2491. Materials pertaining to the proposed rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 24, 2024.

DATED this 7th day of June, 2024.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 24-3302-2401

24.33.02 – RULES FOR THE LICENSURE OF PHYSICIAN ASSISTANTS

000. LEGAL AUTHORITY.
These rules are promulgated pursuant to Sections 54-1806 and 54-1807A, 54-1810A Idaho Code. ~~(3-28-23)~~( )

001. SCOPE.
These rules govern the practice of physician assistants and graduate physician assistants. (3-28-23)

~~**002. – 009. (RESERVED)**~~

~~**010. DEFINITIONS.**~~

~~**01. Approved Program**. A course of study for the education and training of physician assistants that is accredited by the Accreditation Review Commission on Education for Physician Assistants (ARC-PA) or predecessor agency or equivalent agency recognized by the Board as recommended by the Committee. (3-28-23)~~

~~**011. – 019. (RESERVED)**~~

~~**020. REQUIREMENTS FOR LICENSURE.**~~
~~Requirements for licensure and renewal are found in Title 54, Chapter 18, Idaho Code, IDAPA 24.33.03, and on Board-approved forms. (3-28-23)~~

~~021~~002. -- ~~027~~099.(RESERVED)

100. LICENSURE.

01. Acceptable Examination. National Commission on Certification of Physician Assistants (NCCPA) Physician Assistant National Certifying Examination (PANCE). ( )

02. Graduate Physician Assistant. ( )

104. -- 199. (RESERVED)

200. PRACTICE STANDARDS.

~~**028. SCOPE OF PRACTICE.**~~

~~**01. Scope**. The scope of practice of physician assistants and graduate physician assistants includes only those duties and responsibilities identified in a collaborative practice agreement or the facility bylaws or procedures of any facility with credentialing and privileging systems.~~ ~~(3-28-23)~~

0~~2~~1. **Collaborative Practice Agreement**. A collaborative practice agreement ~~will comply with Title 54, Chapter 18, Idaho Code and~~, in addition to complying with Section 54-1807A(2), Idaho Code, will contain the following elements: ~~(3-28-23)~~( )

a. The parties to the agreement; (3-28-23)

b. The authorized scope of practice for each licensed physician assistant or graduate physician assistant; (3-28-23)

~~**c.** A requirement that the physician assistant or graduate physician assistant must collaborate with, consult with, or refer to the collaborating physician or another appropriate physician as indicated by: the condition of the patient; the education, experience and competence of the physician assistant or graduate physician assistant; and the community standard of care; and~~ ~~(3-28-23)~~

~~d~~**c.** If necessary, any monitoring parameters. (3-28-23)

0~~3~~2. **Advertise**. No physician assistant or graduate physician assistant may advertise or represent himself either directly or indirectly, as a physician. (3-28-23)

0~~4~~3. **Emergency or Disaster Care**. A collaborative practice agreement is not necessary for a licensed physician assistant or graduate physician assistant to render medical services to an ill or injured person at the scene of an emergency or disaster (not to be defined as an emergency situation which occurs in the place of one's employment) and while continuing to care for such person. (3-28-23)

~~**029. CONTINUING EDUCATION REQUIREMENTS.**~~

04. Continuing Education Requirements. ~~Requirements for Renewal.~~ Prior to renewal of ~~each~~ a license ~~as set forth by the expiration date on the face of the certificate,~~ physician assistants shall attest to ~~maintenance of~~ current certification by the National Commission on Certification of Physician Assistants or a similar certifying agency approved by the Board~~, which certification requires a minimum of one hundred (100) hours of continuing medical education over a two-year (2) period~~. ~~(3-28-23)~~

~~**030. -- 035. (RESERVED)**~~

~~**036. GRADUATE PHYSICIAN ASSISTANT.**~~

~~**01. Licensure Prior to Certification Examination -- Board Consideration**.~~ Any person who ~~has graduated from an approved physician assistant training program and~~ substantially meets ~~all Idaho~~ the requirements~~, including achieving a college baccalaureate degree, but has not yet taken and passed the certification examination,~~ set forth in Section 54-1803(10)(a), Idaho Code, may ~~be considered by~~ apply to the Board for licensure as a graduate physician assistant for six (6) months ~~when an application for licensure as a graduate physician assistant has been submitted to the Board on forms supplied by the Board and payment of the prescribed fee~~, provided: ~~(3-28-23)~~( )

a. The applicant will submit to the Board~~, within ten (10) business days of receipt,~~ a copy of acknowledgment of sitting for the national certification examination. ~~The applicant will submit to the Board, within ten (10) business days of receipt, a copy of the national certification examination results.~~ ~~(3-28-23)~~

~~**b.** After the graduate physician assistant has passed the certification examination, the Board will~~

~~receive verification of national certification directly from the certifying entity. Once the~~ Upon primary source verification ~~is received~~ of passing the examination by the Board, the graduate physician assistant's license will be converted to a permanent license and he may apply for prescribing authority. ~~(3-28-23)~~( )

~~**c.** The applicant who has failed the certification examination one (1) time, may petition the Board for a one-time extension of his graduate physician assistant license for an additional six (6) months. (3-28-23)~~

~~**d.** If the graduate physician assistant fails to pass the certifying examination on two (2) separate occasions, the graduate physician assistant's license will automatically be canceled upon receipt of the second failing certification examination score. (3-28-23)~~

~~**e.** The graduate physician assistant applicant will agree to execute an authorization for the release of information, attached to his application as Exhibit A, authorizing the Board or its designated agents, having information relevant to the application, including but not limited to the status of the certification examination, to release such information, as necessary, to his supervising physician. (3-28-23)~~

~~**02. Licensure Prior to College Baccalaureate Degree -- Board Consideration.** Licensure as a graduate physician assistant may also be considered upon application made to the Board on forms supplied by the Board and payment of the prescribed fee when all application requirements have been met as set forth in Section 020 of these rules, except receipt of documentation of a college baccalaureate degree, provided: (3-28-23)~~

~~**a.** A college baccalaureate degree from a nationally accredited school with a curriculum approved by the United States Secretary of Education, the Council for Higher Education Accreditation, or both, or from a school accredited by another such agency approved by the Board shall be completed within five (5) years of initial licensure in Idaho; (3-28-23)~~

0~~3~~5. ~~No~~ Graduate Physician Assistant Prescribing Authority. Graduate physician assistants shall not be entitled to issue any written or oral prescriptions ~~unless granted an exemption by the Board. Application for an exemption must be in writing and accompany documentation of a minimum of five (5) years of recent practice as a physician assistant in another state~~. ~~(3-28-23)~~( )

~~037~~201. -- ~~050~~399.(RESERVED)

~~051~~400. FEES~~ -- TABLE~~.
Nonrefundable fees are as follows:

Fees – Table (Non-Refundable)		
Licensure Fee - Physician Assistant & Graduate Physician Assistant	-	Not more than $250
Annual License Renewal Fee	-	Not more than $150
~~Reinstatement Fee~~	-	~~$50 plus past renewal fees~~
~~Reinstatement Fee for Graduate Physician Assistant~~	-	~~Not more than $100~~
~~Inactive License Fee~~	-	~~Not more than $150~~
~~Annual Renewal of Inactive License Fee~~	-	~~Not more than $100~~
~~Inactive Conversion Fee~~	-	~~Not more than $150~~

~~(3-28-23)~~( )

~~052~~401. -- 999. (RESERVED)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.33.03 – GENERAL PROVISIONS OF THE BOARD OF MEDICINE

DOCKET NO. 24-3303-2401 (ZBR CHAPTER REPEAL)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1, 2025, in the year of the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. This rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 54-1806, 54-1806A, 54-1807, 54-1812, 54-1813, 54-1814, 54-1841, 54-1867, 67-2614, 67-9406, and 67-9409, 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 chapter of administrative rules is being repealed. All necessary provisions have been moved and combined into DAPA 24.33.01, Rules of the Board of Medicine for the Practice of Medicine and Osteopathic Medicine in Idaho, under companion docket 24-3301-2401 in this bulletin. There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the July 3, 2024, Idaho Administrative Bulletin, Vol. 24-7, pages 240-241.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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:

This rulemaking is not anticipated to have any negative fiscal impact on the state General Fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Krissy Veseth, Bureau Chief, at (208) 577-2491. Materials pertaining to the pending rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

DATED this 30th day of August, 2024.

Krissy Veseth
Bureau Chief
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 577-2491
Email: krissy.veseth@dopl.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. This rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 6-1002, 54-1806, 54-1806A, 54-1807, 54-1812, 54-1813, 54-1814, 54-1841, 54-1867, 67-2614, 67-9406 and 67-9409, Idaho Code.

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

24.33.03 – General Provisions of the Board of Medicine

Monday, July 15, 2024 – 3:00 p.m. (MT)
Division of Occupational and Professional Licenses
Chinden Campus Building 4
11341 W. Chinden Blvd.
Boise, ID 83714

Virtual Meeting Link

Telephone and web conferencing information will be posted on https://dopl.idaho.gov/calendar/ and https://townhall.idaho.gov/.

The hearing site will be accessible to persons with disabilities, if needed. Requests for accommodation must be made not later than five (5) days prior to the meeting 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 administrative rules is being repealed. All necessary provisions are being moved and combined into IDAPA 24.33.01, Rules of the Board of Medicine for the Practice of Medicine and Osteopathic Medicine in Idaho, under companion docket 24-3301-2401 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 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: This rulemaking is not anticipated to have any negative impact on the State General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted under Docket No. 24-ZBRR-2401. The Omnibus Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 3, 2024, Idaho Administrative Bulletin, Vol. 24-4, p.41.

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, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this proposed rule, contact Krissy Veseth, Bureau Chief, at (208) 577-2491. Materials pertaining to the proposed rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 24, 2024.

DATED this 7th day of June, 2024.

IDAPA 24.33.03 IS BEING REPEALED IN ITS ENTIRETY

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.33.04 – RULES FOR THE LICENSURE OF NATUROPATHIC MEDICAL DOCTORS

DOCKET NO. 24-3304-2401 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1, 2025, in the year of the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. This rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 54-5102, 54-5105, 54-5108, 67-2614, 67-9406, and 67-9409, 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:

Under Executive Order 2020-01, Zero-Based Regulation, the Idaho State Board of Medicine is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the pending rule reflects a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the July 3, 2024, Idaho Administrative Bulletin, Vol. 24-7, pages 242-246.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

As authorized in Sections 54-5108, Idaho Code, the fees in this rulemaking are established in Rule 400. The pending rules do not impose any new or increased fees.

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 is not anticipated to have any negative fiscal impact on the State General Fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Krissy Veseth, Bureau Chief, at (208) 577-2491. Materials pertaining to the pending rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

DATED this 30th day of August, 2024.

Krissy Veseth
Bureau Chief
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 577-2491
Email: krissy.veseth@dopl.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. This rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 6-1002, 54-5102, 54-5105, 54-5108, 67-2614, 67-9406 and 67-9409, Idaho Code.

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

24.33.04 – Rules for the Licensure of Naturopathic Medical Doctors

Monday, July 15, 2024 – 3:00 p.m. (MT)
Division of Occupational and Professional Licenses
Chinden Campus Building 4, Coolwater Room
11341 W. Chinden Blvd.
Boise, ID 83714

Virtual Meeting Link

Telephone and web conferencing information will be posted on https://dopl.idaho.gov/calendar/ and https://townhall.idaho.gov/.

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

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

Under Executive Order 2020-01, Zero-Based Regulation, the Idaho State Board of Medicine is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the proposed rule changes reflect a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. This proposed rulemaking updates the rules to comply with governing statute and Executive Order 2020-01.

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

N/A. The proposed amendments to the rules do not impose any new or increased fees.

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:

This rulemaking is not anticipated to have any negative fiscal impact on the state General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted under Docket No. 24-ZBRR-2401. The Omnibus Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 3, 2024, Idaho Administrative Bulletin, Vol. 24-4, p.43.

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. No materials have been incorporated by reference into the proposed rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this proposed rule, contact Krissy Veseth, Bureau Chief, at (208) 577-2491. Materials pertaining to the proposed rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 24, 2024.

DATED this 7th day of June, 2024.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 24-3304-2401

24.33.04 – RULES FOR THE LICENSURE OF NATUROPATHIC MEDICAL DOCTORS

000. LEGAL AUTHORITY.
These rules are promulgated pursuant to Sections 54-5102, 54-5105~~(2)~~, and 54-5108 Idaho Code. ~~(3-28-23)~~( )

001. SCOPE.
These rules govern the licensure, scope of practice, and discipline of the Naturopathic Medical Doctors in Idaho. (3-28-23)

~~**002. 009. (RESERVED)**~~

~~**010**~~**002. DEFINITIONS.**

~~**01. Council on Naturopathic Medical Education (CNME).** The accrediting organization that is recognized by the United States Department of Education as the accrediting agency for education programs that prepare naturopathic medical doctors.~~ ~~(3-28-23)~~

~~**02. North American Board of Naturopathic Examiners (NABNE).** The independent, nonprofit organization that qualifies applicants to take the Naturopathic Physicians Licensing Exam and submits those results to the regulatory authority.~~ ~~(3-28-23)~~

~~**03. Naturopathic Physicians Licensing Exam (NPLEX).** The board examination for naturopathic medical doctors.~~ ~~(3-28-23)~~

04~~**1**~~**. Naturopathic Medical Doctor**. ~~A person who meets the definition in Section 54-5101(5), Idaho Code.~~ Is a term interchangeable with ~~L~~licensed naturopathic physician, physician of naturopathic medicine, naturopathic medical doctor and NMD ~~are interchangeable terms~~. ~~(3-28-23)~~( )

~~**05. Primary Care.** Comprehensive first contact and/or continuing care for persons with any sign, symptom, or health concern not limited by problem of origin, organ system, or diagnosis. It includes health~~

~~promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illness. It includes collaborating with other health professionals and utilizing consultation or referral as appropriate.~~ ~~(3-28-23)~~

0~~1~~03. – 0~~20~~99. (RESERVED)

~~021~~100. ~~APPLICATION FOR~~ LICENSURE.

01. **~~Application~~Accrediting Organization**. ~~Each applicant for licensure will submit a completed written application to the Board on forms prescribed by the Board, together with the nonrefundable application fee~~ The Council on Naturopathic Medical Education (CNME) is the accrediting organization that is recognized by the United States Department of Education as the accrediting agency for education programs that prepare naturopathic medical doctors. ~~(3-28-23)~~( )

02. **Licensing Examinations**. Each applicant must provide certification of passing the following four (4) sections of the Naturopathic Physicians Licensing Exam (NPLEX) ~~exams~~ administered by the North American Board of Naturopathic Examiners (NABNE): ~~(3-28-23)~~( )

a. Part I Biomedical Science; (3-28-23)

b. Part II Core Clinical Science; (3-28-23)

c. Part II Clinical Elective Minor Surgery; and (3-28-23)

d. Part II Clinical Elective Pharmacology. (3-28-23)

03. Renewal of License. ( )

a. Continuing Medical Education (CME). Every two (2) years, a total of forty-eight (48) hours, twenty (20) of which is pharmacology, of Board approved verifiable CME is required. ( )

101. – 199. (RESERVED)

~~022. AUTHORITY TO PRESCRIBE, DISPENSE, ADMINISTER, AND ORDER.~~
~~Naturopathic medical doctors are allowed to prescribe, dispense, administer, and order the following:~~ ~~(3-28-23)~~

~~01. Laboratory and Diagnostic Procedures~~. ~~Naturopathic medical doctors licensed under this chapter may perform and order physical examinations, laboratory tests, imaging, and other diagnostic tests consistent with primary care.~~ ~~(3-28-23)~~

~~a.~~ ~~All examinations, laboratory, and imaging tests not consistent with primary care must be referred to an appropriately licensed health care professional for treatment and interpretation.~~ ~~(3-28-23)~~

~~b.~~ ~~Any test result or lesion suspicious of malignancy must be referred to the appropriate physician licensed pursuant to Chapter 18, Title 54 Idaho Code.~~ ~~(3-28-23)~~

200. PRACTICE STANDARDS.

0~~2~~1. Naturopathic Formulary. The formulary for naturopathic medical doctors licensed under this chapter consists of non-controlled legend medications (excluding testosterone) deemed appropriate for the primary health care of patients within the scope of practice and training of each naturopathic medical doctor. Prescribing pursuant to the Naturopathic Formulary shall be according to the standard of health care provided by other qualified naturopathic medical doctors in the same community or similar communities, taking into account their training, experience and the degree of expertise to which they hold themselves out to the public. (3-28-23)

0~~3~~2. Formulary Exclusions. The naturopathic formulary does not include: (3-28-23)

a. Scheduled, controlled drugs, except for testosterone used in physiologic doses with regular lab assessment for hormone replacement therapy, gender dysphoria, or hypogonadism; (3-28-23)

b. General anesthetics; (3-28-23)

c. Blood derivatives except for platelet rich plasma; or (3-28-23)

d. Systemic antineoplastic agents, except for the following antineoplastic agents used orally or topically for non-cancer purposes: (3-28-23)

i. Fluorouracil (5FU); (3-28-23)

ii. Anastrozole; and (3-28-23)

iii. Letrozole. (3-28-23)

~~023~~201. – ~~031~~299.(RESERVED)

~~032. GROUNDS FOR DISCIPLINE OR DENIAL OF A LICENSE.~~
300. DISCIPLINE.

01. Ethical Standards of Practice. ~~In addition to statutory grounds for discipline set forth in Section 54-5109, Idaho Code, e~~Every person licensed as a naturopathic medical doctor~~ is subject to discipline by the Board under the following grounds~~ must adhere to the following standards: ~~(3-28-23)~~( )

~~**01. Ability to Practice**. Demonstrating a manifest incapacity to carry out the functions of the licensee's ability to practice naturopathic medicine or deemed unfit by the Board to practice naturopathic medicine; (3-28-23)~~

~~**02**~~**a.** Controlled Substance or Alcohol Abuse. Abstain from ~~U~~using any controlled substance or alcohol in a manner which has or may have a direct and adverse bearing on the licensee's ability to practice naturopathic medicine with reasonable skill and safety; ~~(3-28-23)~~( )

~~**03. Education or Experience**. Misrepresenting educational or experience attainments; (3-28-23)~~

~~**04**~~**b.** Medical Records. ~~Failing to m~~ Maintain adequate naturopathic medical records. Adequate naturopathic medical records mean legible records that contain subjective information, an evaluation or report of objective findings, assessment or diagnosis, and the plan of care; ~~(3-28-23)~~( )

~~**05. Untrained Practice**. Practicing in an area of naturopathic medicine for which the licensee is not trained; (3-28-23)~~

~~**06. Sexual Misconduct**. Committing any act of sexual contact, misconduct, exploitation, or intercourse with a patient or former patient or related to the licensee's practice of naturopathic medicine; (3-28-23)~~

~~**a.** Consent of the patient shall not be a defense. (3-28-23)~~

~~**b.** Subsection 032.06 does not apply to sexual contact between a naturopathic medical doctor and the naturopathic medical doctor's spouse or a person in a domestic relationship who is also a patient. (3-28-23)~~

~~**c.** A former patient includes a patient for whom the naturopathic medical doctor has provided naturopathic medical services within the last twelve (12) months. Sexual or romantic relationships with former patients beyond that period of time may also be a violation if the naturopathic medical doctor uses or exploits the trust, knowledge, emotions, or influence derived from the prior professional relationship with the patient. (3-28-23)~~

~~**07**~~**c.** ~~**Failure to** R~~Reporting. ~~Failing to r~~ Report to the Board any known act or omission of a licensee, applicant, or any other person, that violates any of the rules promulgated by the Board under the authority of the act; ~~(3-28-23)~~( )

~~08~~d. ~~**Interfering with or Influencing**~~ Disciplinary Outcomes. May not ~~Interfering~~ interfere with an investigation or disciplinary proceeding by willful misrepresentation of facts or by use of threats or harassment against any patient, Board or naturopathic medical board, Board staff, hearing officer, or witness in an attempt to influence the outcome of a disciplinary proceeding, investigation or other legal action; ~~(3-28-23)~~( )

~~09~~e. ~~**Failure to**~~ Obey Laws and Rules. ~~Failing to o~~ Obey federal and local laws and rules governing the practice of naturopathic medicine. ~~(3-28-23)~~( )

~~**033. CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS.**~~

~~**01. Renewal**. Every two (2) years, a total of forty-eight (48) hours (twenty (20) of which is pharmacology) of Board-approved CME is required as part of the naturopathic medical doctor's license renewal.~~ ~~(3-28-23)~~

~~**02. Verification of Compliance**. Licensees must, at license renewal, provide a signed statement to the Board indicating compliance. The Board, in its discretion, may require such additional evidence as it deems necessary to verify compliance.~~ ~~(3-28-23)~~

~~034~~301. – ~~040~~399.(RESERVED)

~~041~~400. FEES.
~~Nonrefundable f~~Fees ~~are shown in the following table~~ as follows:

Fees – Table (Non-Refundable)	
Licensure Fee	Not more than $600
Annual License Renewal Fee	Not more than $300
Reinstatement Fee	Not more than $200
~~Inactive License Renewal Fee~~	~~Not more than $100~~
Duplicate Wallet License Fee	Not more than $20
Duplicate Wall Certificate Fee	Not more than $50

~~(3-28-23)~~( )

~~042~~401. – 999. (RESERVED)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.33.05 – RULES FOR THE LICENSURE OF ATHLETIC TRAINERS TO PRACTICE IN IDAHO

DOCKET NO. 24-3305-2401 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1, 2025, in the year of the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. This rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 54-3902, 54-3906, 54-3907, 54-3910, 54-3911, 54-3913, 67-2614, 67-9406, and 67-9409, 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:

Under Executive Order 2020-01, Zero-Based Regulation, the Idaho State Board of Medicine is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the pending rule reflects a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the July 3, 2024, Idaho Administrative Bulletin, Vol. 24-7, pages 247-251.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

As authorized in Sections 54-3907, Idaho Code, the fees in this rulemaking are established in Rule 400. The pending rules do not impose any new or increased fees.

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 is not anticipated to have any negative fiscal impact on the state General Fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Krissy Veseth, Bureau Chief, at (208) 577-2491. Materials pertaining to the pending rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

DATED this 30th day of August, 2024.

Krissy Veseth
Bureau Chief
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 577-2491
Email: krissy.veseth@dopl.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. This rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 6-1002, 54-3902, 54-3906, 54-3907, 54-3910, 54-3911, 54-3913, 67-2614, 67-9406 and 67-9409, Idaho Code.

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

24.33.05 – Rules for the Licensure of Athletic Trainers to Practice in Idaho

Monday, July 15, 2024 – 3:00 p.m. (MT)
Division of Occupational and Professional Licenses
Coolwater Room, Chinden Campus Building 4
11341 W. Chinden Blvd.
Boise, ID 83714

Virtual Meeting Link

Telephone and web conferencing information will be posted on https://dopl.idaho.gov/calendar/ and https://townhall.idaho.gov/.

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

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

Under Executive Order 2020-01, Zero-Based Regulation, the Idaho State Board of Medicine is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the proposed rule changes reflect a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. This proposed rulemaking updates the rules to comply with governing statute and Executive Order 2020-01.

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

N/A. The proposed amendments to the rules do not impose any new or increased fees.

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:

This rulemaking is not anticipated to have any negative fiscal impact on the state General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted under Docket No. 24-ZBRR-2401. The Omnibus Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 3, 2024, Idaho Administrative Bulletin, Vol. 24-4, p.43.

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. No materials have been incorporated by reference into the proposed rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this proposed rule, contact Krissy Veseth, Bureau Chief, at (208) 577-2491. Materials pertaining to the proposed rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 24, 2024.

DATED this 7th day of June, 2024.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 24-3305-2401

24.33.05 – RULES FOR THE LICENSURE OF ATHLETIC TRAINERS TO PRACTICE IN IDAHO

000. LEGAL AUTHORITY.
These rules are promulgated pursuant to Sections 54-3902, 54-3906, 54-3907, 54-3910, 54-3911 and 54-3913~~(2)~~, Idaho Code. ~~(3-28-23)~~( )

001. SCOPE.
These rules govern the practice of athletic training in Idaho. (3-28-23)

002. -- 0~~09~~99. (RESERVED)

100. LICENSURE.
Provisional licenses for athletic trainers will be issued for a period of one (1) year and may not be renewed. ( )

~~**010. DEFINITIONS.**~~

~~**01. Actively Engaged**. A person who is employed in Idaho on a remuneration basis by an educational or health care institution, professional, amateur, or recreational sports club, or other bona fide athletic organization and is involved in athletic training as a responsibility of his employment.~~ ~~(3-28-23)~~

~~**02. Association**. The Idaho Athletic Trainers' Association.~~ ~~(3-28-23)~~

~~**03. Athletic Training Service Plan or Protocol**. A written document, made upon a form provided by the Board, mutually agreed upon, signed and dated by the athletic trainer and directing physician that defines the athletic training services to be provided by the athletic trainer. The Board may review athletic training service plans or protocols, job descriptions, policy statements, or other documents that define the responsibilities of the athletic trainer in the practice setting, and may require such changes as needed to achieve compliance with this chapter and Title 54, Chapter 39, Idaho Code, and to safeguard the public. The Board of Chiropractic Physicians may review those athletic training service plans or protocols or other documents that define the responsibilities of the athletic trainer for those athletic trainers whose directing physicians are chiropractic physicians.~~ ~~(3-28-23)~~

101. -- 199. (RESERVED)

200. PRACTICE STANDARDS.

~~**011. SCOPE OF PRACTICE.**~~

01. Referral by Directing Physician. An athletic injury not incurred in association with an educational institution, professional, amateur, or recreational sports club or organization must be referred by a directing physician, but only after such directing physician has first evaluated the athlete. An athletic trainer treating or evaluating an athlete with an athletic injury incurred in association with an amateur or recreational sports club or organization will especially consider the need for a directing physician to subsequently evaluate the athlete and refer for further athletic training services. (3-28-23)

~~**02. Limitations of Scope of Practice**. The scope of practice of the athletic trainer, as set forth in this chapter and Section 54-3903, Idaho Code, shall be limited to and consistent with the scope of practice of his directing physician. (3-28-23)~~

0~~3~~**2. Identification**. The athletic trainer will at all times when on duty identify himself as an athletic trainer. (3-28-23)

~~**012. ATHLETIC TRAINING SERVICE PLAN OR PROTOCOL.**~~

03. Athletic Training Service Plan or Protocol. Each licensed athletic trainer providing athletic training services will create~~, upon a form provided by the Board,~~ an athletic training service plan or protocol with his directing physician. This~~ athletic training~~ service plan or protocol must be a written document that defines the services to be provided by the athletic trainer, mutually agreed upon by both directing physician and athletic trainer and signed and dated by both. The service plan or protocol shall be reviewed and updated on an annual basis. Each licensed athletic trainer must notify the Board within thirty (30) days of any change in the status of his directing physician. ~~This~~ The plan or protocol ~~will not be sent to the Board, but~~ must be maintained on file at each location in which the athletic trainer is practicing. ~~The Board may review athletic training service plans or protocols, job descriptions, policy statements, or other documents that define the responsibilities of the athletic trainer in the practice setting, and may require such changes as needed to achieve compliance with this chapter, Title 54, Chapter 39, Idaho Code, and to safeguard the public.~~ This plan or protocol will be made immediately available to the Board upon request to allow review of the service plan or protocol, including job descriptions, policy statements, or other documents that define the responsibilities of the athletic trainer in the practice setting, and may require such changes as needed to achieve compliance with the law and to safeguard the public. This plan or protocol will be made immediately available to the Board of Chiropractic Physicians for the same purposes upon request for those athletic trainers whose directing physicians are chiropractic physicians. This plan or protocol will include: ~~(3-28-23)~~( )

~~01~~**a.** Listing of Services and Activities. A listing of the athletic training services to be provided and specific activities to be performed by the athletic trainer. (3-28-23)

~~02~~**b.** Locations and Facilities. The specific locations and facilities in which the athletic trainer will function; and (3-28-23)

~~03~~**c.** Methods to be Used. The methods to be used to ensure responsible direction and control of the activities of the athletic trainer, which will provide for the: (3-28-23)

~~a~~i. Recording of an on-site visit by the directing physician at least semiannually or every semester; (3-28-23)

~~b~~ii. Availability of the directing physician to the athletic trainer in person or by telephone and procedures for providing direction for the athletic trainer in emergency situations; and (3-28-23)

~~c~~iii. Procedures for addressing situations outside the scope of practice of the athletic trainer. (3-28-23)

~~**013. -- 019. (RESERVED)**~~

020. GENERAL QUALIFICATIONS FOR LICENSURE AND RENEWAL.
Requirements for licensure and renewal are found in Title 54, Chapter 39, Idaho Code, IDAPA 24.33.03, and on Board-approved forms. (3-28-23)

021. – 029. (RESERVED)

030. APPLICATION FOR LICENSURE.

01. Application for Provisional Licensure. (3-28-23)

a. The Board, based upon the recommendation of the Board of Athletic Trainers, may issue provisional licensure to applicants who have successfully completed a bachelor's or advanced degree from an accredited four (4) year college or university, and met the minimum athletic training curriculum requirement established by the Board as recommended by the Board of Athletic Trainers and who have met all the other requirements set forth by Section 020 of these rules but who have not yet passed the examination conducted by the National Athletic Trainers' Association Board of Certification or a nationally recognized credentialing agency, approved by the Board as recommended by the Board of Athletic Trainers. (3-28-23)

b. Each applicant for provisional licensure will submit a completed written application to the Board on forms prescribed by the Board, together with the application fee. The application shall be verified, under oath, and include an affidavit signed by an Idaho licensed athletic trainer affirming and attesting to supervise and be responsible for the athletic training services of the provisionally licensed athletic trainer and to review and countersign all records and documentation of services performed by the provisionally licensed athletic trainer. (3-28-23)

ii**04.** **Supervision and Scope of Provisional Licenses**. A provisionally licensed graduate athletic trainer must be in direct association with his directing physician and Idaho licensed athletic trainer who will supervise and be available to render direction in person and on the premises where the athletic training services are being provided. The directing physician and the supervising athletic trainer is are responsible for the athletic training services provided by the provisionally licensed graduate athletic trainer. The extent of communication between the directing physician and supervising athletic trainer and the provisionally licensed athletic trainer is determined by the competency of the provisionally licensed athletic trainer and the practice setting and the type of athletic training services being rendered. (3-28-23)

c. Scope of Practice. The scope of practice of the provisionally licensed athletic trainer, as set forth in this chapter and Section 54-3903, Idaho Code, is limited to and consistent with the scope of practice of his directing physician and supervising athletic trainer and must conform with the established athletic training service plan or protocol. (3-28-23)( )

d. Expiration of Provisional License. All provisional licenses for athletic trainers will expire upon meeting the minimum athletic training curriculum requirement established by the Board as recommended by the Board of Athletic Trainers and meeting all the other requirements set forth by Section 020 of these rules, including passing the certification examination conducted by the National Athletic Trainers' Association Board of Certification or a nationally recognized credentialing agency, approved by the Board as recommended by the Board of Athletic Trainers. (3-28-23)

031. – 051. (RESERVED)

052. DENIAL OR REFUSAL TO RENEW LICENSURE OR SUSPENSION OR REVOCATION OF LICENSURE.

01. Application or Renewal Denial. A new or renewal application for licensure may be denied by the Board and shall be considered a contested case. Every person licensed pursuant to Title 54, Chapter 39, Idaho Code and these rules is subject to discipline pursuant to the procedures and powers established by and set forth in Section 54-3911, Idaho Code, and the Idaho Administrative Procedure Act. (3-28-23)

~~**02. Petitions for Reconsideration of Denial.** All petitions for reconsideration of a denial of a license application or reinstatement application shall be made to the Board within one (1) year from the date of the denial.~~ ~~(3-28-23)~~

~~053~~201. -- ~~060~~399.(RESERVED)

~~061~~400. FEES~~ -- TABLE~~.
~~Nonrefundable f~~Fees are as follows:

Fees – Table (Non-Refundable)		
Athletic Trainer Licensure Fee	-	Not more than $240
Athletic Trainer Annual Renewal Fee	-	Not more than $160
Directing Physician Registration Fee	-	Not more than $50
Annual Renewal of Directing Physician Registration Fee	-	Not more than $25
Alternate Directing Physician Registration/Renewal Fee	-	$0
Provisional Licensure Fee	-	Not more than $80
Annual Renewal of Provisional License Fee	-	Not more than $40
~~Inactive License Renewal Fee~~	-	~~Not more than $80~~
Reinstatement Fee	-	Not more than $50 plus unpaid renewal fees

~~(3-28-23)~~( )

~~062~~401. -- 999. (RESERVED)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.33.06 – RULES FOR LICENSURE OF RESPIRATORY THERAPISTS AND PERMITTING OF POLYSOMNOGRAPHERS IN IDAHO

DOCKET NO. 24-3306-2401 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1, 2025, in the year of the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. This rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 54-4305, 54-4306, 54-4309, 54-4310, 54-4311, 67-2614, 67-9406, and 67-9409, 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:

Under Executive Order 2020-01, Zero-Based Regulation, the Idaho State Board of Medicine is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the pending rule reflects a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the July 3, 2024, Idaho Administrative Bulletin, Vol. 24-7, pages 252-256.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

As authorized in Sections 54-4309, Idaho Code, the fees in this rulemaking are established in Rule 400. The pending rules do not impose any new or increased fees.

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 is not anticipated to have any negative fiscal impact on the state General Fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Krissy Veseth, Bureau Chief, at (208) 577-2491. Materials pertaining to the pending rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

DATED this 30th day of August, 2024.

Krissy Veseth
Bureau Chief
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 577-2491
Email: krissy.veseth@dopl.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. This rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 6-1002, 54-4305, 54-4306, 54-4309, 54-4310, 54-4311, 67-2614, 67-9406 and 67-9409, Idaho Code.

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

24.33.06 – Rules for Licensure of Respiratory Therapists and Permitting of Polysomnographers in Idaho

Monday, July 15, 2024 – 3:00 p.m. (MT)
Division of Occupational and Professional Licenses
Coolwater Room, Chinden Campus Building 4
11341 W. Chinden Blvd.
Boise, ID 83714

Virtual Meeting Link

Telephone and web conferencing information will be posted on https://dopl.idaho.gov/calendar/ and https://townhall.idaho.gov/.

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

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

Under Executive Order 2020-01, Zero-Based Regulation, the Idaho State Board of Medicine is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the proposed rule changes reflect a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. This proposed rulemaking updates the rules to comply with governing statute and Executive Order 2020-01.

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

N/A. The proposed amendments to the rules do not impose any new or increased fees.

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:

This rulemaking is not anticipated to have any negative fiscal impact on the state General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted under Docket No. 24-ZBRR-2401. The Omnibus Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 3, 2024, Idaho Administrative Bulletin, Vol. 24-4, p.43.

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. No materials have been incorporated by reference into the proposed rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this proposed rule, contact Krissy Veseth, Bureau Chief, at (208) 577-2491. Materials pertaining to the proposed rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 24, 2024.

DATED this 7th day of June, 2024.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 24-3306-2401

24.33.06 – RULES FOR LICENSURE OF RESPIRATORY THERAPISTS AND PERMITTING OF POLYSOMNOGRAPHERS IN IDAHO

000. LEGAL AUTHORITY.
These rules are promulgated pursuant to Sections 54-4305, 54-4306, 54-4309, 54-4310, and 54-4311, Idaho Code. ~~(3-28-23)~~( )

001. SCOPE.
These rules govern the practice of respiratory care and polysomnography related to respiratory care. ~~(3-28-23)~~( )

~~**002. -- 009. (RESERVED)**~~

~~**010. DEFINITIONS.**~~

~~**01. Board of Registered Polysomnographic Technologists**. A nationally recognized private testing, examining and credentialing body for the polysomnography related respiratory care profession. (3-28-23)~~

~~**02. Comprehensive Registry Exam**. The comprehensive registry examination administered by the Board of Registered Polysomnographic Technologists, or administered by an equivalent board, recognized by the Board, the successful completion of which entitles a person to the professional designation of Registered Polysomnographic Technologist (RPSGT). (3-28-23)~~

~~**03. Written Registry and Clinical Simulation Examinations**. The certification examinations administered by the National Board of Respiratory Care, Inc., or certification examinations administered by an equivalent board, recognized by the Board, the successful completion of which entitles a person the professional designation of "Registered Respiratory Therapist" (RRT). (3-28-23)~~

0~~11~~02. -- 0~~30~~99. (RESERVED)

~~**031. GENERAL QUALIFICATIONS FOR LICENSURE AND RENEWAL.**~~

~~Requirements for licensure and renewal are found in Title 54, Chapter 43, Idaho Code, IDAPA 24.33.03, and on Board approved forms.~~ ~~(3-28-23)~~

100. LICENSURE.

01. Application for Respiratory Care and Polysomnography Related Respiratory Care Practitioner. ~~(3-28-23)~~

~~**a.**~~ The Board may issue a dual license/permit to perform respiratory care and polysomnography related respiratory care to an applicant who meets the requirements set forth in this chapter and Sections 54-4308 and 54-4307(2) and (3), Idaho Code. ~~A dual license/permit shall authorize the holder to perform respiratory care and polysomnography related respiratory care in this state.~~ ~~(3-28-23)~~( )

~~**b.** Application for a dual license/permit shall be made to the Board on a form prescribed by the Board, together with the application fee.~~ ~~(3-28-23)~~

~~**c.** Such dual license/permit shall expire on the expiration date printed on the face of the certificate unless renewed.~~ ~~(3-28-23)~~

02. Comprehensive Registry Exam. The comprehensive registry examination administered by the Board of Registered Polysomnographic Technologists, or administered by an equivalent board, recognized by the Board, the successful completion of which entitles a person to the professional designation of Registered Polysomnographic Technologist (RPSGT). ( )

03. Provisional Licensure or Permit by Examination. A provisional license or permit may be issued to an applicant following graduation from an accredited or approved respiratory care or polysomnography-related respiratory care educational program and the applicant has either applied to take or has taken the requisite Board-approved national examination(s) and is awaiting results. An applicant who fails to pass the requisite Board-approved national examination(s) during the six (6) month timeframe is not eligible for further temporary licensure or permitting. Provisional licenses and permits issued to examination candidates are issued for a period not to exceed six (6) months and are nonrenewable. ( )

~~**032. CONTINUING EDUCATION.**~~

~~**01. Evidence of Completion**. Prior to renewal, reinstatement or reapplication, each applicant shall submit evidence of successfully completing no less than twelve (12) hours per year of approved respiratory therapy related continuing education. Continuing education activities include but are not limited to: attending or presenting at conferences, seminars or inservice programs; or formal course work in respiratory therapy related subjects.~~ ~~(3-28-23)~~

~~**02. Polysomnographer Continuing Education**. Prior to renewal, reinstatement or reapplication, each applicant shall submit evidence of successfully completing no less than twelve (12) hours per year of approved polysomnographic related respiratory care continuing education. The Board, as recommended by the Licensure Board, may substitute all or a portion of the coursework required in Subsection 032.02 when an applicant for renewal shows evidence of passing an approved challenge exam or of completing equivalent education as determined by the Board, as recommended by the Licensure Board, to be in full compliance with the education requirements of this chapter.~~ ~~(3-28-23)~~

~~**033. PROVISIONAL LICENSE OR PERMIT.**~~

~~**01. Provisional Licensure or Permit by Examination**. A provisional license or permit may be issued until notification of exam results to an applicant following graduation from an accredited or approved respiratory care or polysomnography-related respiratory care educational program as set forth in Sections 54-4303, 54-4306, 54-4307, 54-4308, 54-4309, Idaho Code, if: the applicant otherwise meets the license or permit requirements set forth in Sections 54-4307(2) & (4) or 54-4308, Idaho Code; and the applicant has either applied to take or has taken the requisite Board-approved national examination(s) and is awaiting results. Provisional licenses and permits issued to examination candidates are issued for a period not to exceed six (6) months and are nonrenewable.~~ ~~(3-28-23)~~

~~**02. Unsuccessful Examination Candidates**. An applicant who fails to pass the requisite Board-~~

~~approved national examination(s) during the six (6) month timeframe is not eligible for further temporary licensure or permitting.~~ ~~(3-28-23)~~

04. Continuing Education. Licensees are responsible for choosing respiratory therapy related continuing education programs that focus on protecting the health and safety of the public. ( )

101. -- 199. (RESERVED)

200. PRACTICE STANDARDS.

~~03~~**401. Supervision Of Respiratory Care**. The practice or provision of respiratory care or polysomnography services by persons holding a student, consulting, or training exemption or a provisional license or permit shall be under the supervision of a respiratory care practitioner or licensed physician who shall be responsible for the activities of the person being supervised ~~and shall review and countersign all patient documentation performed by the person being supervised~~. The supervising respiratory care practitioner or licensed physician need not be physically present or on the premises at all times but must be available for telephonic consultation. ~~The extent of communication between the supervising or consulting respiratory care practitioner or licensed physician and the person being supervised shall be determined by the competency of the person, the treatment setting, and the diagnostic category of the client.~~ ~~(3-28-23)~~( )

~~035~~**201. -- ~~045~~399.(RESERVED)**

~~046~~**400. FEES ~~-- TABLE~~.**

01. Fees ~~-- Table~~. Nonrefundable fees ~~for Respiratory Care Practitioners~~ are as follows:

Fees – Table (Non-Refundable)		
~~Respiratory Care Practitioner~~ Initial Licensure Fee	-	Not more than $180
~~Respiratory Care Practitioner~~ Reinstatement Fee	-	$50 plus unpaid renewal fees
~~Annual Renewal Fee for Inactive License~~	-	~~Not more than $100~~
~~Inactive Conversion Fee~~	-	~~Not more than $100~~
Annual Renewal Fee	-	Not more than $140
Provisional License Fee	-	Not more than $90
Dual Licensure/Permit Fee	-	Not more than $180
A person holding a current license or permit, if qualified, may apply for and obtain a dual license/permit without paying an additional fee.		

~~(3-28-23)~~( )

~~**02. Fees -- Table.** Nonrefundable Permit Fees for Polysomnography Related Respiratory Care Practitioners.~~

~~Fees – Table (Non-Refundable)~~		
~~Initial Permit Fee – Registered Polysomnographic Technologist and Polysomnographic Technician~~	~~-~~	~~Not more than $180~~
~~Reinstatement Fee – Registered Polysomnographic Technologist and Polysomnographic Technician~~	~~-~~	~~$50 plus unpaid renewal fees~~
~~Annual Renewal Fee – Registered Polysomnographic Technologist and Polysomnographic Technician~~	~~-~~	~~Not more than $140~~

~~Fees – Table (Non-Refundable)~~		
~~Provisional Permit Fee – Registered Polysomnographic Technologist~~	~~-~~	~~Not more than $90~~
~~Annual Renewal Fee for Inactive License – Polysomnographic Technologist and Polysomnographic Technician~~	~~-~~	~~Not more than $100~~
~~Inactive Conversion Fee~~	~~-~~	~~Not more than $100 plus unpaid active licensure fees for the time inactive~~

~~(3-28-23)~~

~~**03. Fees – Table**. Nonrefundable Dual Licensure/Permit Fees for Practitioners of Respiratory and Polysomnography Related Respiratory Care.~~ ~~(3-28-23)~~

~~**a.** Initial Licensure/Permit Fee. A person holding a current license or permit, if qualified, may apply for and obtain a dual license/permit without paying an additional fee.~~

~~Fees – Table (Non-Refundable)~~		
~~Dual Licensure/Permit Fee~~	~~-~~	~~Not more than $180~~
~~A person holding a current license or permit, if qualified, may apply for and obtain a dual license/permit without paying an additional fee.~~		
~~Reinstatement Fee~~	~~-~~	~~$50 plus unpaid renewal fees~~
~~Annual Renewal Fee~~	~~-~~	~~Not more than $140~~
~~Renewal is required upon the expiration of either the permit or the license, whichever expires first if the two (2) initially were not obtained at the same time.~~		

~~(3-28-23)~~

~~047~~401. -- 999. (RESERVED)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.33.07 – RULES FOR THE LICENSURE OF DIETITIANS

DOCKET NO. 24-3307-2401 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1, 2025, in the year of the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. This rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 54-3505, 54-3509, 67-2614, 67-9406, and 67-9409, 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:

Under Executive Order 2020-01, Zero-Based Regulation, the Idaho State Board of Medicine is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the pending rule reflects a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the July 3, 2024, Idaho Administrative Bulletin, Vol. 24-7, pages 257-259.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

As authorized in Sections 54-3509, Idaho Code, the fees in this rulemaking are established in Rule 400. The pending rules do not impose any new or increased fees.

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 is not anticipated to have any negative fiscal impact on the state General Fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Krissy Veseth, Bureau Chief, at (208) 577-2491. Materials pertaining to the pending rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

DATED this 30th day of August, 2024.

Krissy Veseth
Bureau Chief
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 577-2491
Email: krissy.veseth@dopl.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. This rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 6-1002, 54-3505, 54-3509, 67-2614, 67-9406 and 67-9409, Idaho Code.

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

24.33.07 – Rules for the Licensure of Dietitians

Monday, July 15, 2024 – 3:00 p.m. (MT)
Division of Occupational and Professional Licenses
Chinden Campus Building 4
11341 W. Chinden Blvd.
Boise, ID 83714

Virtual Meeting Link

Telephone and web conferencing information will be posted on https://dopl.idaho.gov/calendar/ and https://townhall.idaho.gov/.

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

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

Under Executive Order 2020-01, Zero-Based Regulation, the Idaho State Board of Medicine is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the proposed rule changes reflect a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. This proposed rulemaking updates the rules to comply with governing statute and Executive Order 2020-01.

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

N/A. The proposed amendments to the rules do not impose any new or increased fees.

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:

This rulemaking is not anticipated to have any negative fiscal impact on the state General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted under Docket No. 24-ZBRR-2401. The Omnibus Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 3, 2024, Idaho Administrative Bulletin, Vol. 24-4, p.43.

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. No materials have been incorporated by reference into the proposed rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this proposed rule, contact Krissy Veseth, Bureau Chief, at (208) 577-2491. Materials pertaining to the proposed rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 24, 2024.

DATED the 7th day of June, 2024.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 24-3307-2401

24.33.07 – RULES FOR THE LICENSURE OF DIETITIANS

000. LEGAL AUTHORITY.
These rules are promulgated pursuant to Section 54-3505~~(2)~~ and 54-3509, Idaho Code. ~~(3-28-23)~~( )

001. SCOPE.
These rules govern the practice of dietetics in Idaho. (3-28-23)

002. -- 0~~19~~99. (RESERVED)

100. LICENSURE.

~~**020. GENERAL QUALIFICATIONS FOR LICENSURE AND RENEWAL.**~~
~~Requirements for licensure and renewal are found in Title 54, Chapter 35, Idaho Code, IDAPA 24.33.03, and on Board-approved forms.~~ ~~(3-28-23)~~

~~**021. PROVISIONAL LICENSURE.**~~

01. Provisional License. The Board may issue a provisional license to a person who ~~has successfully completed the academic requirements of an education program in dietetics approved by the licensure board and has successfully completed a dietetic internship or preprofessional practice program, coordinated program or such other equivalent experience as may be approved by the board and who~~ has met all the other requirements set forth ~~by Section 020 of this rule~~ in Title 54, Chapter 35, Idaho Code but who has not yet passed the examination conducted by the Commission on Dietetic Registration. ~~(3-28-23)~~

~~**02. Provisional License Dietitian/Monitor Affidavit**. The provisionally licensed dietitian must obtain an affidavit signed by an Idaho licensed dietitian affirming and attesting that they will be responsible for the activities of the provisionally licensed dietitian and will review and countersign all patient documentation signed by the provisionally licensed dietitian. The supervising monitor need not be physically present or on the premises at all times but must be available for telephonic consultation. The extent of communication between the monitor and the~~

~~provisionally licensed dietitian will be determined by the competency of the individual, the treatment setting, and the diagnostic category of the patients.~~ ~~(3-28-23)~~

~~**03. Provisional Licensure Expiration**. Provisional licenses will become full active licenses upon the date of receipt of a copy of registration by the Commission on Dietetic Registration.~~ All provisional licenses will expire~~ on the last day of the current renewal cycle~~ one (1) year after issuance. The Board may grant an extension for one (1) additional year upon request. The provisionally licensed dietitian must obtain an affidavit signed by an Idaho licensed dietitian affirming and attesting that they will be responsible for the activities of the provisionally licensed dietitian and will review and countersign all patient documentation signed by the provisionally licensed dietitian. The supervising monitor need not be physically present or on the premises at all times but must be available for telephonic consultation. The extent of communication between the monitor and the provisionally licensed dietitian will be determined by the competency of the individual, the treatment setting, and the diagnostic category of the patients.
~~(3-28-23)~~( )

~~022. -- 031. (RESERVED)~~

~~032. DENIAL OR REFUSAL TO RENEW, SUSPENSION OR REVOCATION OF LICENSE.~~

~~**01. Disciplinary Authority**. A new or renewal application may be denied or a license may be suspended or revoked by the Board, and every person licensed pursuant to Title 54, Chapter 35, Idaho Code and these rules is subject to disciplinary actions or probationary conditions pursuant to the procedures and powers established by and set forth in Section 54-3505, Idaho Code, and the Idaho Administrative Procedure Act.~~ ~~(3-28-23)~~

~~033~~101. -- ~~040~~399.(RESERVED)

~~041~~400. FEES~~ -- TABLE~~.
~~Nonrefundable f~~Fees are as follows:

Fees – Table (Non-Refundable)		
Initial Licensure Fee	-	Not more than $150
Annual Renewal Fee	-	Not more than $100
Reinstatement Fee	-	$50 plus unpaid renewal fees
~~Inactive Conversion Fee~~	~~-~~	~~Not more than $50~~

~~(3-28-23)~~( )

~~042~~401. -- 999. (RESERVED)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.36.01 – RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 24-3601-2402 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2025 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the First Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. This rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, as well as Sections 37-2702, 37-2715, 54-1717, 54-1753, 54-1755, 67-2614, 67-9406, and 67-9409, 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 under Executive Order 2020-01, Zero Based Regulation. Text amended since these rules were published as proposed is as follows:

The Board determined that proposed definition 002.09 Pharmaceutical Care Services included a non-exclusive, unenforceable list, which was struck, with the remainder of the definition incorporated into proposed Rule 200.01 Scope of Practice.

The Exemption from Separate Practitioner Controlled Substance Registration was moved from proposed Rule 100.03 Determination of Need for Nonresident Licensure or Registration to proposed Rule 100.07 Practitioner Controlled Substance Registration, as fitting better under that rule. No language was changed.

Language mirroring other boards, "Not more than," was added to all items on the proposed fee table, capping fees at their current level while allowing the Board greater flexibility in reducing fees.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the August 7, 2024 Idaho Administrative Bulletin, Vol. 24-8, pages 134-172.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: N/A.

The amendments to the rules do not impose any new or increased fees.

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 is not anticipated to have any negative fiscal impact on the state General Fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Krissy Veseth, Bureau Chief, at (208) 577-2491. Materials pertaining to the pending rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

DATED this 4th day of October, 2024.

Krissy Veseth
Bureau Chief
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 577-2491
Email: krissy.veseth@dopl.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. This rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, as well as Sections 37-2702, 37-2715, 54-1717, 54-1753, 54-1755, 67-2614, 67-9406, and 67-9409, Idaho Code.

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

24.36.01 – Rules of the Idaho State Board of Pharmacy

Wednesday, August 21, 2024 – 3:00 p.m. (MT)
Division of Occupational and Professional Licenses
Chinden Campus Building 4
11341 W. Chinden Blvd.
Boise, ID 83714

Virtual Meeting Link

Telephone and web conferencing information will be posted on https://dopl.idaho.gov/calendar/ and https://townhall.idaho.gov/.

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

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

Under Executive Order 2020-01, Zero-Based Regulation, the Idaho State Board of Pharmacy is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the proposed rule changes reflect a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. This proposed rulemaking updates the rules to comply with governing statute and Executive Order 2020-01.

Due to the volume of reformatting of the rule chapter, the redline version of the rules provided in the bulletin will show many sections of the current rules being struck and added back in as new text as they are moving to new

sections for consistent formatting. A redlined document to show what changes were made can be found at https://dopl.idaho.gov/wp-content/uploads/2024/08/BOP-Redlines-V4-06-13-24.pdf.

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

N/A. The proposed amendments to the rules do not impose any new or increased fees.

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:

This rulemaking is not anticipated to have any negative fiscal impact on the state General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted under Docket No. 24-ZBRR-2401. The Omnibus Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 3, 2024, Idaho Administrative Bulletin, Vol. 24-4, p.43.

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. No materials have been incorporated by reference into the proposed rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this proposed rule, contact Krissy Veseth, Bureau Chief, at (208) 577-2491. Materials pertaining to the proposed rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 28, 2024.

DATED this 5th day of July, 2024.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 24-3601-2402

Italicized red text that is *double underscored* indicates amendments to the proposed text as adopted in the pending rule.

24.36.01 – RULES OF THE IDAHO STATE BOARD OF PHARMACY

000. LEGAL AUTHORITY.
This chapter is adopted under the legal authority of the Uniform Controlled Substances Act, Title 37, Chapter 27, Idaho Code; the Idaho Pharmacy Act, the Idaho Wholesale Drug Distribution Act, and the Idaho Legend Drug Donation Act, Title 54, Chapter 17, Idaho Code; and specifically pursuant to Sections 37-2702, 37-2715, 54-1717, 54-1753, and 54-1755, Idaho Code. (3-28-23)

001. SCOPE.
These rules regulate and control the manufacture, distribution, and dispensing of controlled substances within or into the state, pursuant to the Uniform Controlled Substances Act, Section 37-2715, Idaho Code; and regulate and control

the practice of pharmacy, pursuant to the Idaho Pharmacy Act, Title 54, Chapter 17, Idaho Code. (3-28-23)

~~002. 009. (RESERVED)~~

0~~1~~02. DEFINITIONS AND ABBREVIATIONS ~~(A N)~~.
The definitions set forth in Sections 54-1705 and 37-2701, Idaho Code, are applicable to these rules. ~~(3-28-23)~~( )

~~01. ACCME. Accreditation Council for Continuing Medical Education. (3-28-23)~~

~~02. ACPE. Accreditation Council for Pharmacy Education. (3-28-23)~~

0~~3~~1. **ADS – Automated Dispensing and Storage**. A mechanical system that performs operations or activities, other than compounding or administration, relative to the storage, packaging, dispensing, or distribution of drugs and that collects, controls, and maintains transaction information. (3-28-23)

~~04. Change of Ownership. A change of majority ownership or controlling interest of a drug outlet licensed or registered by the Board. (3-28-23)~~

~~05. CME. Continuing medical education. (3-28-23)~~

~~06. CPE. Continuing pharmacy education. (3-28-23)~~

~~07. CPE Monitor. An NABP service that allows pharmacists to electronically keep track of CPE credits from ACPE-accredited providers. (3-28-23)~~

0~~8~~2. **DEA**. United States Drug Enforcement Administration. (3-28-23)

0~~9~~3. **DME - Durable Medical Equipment Outlet**. A registered outlet that may hold for sale at retail durable medical equipment (DME) and the following prescription drugs: pure oxygen for human application, nitrous oxide, sterile sodium chloride, and sterile water for injection. ~~(3-28-23)~~( )

~~10~~04. **Drug Outlet**. Drug outlets include, but are not limited to, sterile product pharmacies, remote dispensing pharmacies, facilities operating narcotic treatment programs, DME outlets, prescriber drug outlets, outsourcing facilities, nuclear pharmacies, cognitive service pharmacies, correctional facilities, offsite ADSs for non-emergency dispensing, reverse distributors, mobile pharmacies, and analytical or research laboratories. (3-28-23)

~~11~~05. **FDA**. United States Food and Drug Administration. (3-28-23)

~~12. Flavoring Agent. An additive in food or drugs in the minimum quantity necessary. (3-28-23)~~

~~13. Floor Stock. Drugs or devices not labeled for a specific patient that are maintained at a nursing station or other department of an institutional facility, excluding the pharmacy, for the purpose of administering to patients of the facility. (3-28-23)~~

~~14. FPGEC Certification. Foreign Pharmacy Graduate Examination Committee Certification. (3-28-23)~~

~~15~~06. **Hazardous Drug**. Any drug listed as such by the National Institute for Occupational Safety and Health or any drug identified by at least one (1) of the following criteria: carcinogenicity; teratogenicity or developmental toxicity; reproductive toxicity in humans; organ toxicity at low doses in humans or animals; genotoxicity; or new drugs that mimic existing hazardous drugs in structure or toxicity. (3-28-23)

~~16~~07. **HIPAA**. Health Insurance Portability and Accountability Act of 1996. (3-28-23)

~~17. NABP. National Association of Boards of Pharmacy. (3-28-23)~~

~~18. NAPLEX. North American Pharmacists Licensure Examination. (3-28-23)~~

~~19~~08. **NDC**. National Drug Code. (3-28-23)

~~011. DEFINITIONS AND ABBREVIATIONS (O – Z).~~
~~The definitions set forth in Sections 54-1705 and 37-2701, Idaho Code, are applicable to these rules. In addition, the following terms have the meanings set forth below:~~ ~~(3-28-23)~~

~~01. **Parenteral Admixture**. The preparation and labeling of sterile products intended for administration by injection.~~ ~~(3-28-23)~~

~~03~~09. **PDMP**. Prescription Drug Monitoring Program. (3-28-23)

~~04. **Prescriber**. An individual currently licensed, registered, or otherwise authorized to prescribe and administer drugs in the course of professional practice.~~ ~~(3-28-23)~~

~~05. **Purple Book**. The list of licensed biological products with reference product exclusivity and biosimilarity or interchangeability evaluations published by the FDA under the Public Health Service Act.~~ ~~(3-28-23)~~

~~06~~10. **Readily Retrievable**. Records are considered readily retrievable if they are able to be completely and legibly produced upon request within seventy-two (72) hours. (3-28-23)

~~07~~11. **Reconstitution**. The process of adding a diluent to a powdered medication to prepare a solution or suspension, according to the product's labeling or the manufacturer's instructions. (3-28-23)

~~08. **Restricted Drug Storage Area**. The area of a drug outlet where prescription drugs are prepared, compounded, distributed, dispensed, or stored.~~ ~~(3-28-23)~~

~~09. **Therapeutic Equivalent Drugs**. Products assigned an "A" code by the FDA in the Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book) and animal drug products published in the FDA Approved Animal Drug Products (Green Book).~~ ~~(3-28-23)~~

1~~0~~2. **USP-NF**. United State Pharmacopeia-National Formulary. (3-28-23)

0~~12~~03. – 099. **(RESERVED)**

~~SUBCHAPTER A – GENERAL PROVISIONS~~
~~(Rules 100 through 199)~~

~~100. PRACTICE OF PHARMACY: GENERAL APPROACH.~~
~~To evaluate whether a specific act is within the scope of pharmacy practice in or into Idaho, or whether an act can be delegated to other individuals under their supervision, a licensee or registrant of the Board must independently determine whether:~~ ~~(3-28-23)~~

~~01. **Express Prohibition**. The act is expressly prohibited by:~~ ~~(3-28-23)~~

~~a. The Idaho Pharmacy Act, Title 54, Chapter 17, Idaho Code;~~ ~~(3-28-23)~~

~~b. The Uniform Controlled Substances Act, Title 37, Chapter 27, Idaho Code;~~ ~~(3-28-23)~~

~~c. The rules of the Idaho State Board of Pharmacy; or~~ ~~(3-28-23)~~

~~d. Any other applicable state or federal laws or regulations.~~ ~~(3-28-23)~~

~~02. **Education, Training, and Experience**. The act is consistent with licensee or registrant's education, training, and experience.~~ ~~(3-28-23)~~

~~03. **Standard of Care**. Performance of the act is within the accepted standard of care that would be~~

provided in a similar setting by a reasonable and prudent licensee or registrant with similar education, training and experience. (3-28-23)

101. PRESCRIBER PERFORMANCE OF PHARMACY FUNCTIONS.
For the purposes of this chapter, any function that a pharmacist may perform may similarly be performed by an Idaho prescriber or may be delegated by an Idaho prescriber to appropriate support personnel, in accordance with the prescriber's practice act. (3-28-23)

102. WAIVERS OR VARIANCES.

01. Emergency Waiver. In the event of an emergency declared by the President of the United States, the Governor of the State of Idaho, or by any other person with legal authority to declare an emergency, the division administrator may waive any requirement of these rules for the duration of the emergency. (3-28-23)

103. BOARD INSPECTIONS AND INVESTIGATIONS.

01. Records Subject to Board Inspection. Records created, maintained, or retained by Board licensees or registrants in compliance with statutes or rules enforced by the Board must be made available for inspection upon request by Board inspectors or authorized agents. It is unlawful to refuse to permit or to obstruct a Board inspection. (3-28-23)

02. Inspections. Prior to the commencement of business, as applicable, and thereafter at regular intervals, registrants and licensees must permit the Board or its compliance officers to enter and inspect the premises and to audit the records of each drug outlet for compliance with laws enforced by or under the Board's jurisdiction. (3-28-23)

03. Inspection Deficiencies. Deficiencies noted must be promptly remedied, and if requested, the Board office notified of corrective measures. One (1) follow-up inspection may be performed by the Board at no cost. For additional follow-up inspections, the drug outlet will be charged actual travel and personnel costs incurred in the inspection to be paid within ninety (90) days of inspection. (3-28-23)

04. Inspection Reports. Inspection reports must be reviewed with the Board inspector and signed by an agent of the drug outlet upon completion of the exit interview. (3-28-23)

05. Investigations. Licensees or registrants must fully cooperate with Board investigations conducted to confirm compliance with laws enforced by the Board, to gather information pertinent to a complaint received by the Board, or to enforce disciplinary actions. (3-28-23)

104. UNPROFESSIONAL CONDUCT.
The following acts or practices by any licensee or registrant are declared to be specifically, but not by way of limitation, unprofessional conduct and conduct contrary to the public interest. (3-28-23)

01. Unethical Conduct. Conduct in the practice of pharmacy or in the operation of a pharmacy that may reduce the public confidence in the ability and integrity of the profession of pharmacy or endangers the public health, safety, and welfare. A violation of this section includes committing fraud, misrepresentation, negligence, concealment, or being involved in dishonest dealings, price fixing, or breaching the public trust with respect to the practice of pharmacy. (3-28-23)

02. Lack of Fitness. A lack of fitness for professional practice due to incompetency, personal habits, drug or alcohol dependence, physical or mental illness, or for any other cause that endangers public health, safety, or welfare. (3-28-23)

03. On-Duty Intoxication or Impairment. Intoxication, impairment, or consumption of alcohol or drugs while on duty, including break periods after which the individual is expected to return to work, or prior to reporting to work. (3-28-23)

04. Diversion of Drug Products and Devices. Supplying or diverting drugs, biologicals, and other

~~medicines, substances, or devices legally sold in pharmacies that allows the circumvention of laws pertaining to the legal sale of these articles.~~ ~~(3-28-23)~~

~~**05. Unlawful Possession or Use of Drugs**. Possessing or using a controlled substance without a lawful prescription drug order. A failed drug test creates a rebuttable presumption of a violation of this rule.~~ ~~(3-28-23)~~

~~**06. Prescription Drug Order Noncompliance**. Failing to follow the instructions of the person writing, making, or ordering a prescription as to its refills, contents, or labeling except as provided in these rules.~~ ~~(3-28-23)~~

~~**07. Failure to Confer**. Failure to confer with the prescriber when necessary or appropriate or filling a prescription if necessary components of the prescription drug order are missing or questionable.~~ ~~(3-28-23)~~

~~**08. Excessive Provision of Controlled Substances**. Providing an excessive amount of controlled substances. Evidentiary factors of a clearly excessive amount include, but are not limited to, the amount of controlled substances furnished and previous ordering patterns (including size and frequency of orders).~~ ~~(3-28-23)~~

~~**09. Failure to Counsel or Offer Counseling**. Failing to counsel or offer counseling, unless specifically exempted or refused.~~ ~~(3-28-23)~~

~~**10. Substandard, Misbranded, Adulterated, or Expired Products**. Manufacturing, compounding, delivering, distributing, dispensing, or permitting to be manufactured, compounded, delivered, distributed or dispensed substandard, misbranded, or adulterated drugs or preparations or those made using secret formulas. Failing to remove expired drugs from stock.~~ ~~(3-28-23)~~

~~**11. Prescriber Incentives**. Allowing a commission or rebate to be paid, or personally paying a commission or rebate, to a person writing, making, or otherwise ordering a prescription.~~ ~~(3-28-23)~~

~~**12. Exclusive Arrangements**. Participation in a plan or agreement that compromises the quality or extent of professional services or limits access to provider facilities at the expense of public health or welfare.~~ ~~(3-28-23)~~

~~**13. Failure to Report**. Failing to report to the Board any violation of statutes or rules pertaining to the practice of pharmacy or any act that endangers the health, safety, or welfare of patients or the public.~~ ~~(3-28-23)~~

~~**14. Failure to Follow Board Order**. Failure to follow an order of the Board.~~ ~~(3-28-23)~~

~~**15. Use of False Information**. Knowingly using false information in connection with the prescribing, delivering, administering, or dispensing of a controlled substance or other drug product.~~ ~~(3-28-23)~~

~~**16. Standard of Care**. Acts or omissions within the practice of pharmacy which fail to meet the standard provided by other qualified licensees or registrants in the same or similar setting.~~ ~~(3-28-23)~~

~~**17. Unnecessary Services or Products**. Directly promoting or inducing for the provisions of health care services or products that are unnecessary or not medically indicated.~~ ~~(3-28-23)~~

~~**18. Controlled Substance Non-Compliance**. Violating provisions of the federal Controlled Substances Act or Title 37, Chapter 27, Idaho Code.~~ ~~(3-28-23)~~

~~**105. 199. (RESERVED)**~~

~~SUBCHAPTER B RULES GOVERNING LICENSURE AND REGISTRATION (Rules 200 through 299)~~

~~**200. BOARD OF PHARMACY LICENSURE AND REGISTRATION.**~~
~~The Board will issue or renew a license or certificate of registration upon application and determination that the applicant has satisfied the requirements of applicable statutes, and any additional criteria specified by these rules.~~

~~Licenses or registrations must be obtained prior to engaging in these practices or their supportive functions.~~ ~~(3-28-23)~~

~~201. LICENSURE AND REGISTRATION: GENERAL REQUIREMENTS.~~

~~**01. Board Forms**. Initial applications, annual renewal applications, and other forms used for licensure, registration, or other purposes must be in such form as designated by the Board.~~ ~~(3-28-23)~~

~~**02. Incomplete Applications**. Information requested on any form must be provided and submitted to the Board office with the applicable fee or the submission will be considered incomplete and will not be processed. Applications that remain incomplete after six (6) months from the date of initial submission will expire.~~ ~~(3-28-23)~~

~~**03. On-Time Annual Renewal Application**. Licenses and registrations must be renewed annually prior to expiration to remain valid. Timely submission of the renewal application is the responsibility of each licensee or registrant. Licenses and certificates of registration issued to individuals will expire annually on the last day of the individual's birth month, and on December 31 for facilities, unless an alternate expiration term or date is stated in these rules.~~ ~~(3-28-23)~~

~~**04. Late Renewal Application**. Failure to submit a renewal application prior to the expiration date will cause the license or registration to lapse and will result in the assessment of a late fee and possible disciplinary action. A lapsed license or registration is invalid until renewal is approved by the Board and if not renewed within thirty (30) days after its expiration will require reinstatement.~~ ~~(3-28-23)~~

~~**05. Exemption**. New licenses and registrations issued ten (10) weeks or less prior to the renewal due date are exempt from the renewal requirements that year only.~~ ~~(3-28-23)~~

~~**06. Cancellation and Registration**. Failure to maintain the requirements for any registration will result in the cancellation of the registration.~~ ~~(3-28-23)~~

~~**07. Reinstatement of License or Registration**. Unless otherwise specified in Board rule, consideration of a request for reinstatement of a license or registration will require a completed application on a Board form, submission of a completed fingerprint card, as applicable, and payment of any applicable fees due or delinquent at the time reinstatement is requested.~~ ~~(3-28-23)~~

~~**08. Parent or Legal Guardian Consent**. No person under the age of eighteen (18), unless an emancipated minor, may submit an application for licensure or registration without first providing the Board with written consent from a parent or legal guardian.~~ ~~(3-28-23)~~

~~202. BOARD FEES.~~

~~**01. Fee Determination and Collection**. Pursuant to the authority and limitations established by Sections 37-2715 and 54-1720(5)(a), Idaho Code, the Board has determined and will collect fees for the issuance, annual renewal, or reinstatement of licenses and certificates of registration to persons and drug outlets engaged in acts or practices regulated by the Board.~~ ~~(3-28-23)~~

~~**02. Time and Method of Payment**. Fees are due at the time of application payable to the "Idaho State Board of Pharmacy."~~ ~~(3-28-23)~~

~~**03. Fee for Dishonored Payment**. A reasonable administrative fee may be charged for a dishonored check or other form of payment. If a license or registration application has been approved or renewed by the Board and payment is subsequently dishonored, the approval or renewal is immediately canceled on the basis of the submission of an incomplete application. The board may require subsequent payments to be made by cashier's check, money order, or other form of guaranteed funds.~~ ~~(3-28-23)~~

~~**04. Fee Exemption for Controlled Substance Registrations**. Persons exempt pursuant to federal law from fee requirements applicable to controlled substance registrations issued by the DEA are also exempt from fees applicable to controlled substance registrations issued by the Board.~~ ~~(3-28-23)~~

~~203. FEE SCHEDULE.~~

~~01. Licenses and Registrations – Professionals.~~

~~License/Registration~~	~~Initial Fee~~	~~Annual Renewal Fee~~
~~Pharmacist License~~	~~$140~~	~~$130~~
~~Nonresident PIC Registration~~	~~$290~~	~~$290~~
~~Pharmacist Intern~~	~~$50~~	~~$50~~
~~Technician~~	~~$35~~	~~$35~~
~~Practitioner Controlled Substance Registration~~	~~$60~~	~~$60~~

~~(3-28-23)~~

~~02. Certificates of Registration and Licensure – Facilities.~~

~~License/Registration~~	~~Initial Fee~~	~~Annual Renewal Fee~~
~~Drug Outlet (unless otherwise listed)~~	~~$100~~	~~$100~~
~~Wholesale License~~	~~$180~~	~~$180~~
~~Wholesale Registration~~	~~$150~~	~~$150~~
~~Central Drug Outlet (Nonresident)~~	~~$500~~	~~$250~~
~~Mail Service Pharmacy~~	~~$500~~	~~$250~~
~~Durable Medical Equipment Outlet~~	~~$50~~	~~$50~~
~~Outsourcing Facility (Nonresident)~~	~~$500~~	~~$250~~
~~Manufacturer~~	~~$150~~	~~$150~~
~~Veterinary Drug Outlet~~	~~$35~~	~~$35~~

~~(3-28-23)~~

~~03. Late Fees and Reinstatements.~~

~~Category~~	~~Fee~~
~~Late payment processing fee~~	~~$50~~
~~License or registration reinstatement fee~~	~~One-half (1/2) of the amount of the annual renewal~~

~~(3-28-23)~~

~~04. Administrative Services.~~

~~Category~~	~~Fee~~
~~Experiential hours certification~~	~~$25~~
~~Duplicate pharmacist certificate of licensure~~	~~$35~~

~~(3-28-23)~~

204. – 209. (RESERVED)

210. DETERMINATION OF NEED FOR NONRESIDENT LICENSURE OR REGISTRATION.

01. Independent Practice. Nonresident pharmacists must be licensed if engaged in the independent practice of pharmacy across state lines and not practicing for an Idaho registered drug outlet. (3-28-23)

02. Practice for an Idaho Registered Drug Outlet. A nonresident pharmacist serving as the PIC for an Idaho registered nonresident drug outlet must be registered to practice into Idaho. All other nonresident pharmacists who are employed by, or affiliated with, and practicing for the Idaho registered nonresident drug outlet, but who are not the PIC, are exempt from license and registration requirements for practice into Idaho. (3-28-23)

03. Multistate Pharmacists. Multistate pharmacists, as defined in Section 54-1723B, Idaho Code, are exempt from separate licensure or registration in Idaho. (3-28-23)

04. Exemption from Separate Controlled Substance Registration. All pharmacists who are practicing in or into Idaho are exempt from obtaining a separate controlled substance registration, but are subject to compliance with all requirements under Title 37, Chapter 27, Idaho Code. (3-28-23)

211. PHARMACIST LICENSURE BY EXAMINATION.
To be considered for licensure, a person must satisfy the requirements of Section 54-1722(1)(a) through (e), Idaho Code, submit to the Board an application for licensure by examination, and meet the following: (3-28-23)

01. Graduates of U.S. Pharmacy Schools. Graduate from an ACPE-accredited school or college of pharmacy within the United States. (3-28-23)

02. Graduates of Foreign Pharmacy Schools. Graduate from a school or college of pharmacy located outside of the United States, submit certification by the FPGEC, and complete a minimum of seventeen hundred forty (1,740) experiential hours as verified on an employer's affidavit signed by a pharmacist licensed and practicing in the United States. The Board may request verifiable business records to document the hours. (3-28-23)

03. Licensure Examinations. Qualified applicants must pass the NAPLEX in accordance with NABP standards. A candidate who fails the NAPLEX three (3) times must complete at least thirty (30) hours of continuing education accredited by an ACPE accredited provider prior to being eligible to sit for each subsequent reexamination. Candidates are limited to five (5) total NAPLEX attempts. (3-28-23)

04. Score Transfer. Score transfers into Idaho during the examination registration process are accepted for one (1) year. After taking the exam, score transfers into Idaho must be submitted within eighty-nine (89) days. (3-28-23)

212. PHARMACIST LICENSURE BY RECIPROCITY.
An applicant for pharmacist licensure by reciprocity must satisfy the requirements of Section 54-1723, Idaho Code, and submit a preliminary application for licensure transfer through NABP. An applicant whose pharmacist license is currently restricted by a licensing entity in another state must appear before the Board to petition for licensure by reciprocity. An applicant not actively engaged in the practice of pharmacy during the year preceding the date of application may have to complete intern hours for each year away from the practice of pharmacy. (3-28-23)

213. PHARMACIST LICENSE: CPE REQUIREMENTS.
Each pharmacist must complete fifteen (15) CPE hours each calendar year between January 1 and December 31. (3-28-23)

01. ACPE. At least twelve (12) of the CPE hours obtained must be from programs by an ACPE that have a participant designation of "P" (for pharmacist) as the suffix of the ACPE universal program number. ACPE credits must be reported to and documented in CPE Monitor in order to be accepted. (3-28-23)

02. CME. A maximum of three (3) of the hours may be obtained from CME, if the credits are:

(3-28-23)

a. Obtained from an ACCME accredited provider; and (3-28-23)

b. A certificate is furnished that identifies the name of the ACCME accredited provider and a clear reference to its accreditation status, the title of the CME program, the completed hours of instruction, the date of completion, and the name of the individual obtaining the credit. Upon audit, all CME certificates must be submitted to the Board. (3-28-23)

03. **Alternative to CPE**. If audited, a pharmacist may substitute a current certification by a nationally accredited pharmacy practice specific specialty certification program. (3-28-23)

214. PHARMACIST LICENSE: REINSTATEMENT.

The Board may, at its discretion, consider reinstatement of a pharmacist license upon receipt of a completed application, background check, and payment of the reinstatement and other fees due or delinquent at the time reinstatement is requested. (3-28-23)

01. **Satisfactory Evidence**. Reinstatement applicants must provide satisfactory evidence of completion of a minimum of thirty (30) CPE hours within the twenty-four (24) months prior to reinstatement and compliance with any direct orders of the Board. (3-28-23)

02. **Additional Requirements**. A pharmacist reinstatement applicant may be required to appear before the Board. The Board may also, at its discretion, impose additional requirements on a pharmacist reinstatement applicant who has not practiced as a pharmacist for the preceding twelve (12) months or longer that may include taking and passing an examination, completion of intern hours, completion of additional CPE hours, or other requirements determined necessary to acquire or demonstrate professional competency. (3-28-23)

215. NONRESIDENT PIC REGISTRATION TO PRACTICE PHARMACY INTO IDAHO.

To be registered as a nonresident PIC, an applicant must submit an application on a Board form including, but not limited to: (3-28-23)

01. **Individual License Information**. Current pharmacist licensure information in all other states, including each state of licensure and each license number; (3-28-23)

02. **Facility License Information**. The license or registration number of the facility for which the applicant will be practicing. (3-28-23)

216. PHARMACIST INTERN REGISTRATION.

01. **Registration Requirements**. To be approved for and maintain registration as a pharmacist intern, the applicant must: (3-28-23)

a. Currently be enrolled and in good standing in an accredited school or college of pharmacy, pursuing a professional degree in pharmacy; or (3-28-23)

b. Be a graduate of an accredited school or college of pharmacy within the United States and awaiting examination for pharmacist licensure; or (3-28-23)

c. Be a graduate of a school or college of pharmacy located outside the United States, obtain certification by the FPGEC, and be awaiting finalization of pharmacist licensure. (3-28-23)

02. **Renewal**. (3-28-23)

a. Current Students. A pharmacist intern registration must be renewed annually by July 15; however, the renewal fee will be waived, if renewed on time, for the duration of the student's enrollment in the school or college of pharmacy. Following graduation, if a pharmacist license application has been submitted, the pharmacist intern license will be extended at no cost for up to six (6) additional months from the date of application as a

pharmacist, after which time the individual will need to submit a new application to continue to be a pharmacist intern. (3-28-23)

b. Pharmacy Graduates. A graduate pharmacist intern registration may be obtained and renewed once within one (1) year from the date of issuance. The Board may, at its discretion, grant additional time to complete internship experience if unique circumstances present. (3-28-23)

217. – 219. (RESERVED)

220. TECHNICIAN REGISTRATION.

01. Registration Requirements. A person may apply for registration as a technician if the person satisfies the following requirements: (3-28-23)

a. Age. Be at least sixteen (16) years of age. (3-28-23)

b. Exemption from Criminal Background Check. Technician candidates under the age of eighteen (18) are exempt from the fingerprint-based criminal history check requirement of Idaho Code. (3-28-23)

02. Certified Technician Registration. To be approved for registration as a certified technician, a person must have obtained and maintained certified pharmacy technician (CPhT) status through the Pharmacy Technician Certification Board (PTCB), the National Healthcareer Association (NHA), or their successors. (3-28-23)

221. – 223. (RESERVED)

224. PRACTITIONER CONTROLLED SUBSTANCE REGISTRATION.
Any practitioner in Idaho who intends to prescribe, administer, dispense, or conduct research with a controlled substance must first obtain an Idaho practitioner controlled substance registration and: (3-28-23)

01. State License. Hold a valid license or registration to prescribe medications from a licensing entity established under Title 54, Idaho Code. (3-28-23)

02. DEA Registration. Obtain a valid federal DEA registration, if needed under federal law. (3-28-23)

a. Failure to obtain a federal DEA registration for any reason within forty-five (45) days of the issuance of the Idaho Practitioner Controlled Substance Registration will result in automatic cancellation. (3-28-23)

225. – 229. (RESERVED)

230. DRUG OUTLET LICENSURE AND REGISTRATION: GENERAL REQUIREMENTS.
A license or a certificate of registration is required for drug outlets prior to doing business in or into Idaho. A license or certificate of registration will be issued by the Board to drug outlets pursuant to, and in the general classifications defined by, Section 54-1729, Idaho Code. (3-28-23)

01. New Drug Outlet Inspections. Following the issuance of a new license or registration, each drug outlet will be inspected to confirm that the facility is compliant with applicable law. A change of ownership of a currently registered pharmacy will not require an onsite inspection of a new pharmacy registration unless a change of location occurs. (3-28-23)

02. License and Registration Transferability. Drug outlet licenses and registrations are location and owner specific and are nontransferable as to person or place. (3-28-23)

03. Nonresident Drug Outlet. The Board may license or register a drug outlet licensed or registered under the laws of another state if the other state's standards are comparable to those in Idaho and acceptable to the Board, evidenced by an inspection report. (3-28-23)

04. Change of Location. At least ten (10) days prior to the event, the registrant must notify the Board of a drug outlet's change of location through the completion of an application for a new license or registration. When a licensee or registrant has made a timely and complete application for a new license or registration, the existing license does not expire until the application has been finally determined by the Board, and, in case the application is denied or the terms of the new license limited, until the last day for seeking review of the Board order. This does not preclude the Board from taking immediate action to protect the public interest. (3-28-23)

05. Change of Ownership. The registrant must notify the Board of a drug outlet's change of ownership within thirty (30) days of the event on a Board form. (3-28-23)

06. Permanent Closing. A registrant must notify the Board and the general public of the pharmacy's permanent closing at least ten (10) days prior to closing. The notice must include the proposed date of closure, and the new location of the prescription files. The notice to the board is to include the location where the closing inventory record of controlled substances is retained. (3-28-23)

07. Exemption from Separate Controlled Substance Registration. All drug outlets doing business in or into Idaho who hold a valid license or registration from the Board are exempt from obtaining a separate controlled substance registration, but are subject to compliance with all requirements under Title 37, Chapter 27, Idaho Code. (3-28-23)

08. Sterile Preparation Endorsement. A drug outlet engaged in sterile preparation must obtain a single endorsement for one (1) or more hood or aseptic environmental control devices. (3-28-23)

231. – 239. (RESERVED)

240. WHOLESALER LICENSURE AND REGISTRATION.

01. Wholesaler Licensure. The following information must be provided under oath by each applicant for wholesaler licensure as part of the initial licensing procedure and for each renewal on a Board form: (3-28-23)

a. Any felony conviction or any conviction of the applicant relating to wholesale or retail prescription drug distribution or distribution of controlled substances. (3-28-23)

b. Any discipline of the applicant by a regulatory agency in any state for violating any law relating to wholesale or retail prescription drug distribution or distribution of controlled substances. (3-28-23)

02. NABP Accreditation. The Board will recognize a wholesaler's accreditation by NABP for purposes of reciprocity and satisfying the new drug outlet inspection requirements of these rules. (3-28-23)

03. Wholesaler Registration. Except when licensed pursuant to the Idaho Wholesale Drug Distribution Act and these rules, a wholesaler that engages in wholesale distribution of DME supplies, prescription medical devices, or products that contain pseudoephedrine in or into Idaho must be registered by the Board. (3-28-23)

241. – 249. (RESERVED)

250. MANUFACTURER REGISTRATION.
Manufacturers must be registered as follows: (3-28-23)

01. Mail Service Pharmacy. Those that ship, mail, or deliver dispensed prescription drugs or devices to an Idaho resident will be registered by the Board as a mail service pharmacy. (3-28-23)

02. Manufacturer. Those engaged in wholesale distribution will be registered as a manufacturer and comply with the Idaho Wholesale Drug Distribution Act and rules, as applicable. (3-28-23)

251. – 299. (RESERVED)

SUBCHAPTER C – DRUG OUTLET PRACTICE STANDARDS (Rules 300 through 399)

300. DRUG OUTLETS: MINIMUM FACILITY STANDARDS.
A resident drug outlet that dispenses prescription drugs to patients in Idaho must meet the following minimum requirements: (3-28-23)

01. Security and Privacy. A drug outlet must be constructed and equipped with adequate security to protect its equipment, records and supply of drugs, devices and other restricted sale items from unauthorized access, acquisition or use. All protected health information must be stored and maintained in accordance with HIPAA. (3-28-23)

02. Controlled Substance Storage. Drug outlets must store controlled substances in accordance with federal law. (3-28-23)

03. Authorized Access to the Restricted Drug Storage Area. Access to the restricted drug storage area must be limited to authorized personnel. (3-28-23)

04. Staffing. A drug outlet must be staffed sufficiently to allow for appropriate supervision, to otherwise operate safely and, if applicable, to remain open during the hours posted as open to the public for business. (3-28-23)

05. Electronic Recordkeeping System. A drug outlet that dispenses more than twenty (20) prescriptions per day must use an electronic recordkeeping system to establish and store patient medication records and prescription drug order, refill, transfer information, and other information necessary to provide safe and appropriate patient care. The electronic recordkeeping system must have audit trail functionality that documents for each prescription drug order the identity of each individual involved at each step of its processing, filling, and dispensing or, alternatively, the identity of the pharmacist or prescriber responsible for the accuracy of these processes. (3-28-23)

301. DRUG OUTLETS THAT DISPENSE PRESCRIPTION DRUGS: MINIMUM PRESCRIPTION FILLING REQUIREMENTS.
Unless exempted by these rules, each drug outlet that dispenses prescription drugs to patients in Idaho must meet the following minimum requirements either at the drug outlet or through offsite pharmacy services: (3-28-23)

01. Valid Prescription Drug Order. Prescription drugs may only be dispensed pursuant to a valid prescription drug order as set forth in Subchapter E of these rules. (3-28-23)

02. Prospective Drug Review. Prospective drug review must be provided. (3-28-23)

03. Labeling. Each drug must bear a complete and accurate label as set forth in these rules. (3-28-23)

04. Verification of Dispensing Accuracy. Verification of dispensing accuracy must be performed to compare the drug stock selected to the drug prescribed. If not performed by a pharmacist or prescriber, an electronic verification system must be used that confirms the drug stock selected to fill the prescription is the same as indicated on the prescription label. (7-1-24)

05. Patient Counseling. Counseling must be provided. (3-28-23)

302. DRUG OUTLETS THAT DISPENSE DRUGS TO PATIENTS WITHOUT AN ONSITE PHARMACIST OR PRESCRIBER.
A drug outlet that dispenses drugs to patients in Idaho that does not have a pharmacist or prescriber onsite to perform or supervise pharmacy operations must comply with the following requirements: (3-28-23)

01. Security and Access. Maintain adequate video surveillance of the facility and retain a high quality recording for a minimum of thirty (30) days. (3-28-23)

02. Technology. The video or audio communication system used to counsel and interact with each patient or patient's caregiver, must be clear, secure, and HIPAA compliant. (3-28-23)

03. Technical Limitation Closure. The drug outlet must be, or remain, closed to the public if any component of the surveillance or video and audio communication system is malfunctioning, until system corrections or repairs are completed. (3-28-23)

04. Exemption for Self-Service Systems. A self-service ADS that is operating as a drug outlet is exempt from the video surveillance requirement and the self-inspection requirement of this rule. In addition, if counseling is provided by an onsite prescriber or pharmacist, a self-service ADS is exempt from the video and audio communication system requirements of this rule. (3-28-23)

05. Exemption for Veterinarians. Veterinarians practicing in accordance with their Idaho practice act are exempt from this rule. (3-28-23)

303. DRUGS STORED OUTSIDE OF A DRUG OUTLET FOR RETRIEVAL BY A LICENSED HEALTH PROFESSIONAL.

Drugs may be stored in an alternative designated area outside the drug outlet, including, but not limited to, floor stock, in an emergency cabinet, in an emergency kit, or as emergency outpatient drug delivery from an emergency room at a registered institutional facility, provided the following conditions are met: (3-28-23)

01. Supervising Drug Outlet. Drugs stored in such a manner must remain under the control of, and be routinely monitored by, the supervising drug outlet. (3-28-23)

02. Secure Storage. The area is appropriately equipped to ensure security and protection from diversion or tampering. (3-28-23)

03. Controlled Substances. Controlled substances may only be stored in an alternative designated area as permitted by, and in accordance with, federal law. (3-28-23)

04. Stocking and Replenishing. Stocking or replenishing drugs in an alternative designated area may be performed by a pharmacist or prescriber, or by appropriate support personnel using either an electronic verification system or a two (2) person checking system. (3-28-23)

304. -- 349. (RESERVED)

SUBCHAPTER D -- RULES GOVERNING PHARMACIST PRESCRIPTIVE AUTHORITY (Rules 350 through 399)

350. PHARMACIST PRESCRIBING: GENERAL REQUIREMENTS.

In accordance with Section 54-1705, Idaho Code, a pharmacist may independently prescribe provided the following general requirements are met by the pharmacist: (3-28-23)

01. Education. Only prescribe drugs or devices for conditions for which the pharmacist is educationally prepared and for which competence has been achieved and maintained. (3-28-23)

02. Patient-Prescriber Relationship. Only issue a prescription for a legitimate medical purpose arising from a patient-prescriber relationship as defined in Section 54-1733, Idaho Code. (3-28-23)

03. Patient Assessment. Obtain adequate information about the patient's health status to make appropriate decisions based on the applicable standard of care and the best available evidence. (3-28-23)

04. Collaboration with Other Health Care Professionals. Recognize the limits of the pharmacist's own knowledge and experience and consult with and refer to other health care professionals as appropriate. (3-28-23)

05. Documentation. Maintain documentation adequate to justify the care provided including, but not limited to, the information collected as part of the patient assessment, the prescription record, provider notification,

and the follow-up care plan. (3-28-23)

06. Prescribing Exemption. The general requirements set forth in this section do not apply to collaborative pharmacy practice agreements, devices, and nonprescription drugs. (3-28-23)

351. COLLABORATIVE PHARMACY PRACTICE.
Collaborative pharmacy practice may be performed in accordance with an agreement that identifies the parties to the agreement, the pharmacist's scope of practice authorized, and if necessary, any monitoring parameters. (3-28-23)

352. -- 399. (RESERVED)

SUBCHAPTER E -- FILLING AND DISPENSING PRESCRIPTION DRUGS (Rules 400 through 499)

400. PRESCRIPTION DRUG ORDER: VALIDITY.
Prior to filling or dispensing a prescription drug order, a pharmacist must verify its validity. (3-28-23)

01. Invalid Prescription Drug Orders. A prescription drug order is invalid if not issued by a licensed prescriber for a legitimate medical purpose, and within the course and scope of the prescriber's professional practice and prescriptive authority. (3-28-23)

02. Antedating or Postdating. A prescription drug order is invalid if antedated or postdated. (3-28-23)

03. Tampering. A prescription drug order is invalid if, at the time of presentation, it shows evidence of alteration, erasure, or addition by any person other than the person who wrote it. (3-28-23)

04. Prescriber Self-Use. A prescription drug order written for a controlled substance is invalid if written for the prescriber's own use. (3-28-23)

05. Digital Image Prescriptions. A digital image of a prescription drug order is invalid if it is for a controlled substance or if the patient intends to pay cash for the drug in whole. (3-28-23)

401. PRESCRIPTION DRUG ORDER: MINIMUM REQUIREMENTS.
A prescription drug order must comply with applicable requirements of federal law and, except as differentiation is permitted for an institutional drug order, include at least the following: (3-28-23)

01. Patient's Name. The patient's or authorized entity's name and: (3-28-23)

a. If for a controlled substance, the patient's full name and address; and (3-28-23)

b. If for an animal, the species. (3-28-23)

02. Date. The date issued. (3-28-23)

03. Drug Information. The drug name, strength, and quantity. (3-28-23)

04. Directions. The directions for use. (3-28-23)

05. Prescriber Information. The name and, if for a controlled substance, the address and DEA registration number of the prescriber. (3-28-23)

06. Signature. A signature sufficient to evidence a valid prescription of either the prescriber or, if a renewal of a previous prescription, the prescriber's agent, when authorized by the prescriber. (3-28-23)

07. Institutional Drug Order Exemptions. An institutional drug order may exempt the patient's address, the dosage form, quantity, prescriber's address, and prescriber's DEA registration number. (3-28-23)

08. Exemptions for Non-Controlled Substances. A prescriber may omit drug information and directions and make an indication for the pharmacist to finalize the patient's drug therapy plan. (3-28-23)

402. FILLING PRESCRIPTION DRUG ORDERS: PRACTICE LIMITATIONS.

01. Drug Product Selection. Drug product selection is allowed only between therapeutic equivalent drugs. If a prescriber orders by any means that a brand name drug must be dispensed, then no drug product selection is permitted. (3-28-23)

02. Partial Filling. A prescription drug order may be partially filled within the limits of federal law. The total quantity dispensed in partial fillings must not exceed the total quantity prescribed. (3-28-23)

03. Refill Authorization. A prescription drug order may be refilled when permitted by state and federal law and as specifically authorized by the prescriber. A pharmacist may also refill a prescription for a non-controlled drug to ensure continuity of care. (3-28-23)

403. FILLING PRESCRIPTION DRUG ORDERS: ADAPTATION.
A pharmacist may adapt drugs as specified in this rule. (3-28-23)

01. Change Quantity. A pharmacist may change the quantity of medication prescribed if: (3-28-23)

a. The prescribed quantity or package size is not commercially available; (3-28-23)

b. The change in quantity is related to a change in dosage form, strength, or therapeutic interchange; (3-28-23)

c. The change is intended to dispense up to the total amount authorized by the prescriber including refills; or (3-28-23)

d. The change extends a maintenance drug for the limited quantity necessary to coordinate a patient's refills in a medication synchronization program. (3-28-23)

02. Change Dosage Form. A pharmacist may change the dosage form of the prescription if it is in the best interest of patient care, so long as the prescriber's directions are also modified to equate to an equivalent amount of drug dispensed as prescribed. (3-28-23)

03. Complete Missing Information. A pharmacist may complete missing information on a prescription if there is evidence to support the change. (3-28-23)

04. Documentation. The adaption must be documented in the patient's record. (3-28-23)

404. FILLING PRESCRIPTION DRUG ORDERS: DRUG PRODUCT SUBSTITUTION.
Drug product substitutions in which a pharmacist dispenses a drug product other than that prescribed are allowed only as follows: (3-28-23)

01. Hospital. Pursuant to a formulary or drug list prepared by the pharmacy and therapeutics committee of a hospital; (3-28-23)

02. Institutional Facility. At the direction of the quality assessment and assurance committee of an institutional facility; (3-28-23)

03. Biosimilars. A pharmacist may substitute an interchangeable biosimilar product for a prescribed biological product if: (3-28-23)

a. The biosimilar has been determined by the FDA to be interchangeable and published in the Purple Book; (3-28-23)

b. The name of the drug and the manufacturer or the NDC number is documented in the patient medical record. (3-28-23)

04. Therapeutic Interchange. A pharmacist may substitute a drug with another drug in the same therapeutic class, provided the substitution lowers the cost to the patient or occurs during a drug shortage. (3-28-23)

405. FILLING PRESCRIPTION DRUG ORDERS: TRANSFERS.
A prescription drug order may be transferred within the limits of federal law. Drug outlets using a common electronic file are exempt from transfer limits. (3-28-23)

406. LABELING STANDARDS.
All prescription drugs must be in an appropriate container and bear information that identifies the drug product, any additional components as appropriate, and the individual responsible for its final preparation. (3-28-23)

01. Standard Prescription Drug. A prescription drug for outpatient dispensing must be labeled in accordance with federal law. (3-28-23)

02. Parenteral Admixture. If one (1) or more drugs are added to a parenteral admixture, the admixture's container must include the date and time of the addition, or alternatively, the beyond use date. (3-28-23)

03. Prepackaged Product. The containers of prepackaged drugs must include an expiration date that is the lesser of the manufacturer's original expiration date, one (1) year from the date the drug is prepackaged, or a shorter period if warranted. (3-28-23)

04. Repackaged Drug. If a previously dispensed drug is repackaged, it must contain the serial number and contact information for the original dispensing pharmacy, as well as a statement that indicates that the drug has been repackaged, and the contact information of the repackaging pharmacy. (3-28-23)

05. Distributed Compounded Drug Product. Compounded and sterile prepackaged drug product distributed in the absence of a patient specific prescription must be labeled as follows: (3-28-23)

a. If from a pharmacy, the statement: "not for further dispensing or distribution." (3-28-23)

b. If from an outsourcing facility, the statements: "office use only" and "not for resale." (3-28-23)

407. PRESCRIPTION DELIVERY: RESTRICTIONS.

01. Acceptable Delivery. A drug outlet that dispenses drugs to patients in Idaho may deliver filled prescriptions in accordance with federal law, as long as appropriate measures are taken to ensure product integrity and safety. (3-28-23)

02. Pick-up or Return by Authorized Personnel. Filled prescriptions may be picked up for or returned from delivery by authorized personnel from a secured delivery area. (3-28-23)

408. DESTRUCTION OR RETURN OF DRUGS OR DEVICES: RESTRICTIONS.
A drug outlet registered with the DEA as a collector may collect controlled and non-controlled drugs for destruction in accordance with applicable federal law. Otherwise a dispensed drug or prescription device may only be accepted for return as follows: (3-28-23)

01. Potential Harm. When the pharmacist determines that harm could result if the drug is not returned. (3-28-23)

02. Did Not Reach Patient. Non-controlled drugs that have been maintained in the custody and control of the institutional facility, dispensing pharmacy, or their related clinical facilities may be returned if product integrity can be assured. Controlled substances may only be returned from a hospital daily delivery system under which a pharmacy dispenses no more than a seventy-two (72) hour supply for a drug order. (3-28-23)

03. Donation. Those that qualify for return under the provisions of the Idaho Legend Drug Donation Act as specified in Section 54-1762, Idaho Code. (3-28-23)

409. – 499. (RESERVED)

SUBCHAPTER F – REPORTING REQUIREMENTS AND DRUG OUTLET RECORDKEEPING (Rules 500 through 599)

500. RECORDKEEPING: MAINTENANCE AND INVENTORY REQUIREMENTS.

01. Records Maintenance and Retention Requirement. Unless an alternative standard is stated for a specified record type, form, or format, records required to evidence compliance with statutes or rules enforced by the Board must be maintained and retained in a readily retrievable form and location for at least three (3) years from the date of the transaction. (3-28-23)

02. Prescription Retention. A prescription drug order must be retained in a readily retrievable manner by each drug outlet and maintained in accordance with federal law: (3-28-23)

03. Inventory Records. Each drug outlet must maintain a current, complete and accurate record of each controlled substance manufactured, imported, received, ordered, sold, delivered, exported, dispensed or otherwise disposed of by the registrant. Drug outlets must maintain inventories and records in accordance with federal law. An annual inventory must be conducted at each registered location no later than seven (7) days after the date of the most recent inventory in a form and manner that satisfies the inventory requirements of federal law. Drugs stored outside a drug outlet in accordance with these rules must be regularly inventoried and inspected to ensure that they are properly stored, secured, and accounted for. Additional inventories are necessary when required by federal law. (3-28-23)

04. Rebuttal Presumption of Violation. Evidence of an amount of a controlled substance that differs from the amount reflected on a record or inventory required by state or federal law creates a rebuttable presumption that the registrant has failed to keep records or maintain inventories in conformance with the recordkeeping and inventory requirements of state and federal law. (3-28-23)

05. Drug Distributor Records. Wholesalers and other entities engaged in wholesale drug distribution must maintain inventories and records or transactions pertaining to the receipt and distribution or other disposition of drugs in accordance with federal law that include at least: (3-28-23)

a. The source of the drugs, including the name and principal address of the seller or transferor, and the address of the location from which the drugs were shipped; (3-28-23)

b. The identity and quantity of the drugs received and distributed or disposed of; (3-28-23)

c. The dates of receipt and distribution or other disposition of the drugs; and (3-28-23)

d. Controlled substance distribution invoices, in the form and including the requirements of federal law. (3-28-23)

06. Central Records Storage. Records may be retained at a central location in compliance with federal law. (3-28-23)

07. Electronic Records Storage. Records may be electronically stored and maintained if they remain legible and are in a readily retrievable format, and if federal law does not require them to be kept in a hard copy format. (3-28-23)

501. REPORTING REQUIREMENTS.

01. Theft or Loss of Controlled Substances. A registrant must report to the Board on the same day

reported to the DEA a theft or loss of a controlled substance that includes the information required by federal law. (3-28-23)

02. Individual and Outlet Information Changes. Changes in employment or changes to information provided on or with the initial or renewal application must be reported to the Board within ten (10) days of the change. (3-28-23)

03. Drug Distributor Monthly Reports. An authorized distributor must report specified data on drugs distributed at least monthly to the Board in a form and manner prescribed by the Board. (3-28-23)

502. – 599. (RESERVED)

SUBCHAPTER C – PRESCRIPTION DRUG MONITORING PROGRAM REQUIREMENTS (Rules 600 through 699)

600. CONTROLLED SUBSTANCES: PDMP.
Specified data on controlled substances must be reported by the end of the next business day by all drug outlets that dispense controlled substances in or into Idaho and prescribers that dispense controlled substances to humans. (3-28-23)

01. Online Access to PDMP. To obtain online access, a prescriber or pharmacist, or their delegate must complete and submit a registration application and agree to adhere to the access restrictions and limitations established by law. (3-28-23)

02. Use Outside Scope of Practice. Information obtained from the PDMP must not be used for purposes outside the prescriber's or pharmacist's scope of professional practice. A delegate may not access the PDMP outside of their supervisor's scope of professional practice. (3-28-23)

03. Profile Requests. Authorized persons without online access may obtain a profile by completing a Board form and submitting it to the Board office with proof of identification and other credentials necessary to confirm the requestor's authorized status pursuant to Section 37-2726, Idaho Code. (3-28-23)

601. – 699. (RESERVED)

SUBCHAPTER H – RULES GOVERNING DRUG COMPOUNDING (Rules 700 through 799)

700. COMPOUNDING DRUG PREPARATIONS.
Any compounding that is not permitted herein is considered manufacturing. (3-28-23)

01. Application. This rule applies to any person, including any business entity, authorized to engage in the practice of non-sterile compounding, sterile compounding, and sterile prepackaging of drug products in or into Idaho, except these rules do not apply to: (3-28-23)

a. Compound positron emission tomography drugs; (3-28-23)

b. Radiopharmaceutics; (3-28-23)

c. The reconstitution of a non-sterile drug or a sterile drug for immediate administration; (3-28-23)

d. The addition of a flavoring agent to a drug product; and (3-28-23)

e. Product preparation of a non-sterile, non-hazardous drug according to the manufacturer's FDA approved labeling. (3-28-23)

02. General Compounding Standards. (3-28-23)

~~a. Active Pharmaceutical Ingredients. All active pharmaceutical ingredients must be obtained from an FDA registered manufacturer. FDA registration as a foreign manufacturer satisfies this requirement. (3-28-23)~~

~~b. Certificate of Analysis (COA). Unless the active pharmaceutical ingredient complies with the standards of an applicable USP-NF monograph, a COA must be obtained for all active pharmaceutical ingredients procured for compounding and retained for a period of not less than three (3) years from the date the container is emptied, expired, returned, or disposed of. The following minimum information is necessary on the COA: product name, lot number, expiration date, and assay. (3-28-23)~~

~~c. Equipment. Equipment and utensils must be of suitable design and composition and cleaned, sanitized, or sterilized as appropriate prior to use. (3-28-23)~~

~~d. Disposal of Compromised Drugs. When the correct identity, purity, strength, and sterility of ingredients and components cannot be confirmed (in cases of, for example, unlabeled syringes, opened ampoules, punctured stoppers of vials and bags, and containers of ingredients with incomplete labeling) or when the ingredients and components do not possess the expected appearance, aroma, and texture, they must be removed from stock and isolated for return, reclamation, or destruction. (3-28-23)~~

~~03. Prohibited Compounding. Compounding any drug product for human use that the FDA has identified as presenting demonstrable difficulties in compounding or has withdrawn or removed from the market for safety or efficacy reasons is prohibited. (3-28-23)~~

~~04. Limited Compounding. (3-28-23)~~

~~a. Triad Relationship. A pharmacist may compound a drug product in the usual course of professional practice for an individual patient pursuant to an established prescriber/patient/pharmacist relationship and a valid prescription drug order. (3-28-23)~~

~~b. Commercially Available Products. A drug product that is commercially available may only be compounded if not compounded regularly or in inordinate amounts and if: (3-28-23)~~

~~i. It is medically warranted to provide an alternate ingredient, dosage form, or strength of significance; or (3-28-23)~~

~~ii. The commercial product is not reasonably available in the market in time to meet the patient's needs. (3-28-23)~~

~~c. Anticipatory Compounding. Limited quantities of a drug product may be compounded or sterile prepackaged prior to receiving a valid prescription drug order based on a history of receiving valid prescription drug orders for the compounded or sterile prepackaged drug product. (3-28-23)~~

~~05. Drug Compounding Controls. (3-28-23)~~

~~a. Policies and Procedures. In consideration of the applicable provisions of USP Chapter 795 concerning pharmacy compounding of non-sterile preparations, USP Chapter 797 concerning sterile preparations, Chapter 1075 of the USP-NF concerning good compounding practices, and Chapter 1160 of the USP-NF concerning pharmaceutical calculations, policies and procedures for the compounding or sterile prepackaging of drug products must ensure the safety, identity, strength, quality, and purity of the finished product, and must include any of the following that are applicable to the scope of compounding practice being performed: (3-28-23)~~

~~i. Appropriate packaging, handling, transport, and storage requirements; (3-28-23)~~

~~ii. Accuracy and precision of calculations, measurements, and weighing; (3-28-23)~~

~~iii. Determining ingredient identity, quality, and purity; (3-28-23)~~

~~iv. Labeling accuracy and completeness; (3-28-23)~~

v. Beyond use dating; (3-28-23)

vi. Auditing for deficiencies, including routine environmental sampling, quality and accuracy testing, and maintaining inspection and testing records; (3-28-23)

vii. Maintaining environmental quality control; and (3-28-23)

viii. Safe limits and ranges for strength of ingredients, pH, bacterial endotoxins, and particulate matter. (3-28-23)

b. Accuracy. Components including, but not limited to, bulk drug substances, used in the compounding or sterile prepackaging of drug products must be accurately weighed, measured, or subdivided, as appropriate. The amount of each active ingredient contained within a compounded drug product must not vary from the labeled potency by more than the drug product's acceptable potency range listed in the USP-NF monograph for that product. If USP-NF does not publish a range for a particular drug product, the active ingredients must not contain less than ninety percent (90%) and not more than one hundred ten percent (110%) of the potency stated on the label. (3-28-23)

c. Non-Patient-Specific Records. Except for drug products that are being compounded or sterile prepackaged for direct administration, a production record of drug products compounded or sterile prepackaged in anticipation of receiving prescription drug orders or distributed in the absence of a patient specific prescription drug order ("office use") solely as permitted in these rules, must be prepared and kept for each drug product prepared, including: (3-28-23)

i. Production date; (3-28-23)

ii. Beyond use date; (3-28-23)

iii. List and quantity of each ingredient; (3-28-23)

iv. Internal control or serial number; and (3-28-23)

v. Initials or unique identifier of all persons involved in the process or the compounder responsible for the accuracy of these processes. (3-28-23)

701. STERILE PREPARATION.

01. Application. In addition to all other applicable rules in this chapter, including the rules governing Compounding Drug Preparations, these rules apply to all persons, including any business entity, engaged in the practice of sterile compounding and sterile prepackaging in or into Idaho. (3-28-23)

02. Dosage Forms Requiring Sterility. The sterility of compounded biologics, diagnostics, drugs, nutrients, and radiopharmaceuticals must be maintained or the compounded drug preparation must be sterilized when prepared in the following dosage forms: (3-28-23)

a. Aqueous bronchial and nasal inhalations, except sprays and irrigations intended to treat nasal mucosa only; (3-28-23)

b. Baths and soaks for live organs and tissues; (3-28-23)

c. Injections (for example, colloidal dispersions, emulsions, solutions, suspensions); (3-28-23)

d. Irrigations for wounds and body cavities; (3-28-23)

e. Ophthalmic drops and ointments; and (3-28-23)

f. Tissue implants. (3-28-23)

03. Compounder Responsibilities. Compounders and sterile prepackagers are responsible for ensuring that sterile products are accurately identified, measured, diluted, and mixed and are correctly purified, sterilized, packaged, sealed, labeled, stored, dispensed, and distributed, as well as prepared in a manner that maintains sterility and minimizes the introduction of particulate matter; (3-28-23)

a. Unless following manufacturer's guidelines or another reliable literature source, opened or partially used packages of ingredients for subsequent use must be properly stored as follows; (3-28-23)

i. Opened or entered single dose containers, such as bags, bottles, syringes, and vials of sterile products and compounded sterile preparations are to be used within one (1) hour if opened in non-sterile conditions, and any remaining contents must be discarded; (3-28-23)

ii. Single-dose vials needle-punctured in a sterile environment may be used up to six (6) hours after initial needle puncture; (3-28-23)

iii. Opened single-dose ampules may not be stored for any time period; and (3-28-23)

iv. Multiple-dose containers that are formulated for removal of portions on multiple occasions because they contain antimicrobial preservatives, may be used for up to twenty-eight (28) days after initial opening or entering, unless otherwise specified by the manufacturer; (3-28-23)

b. Water-containing compounded sterile products that are non-sterile during any phase of the compounding procedure must be sterilized within six (6) hours after completing the preparation in order to minimize the generation of bacterial endotoxins; (3-28-23)

c. No food, drinks, or materials exposed in patient care and treatment areas may enter ante-areas, buffer areas, or segregated areas where components and ingredients of sterile preparations are prepared. (3-28-23)

04. Environmental Controls. Except when prepared for immediate administration, the environment for the preparation of sterile preparations in a drug outlet must be in an isolated area, designed to avoid unnecessary traffic and airflow disturbances, and equipped to accommodate aseptic techniques and conditions. (3-28-23)

a. Hoods and aseptic environmental control devices must be certified for operational efficiency as often as recommended by the manufacturer or at least every six (6) months or if relocated. (3-28-23)

b. Filters must be inspected and replaced in accordance with the manufacturer's recommendations. (3-28-23)

05. Sterile Preparation Equipment. A drug outlet in which sterile preparations are prepared must be equipped with at least the following: (3-28-23)

a. Protective apparel including gowns, masks, and sterile (or the ability to sterilize) non-vinyl gloves, unless written documentation can be provided from the aseptic isolator manufacturer that any component of garbing is not necessary; (3-28-23)

b. A sink; (3-28-23)

c. A refrigerator for proper storage of additives and finished sterile preparations prior to delivery when necessary; and (3-28-23)

d. An appropriate laminar airflow hood or other aseptic environmental control device such as a laminar flow biological safety cabinet, or a comparable compounding area when authorized by USP Chapter 797. (3-28-23)

06. Documentation Requirements. The following documentation must also be maintained by a drug

outlet in which sterile preparations are prepared: (3-28-23)

a. Justification of beyond use dates assigned, pursuant to direct testing or extrapolation from reliable literature sources; (3-28-23)

b. Training records, evidencing that personnel are trained on a routine basis and are adequately skilled, educated, and instructed; (3-28-23)

c. Audits appropriate for the risk of contamination for the particular sterile preparation including: (3-28-23)

i. Visual inspection to ensure the absence of particulate matter in solutions, the absence of leakage from bags and vials, and the accuracy of labeling with each dispensing; (3-28-23)

ii. Periodic hand hygiene and garbing competency; (3-28-23)

iii. Media fill test procedures (or equivalent), aseptic technique, and practice related competency evaluation at least annually by each compounder or sterile prepackager; (3-28-23)

iv. Environmental sampling testing at least upon registration of a new drug outlet, following the servicing or re-certification of facilities and equipment, or in response to identified problems with end products, staff techniques or patient-related infections, or every six (6) months. (3-28-23)

v. Gloved fingertip sampling testing at least annually for personnel who compound low- and medium-risk level compounded sterile preparations and every six (6) months for personnel who compound high-risk level compounded sterile preparations. (3-28-23)

vi. Sterility testing of high risk batches of more than twenty-five (25) identical packages (ampules, bags, vials, etc.) before dispensing or distributing; (3-28-23)

d. Temperature, logged daily; (3-28-23)

e. Beyond use date and accuracy testing, when appropriate; and (3-28-23)

f. Measuring, mixing, sterilizing, and purification equipment inspection, monitoring, cleaning, and maintenance to ensure accuracy and effectiveness for their intended use. (3-28-23)

07. Policy and Procedures Manual. Maintain a policy and procedures manual to ensure compliance with this rule. (3-28-23)

702. HAZARDOUS DRUGS PREPARATION.

In addition to all other applicable rules in this chapter, including the rules governing Compounding Drug Preparations and Sterile Preparation, these rules apply to all persons, including any business entity, engaged in the practice of compounding or sterile prepackaging with hazardous drugs. Such persons must: (3-28-23)

01. Ventilation. Ensure the storage and compounding areas have sufficient general exhaust ventilation to dilute and remove any airborne contaminants. (3-28-23)

02. Ventilated Cabinet. Utilize a ventilated cabinet designed to reduce worker exposures while preparing hazardous drugs. (3-28-23)

a. Sterile hazardous drugs must be prepared in a dedicated Class II biological safety cabinet or a barrier isolator of appropriate design to meet the personnel exposure limits described in product material safety data sheets; (3-28-23)

b. When asepsis is not required, a Class I BSC, powder containment hood or an isolator intended for containment applications may be sufficient. (3-28-23)

~~**c.** A ventilated cabinet that re-circulates air inside the cabinet or exhausts air back into the room environment is prohibited, unless:~~ ~~(3-28-23)~~

~~i. The hazardous drugs in use will not volatilize while they are being handled; or~~ ~~(3-28-23)~~

~~ii. Written documentation from the manufacturer attesting to the safety of such ventilation.~~ ~~(3-28-23)~~

~~**03. Clear Identification**. Clearly identify storage areas, compounding areas, containers, and prepared doses of hazardous drugs.~~ ~~(3-28-23)~~

~~**04. Labeling**. Label hazardous drugs with proper precautions, and dispense them in a manner to minimize risk of hazardous spills.~~ ~~(3-28-23)~~

~~**05. Protective Equipment and Supplies**. Provide and maintain appropriate personal protective equipment and supplies necessary for handling hazardous drugs, spills and disposal.~~ ~~(3-28-23)~~

~~**06. Contamination Prevention**. Unpack, store, prepackage, and compound hazardous drugs separately from other inventory in a restricted area in a manner to prevent contamination and personnel exposure until hazardous drugs exist in their final unit of use packaging.~~ ~~(3-28-23)~~

~~**07. Compliance With Laws**. Comply with applicable local, state, and federal laws including for the disposal of hazardous waste.~~ ~~(3-28-23)~~

~~**08. Training**. Ensure that personnel working with hazardous drugs are trained in hygiene, garbing, receipt, storage, handling, transporting, compounding, spill control, clean up, disposal, dispensing, medical surveillance, and environmental quality and control.~~ ~~(3-28-23)~~

~~**09. Policy and Procedures Manual**. Maintain a policy and procedures manual to ensure compliance with this rule.~~ ~~(3-28-23)~~

~~703. OUTSOURCING FACILITY.~~

~~**01. Federal Act Compliance**. An outsourcing facility must ensure compliance with 21 U.S.C. Section 353b of the Federal Food, Drug and Cosmetic Act.~~ ~~(3-28-23)~~

~~**02. Adverse Event Reports**. Outsourcing facilities must submit to the Board a copy of all adverse event reports submitted to the secretary of Health and Human Services in accordance with Section 310.305 of Title 21 of the Code of Federal Regulations.~~ ~~(3-28-23)~~

~~704. -- 999. (RESERVED)~~

100. LICENSURE.

01. Licensure and Registration: Special Requirements. ( )

a. Out-of-Practice. The Board may require any applicant who has both failed to maintain an active license in Idaho and has not practiced as a pharmacist for the preceding twelve (12) months or longer to take and pass an examination, complete intern hours, complete additional continuing education hours, or complete other requirements determined necessary to acquire or demonstrate professional competency. ( )

b. Cancellation and Registration. Failure to maintain the requirements for any registration will result in the cancellation of the registration. ( )

c. Reinstatement of License or Registration. Reinstatement applicants must provide satisfactory evidence of completion of a minimum of thirty (30) continuing education hours within the twenty-four (24) months prior to reinstatement and compliance with any direct orders of the Board. ( )

02. Pharmacist Continuing Education Requirement. To meet the standard of care, pharmacists are expected to complete sufficient continuing education germane to the practice of pharmacy to maintain their professional competence. At license renewal, every pharmacist shall attest that they have maintained competence through continuing education commensurate with their active practice setting. ( )

03. Determination of Need for Nonresident Licensure or Registration. ( )

a. Independent Practice. Nonresident pharmacists must be licensed if engaged in the independent practice of pharmacy across state lines and not practicing for an Idaho registered drug outlet. ( )

b. Practice for an Idaho Registered Drug Outlet. A nonresident pharmacist serving as the PIC for an Idaho registered nonresident drug outlet must be registered to practice into Idaho. All other nonresident pharmacists who are employed by, or affiliated with, and practicing for the Idaho registered nonresident drug outlet, but who are not the PIC, are exempt from license and registration requirements for practice into Idaho. ( )

c. Multistate Pharmacists. Multistate pharmacists, as defined in Section 54-1723B, Idaho Code, are exempt from separate licensure or registration in Idaho. ( )

d. Exemption from Separate Practitioner Controlled Substance Registration. All pharmacists who manufacture, distribute, administer, dispense, or conduct research with any controlled substance in or into Idaho are exempt from obtaining a separate controlled substance registration, subject to compliance with all requirements of Title 37, Chapter 27, Idaho Code. This exemption does not apply to pharmacists who prescribe controlled substances in Idaho. ( )

04. Nonresident PIC Registration to Practice Pharmacy into Idaho. To be registered as a nonresident PIC, an applicant must submit an application on a Board form including, but not limited to: ( )

a. Individual License Information. Current pharmacist licensure information in all other states, including each state of licensure and each license number; ( )

b. Facility License Information. The license or registration number of the facility for which the applicant will be practicing. ( )

05. Pharmacist Intern Registration. ( )

a. Registration Requirements. To be approved for and maintain registration as a pharmacist intern, the applicant must: ( )

i. Currently be enrolled and in good standing in an accredited school or college of pharmacy, pursuing a professional degree in pharmacy; or ( )

ii. Be a graduate of an accredited school or college of pharmacy within the United States and awaiting examination for pharmacist licensure; or ( )

iii. Be a graduate of a school or college of pharmacy located outside the United States, obtain certification by the FPGEC, and be awaiting finalization of pharmacist licensure. ( )

b. Renewal. ( )

i. Current Students. A pharmacist intern registration must be renewed biennially; however, the renewal fee will be waived, if renewed on time, for the duration of the student's enrollment in the school or college of pharmacy. Following graduation, if a pharmacist license application has been submitted, the pharmacist intern license will be extended at no cost for up to six (6) additional months from the date of application as a pharmacist, after which time the individual will need to submit a new application to continue to be a pharmacist intern. ( )

ii. Pharmacy Graduates. A graduate pharmacist intern registration may be obtained and renewed once

within one (1) year from the date of issuance. The Board may, at its discretion, grant additional time to complete internship experience if unique circumstances present. ( )

06. Technician Exemption from Criminal Background Check. Technician candidates under the age of eighteen (18) are exempt from the fingerprint-based criminal history check requirement of Idaho Code. ( )

07. Practitioner Controlled Substance Registration. Any practitioner in Idaho who intends to prescribe, administer, dispense, or conduct research with a controlled substance must first obtain an Idaho practitioner controlled substance registration and: ( )

a. State License. Hold a valid license or registration to prescribe medications from a licensing entity established under Title 54, Idaho Code. ( )

b. DEA Registration. Obtain a valid federal DEA registration, if needed under federal law. Failure to obtain a federal DEA registration for any reason within forty-five (45) days of the issuance of the Idaho Practitioner Controlled Substance Registration will result in automatic cancellation. ( )

c. Idaho Practice Address. An Idaho practitioner controlled substance registration requires the applicant to establish an Idaho practice address, subject to inspection by the Board. This requirement does not apply to out-of-state practitioners who only prescribe into Idaho. ( )

d. *Exemption from Separate Practitioner Controlled Substance Registration. All pharmacists who manufacture, distribute, administer, dispense, or conduct research with any controlled substance in or into Idaho are exempt from obtaining a separate controlled substance registration, subject to compliance with all requirements of Title 37, Chapter 27, Idaho Code. This exemption does not apply to pharmacists who prescribe controlled substances in Idaho.* ( )

08. Drug Outlet Licensure and Registration: General Requirements. A license or a certificate of registration is required for drug outlets prior to doing business in or into Idaho. A license or certificate of registration will be issued by the Board to drug outlets pursuant to, and in the general classifications defined by, Section 54-1729, Idaho Code. ( )

a. New Drug Outlet Inspections. Following the issuance of a new license or registration, each drug outlet will be inspected to confirm that the facility is compliant with applicable law. A change of ownership of a currently registered pharmacy will not require an onsite inspection of a new pharmacy registration unless a change of location occurs. ( )

b. License and Registration Transferability. Drug outlet licenses and registrations are location and owner specific and are nontransferable as to person or place. ( )

c. Nonresident Drug Outlet. The Board may license or register a drug outlet licensed or registered under the laws of another state if the other state's standards are comparable to those in Idaho and acceptable to the Board, evidenced by an inspection report. ( )

d. Change of Location. At least ten (10) days prior to the event, the registrant must notify the Board of a drug outlet's change of location through the completion of an application for a new license or registration. When a licensee or registrant has made a timely and complete application for a new license or registration, the existing license does not expire until the application has been finally determined by the Board, and, in case the application is denied or the terms of the new license limited, until the last day for seeking review of the Board order. This does not preclude the Board from taking immediate action to protect the public interest. ( )

e. Change of Ownership. The registrant must notify the Board of any change to the operating legal entity's majority ownership of a drug outlet within thirty (30) days of the event. ( )

f. Permanent Closing. A registrant must notify the Board and the general public of the pharmacy's permanent closing at least ten (10) days prior to closing. The notice must include the proposed date of closure, and the new location of the prescription files. The notice to the board is to include the location where the closing

inventory record of controlled substances is retained. ( )

g. Exemption from Separate Controlled Substance Registration. All drug outlets doing business in or into Idaho who hold a valid license or registration from the Board are exempt from obtaining a separate controlled substance registration, but are subject to compliance with all requirements under Title 37, Chapter 27, Idaho Code. ( )

09. Wholesaler Licensure and Registration. ( )

a. Wholesaler Licensure. The following information must be provided under oath by each applicant for wholesaler licensure as part of the initial licensing procedure and for each renewal on a Board form: ( )

i. Any felony conviction or any conviction of the applicant relating to wholesale or retail prescription drug distribution or distribution of controlled substances. ( )

ii. Any discipline of the applicant by a regulatory agency in any state for violating any law relating to wholesale or retail prescription drug distribution or distribution of controlled substances. ( )

b. Accreditation. The Board will recognize a wholesaler's accreditation by National Association of Boards of Pharmacy for purposes of reciprocity and satisfying the new drug outlet inspection requirements of these rules. ( )

c. Wholesaler Registration. Except when licensed pursuant to title 54, chapter 17, Idaho Code, and these rules, a wholesaler that engages in wholesale distribution of Durable Medical Equipment supplies, prescription medical devices, or products that contain pseudoephedrine in or into Idaho must be registered by the Board. ( )

10. Manufacturer Registration. Manufacturers that ship, mail, or deliver dispensed prescription drugs or devices to an Idaho resident must also register with the Board as a nonresident drug outlet. Those manufacturers that only engage in the wholesale distribution of their own product are exempt from wholesale licensure. ( )

101. -- 199. (RESERVED)

200. PRACTICE STANDARDS.

01. Scope of Practice. Subject to Idaho Code § 54-1705, pharmacists may perform pharmaceutical care services, *which include a broad range of services for patients performed independently or in collaboration with other health care professionals*. ( )

02. Waivers or Variances. In the event of an emergency declared by the President of the United States, the Governor of the State of Idaho, or by any other person with legal authority to declare an emergency, the division administrator may waive any requirement of these rules for the duration of the emergency. ( )

03. Drug Outlets: Minimum Facility Standards. A resident drug outlet that dispenses prescription drugs to patients in Idaho must meet the following minimum requirements: ( )

a. Security and Privacy. A drug outlet must be constructed and equipped with adequate security to protect its equipment, records and supply of drugs, devices and other restricted sale items from unauthorized access, acquisition or use. All protected health information must be stored and maintained in accordance with HIPAA. ( )

b. Controlled Substance Storage. Drug outlets must store controlled substances in accordance with federal law. ( )

c. Authorized Access to the Restricted Drug Storage Area. Access to the area where prescription drugs are prepared, compounded, distributed, dispensed, or stored must be limited to authorized personnel. ( )

d. Staffing. A drug outlet must be staffed sufficiently to allow for appropriate supervision, to otherwise operate safely and, if applicable, to remain open during the hours posted as open to the public for business. ( )

e. Electronic Recordkeeping System. A drug outlet that dispenses more than twenty (20) prescriptions per day must use an electronic recordkeeping system to establish and store patient medication records and prescription drug order, refill, transfer information, and other information necessary to provide safe and appropriate patient care. The electronic recordkeeping system must have audit trail functionality that documents for each prescription drug order the identity of each individual involved at each step of its processing, filling, and dispensing or, alternatively, the identity of the pharmacist or prescriber responsible for the accuracy of these processes. ( )

04. Drug Outlets that Dispense Prescription Drugs: Minimum Prescription Filling Requirements. Unless exempted by these rules, each drug outlet that dispenses prescription drugs to patients in Idaho must meet the following minimum requirements either at the drug outlet or through offsite pharmacy services: ( )

a. Valid Prescription Drug Order. Prescription drugs may only be dispensed pursuant to a valid prescription drug order as set forth below in Rules 200.08 and 200.09. ( )

b. Prospective Drug Review. Prospective drug review must be provided. ( )

c. Labeling. Each drug must bear a complete and accurate label as set forth in these rules. ( )

d. Verification of Dispensing Accuracy. Verification of dispensing accuracy must be performed to compare the drug stock selected to the drug prescribed. If not performed by a pharmacist or prescriber, either an electronic verification system or verification by two (2) support persons must be used that confirms the drug stock selected to fill the prescription is the same as indicated on the prescription label. ( )

e. Patient Counseling. Counseling must be provided. ( )

05. Drug Outlets that Dispense Drugs to Patients without an Onsite Pharmacist or Prescriber. A drug outlet that dispenses drugs to patients in Idaho that does not have a pharmacist or prescriber onsite to perform or supervise pharmacy operations must comply with the following requirements: ( )

a. Security and Access. Maintain adequate video surveillance of the facility and retain a high quality recording for a minimum of thirty (30) days. ( )

b. Technology. The video or audio communication system used to counsel and interact with each patient or patient's caregiver, must be clear, secure, and HIPAA-compliant. ( )

c. Technical Limitation Closure. The drug outlet must be, or remain, closed to the public if any component of the surveillance or video and audio communication system is malfunctioning, until system corrections or repairs are completed. ( )

d. Exemptions. ( )

i. A self-service ADS that operates as a drug outlet is exempt from the video surveillance requirement of this rule. In addition, if counseling is provided by an onsite prescriber or pharmacist, a self-service ADS is exempt from the video and audio communication system requirements of this rule. ( )

ii. Veterinarians are exempt from this rule. ( )

06. Drugs Stored Outside of a Drug Outlet for Retrieval by a Licensed Health Professional. Drugs may be stored in an alternative designated area outside the drug outlet, including, but not limited to, in an emergency cabinet, in an emergency kit, or as emergency outpatient drug delivery from an emergency room at a registered institutional facility, provided the following conditions are met: ( )

a. Supervising Drug Outlet. Drugs stored in such a manner must remain under the control of, and be

routinely monitored by, the supervising drug outlet. ( )

b. Secure Storage. The area is appropriately equipped to ensure security and protection from diversion or tampering. ( )

c. Controlled Substances. Controlled substances may only be stored in an alternative designated area as permitted by, and in accordance with, federal law. ( )

d. Stocking and Replenishing. Stocking or replenishing drugs in an alternative designated area may be performed by a pharmacist or prescriber, or by appropriate support personnel using either an electronic verification system or two (2) persons. ( )

07. Pharmacist Prescribing: General Requirements. In accordance with Section 54-1704, Idaho Code, a pharmacist may independently prescribe provided the following general requirements are met by the pharmacist: ( )

a. Education. Only prescribe drugs or devices for conditions for which the pharmacist is educationally prepared and for which competence has been achieved and maintained. ( )

b. Patient-Prescriber Relationship. Only issue a prescription for a legitimate medical purpose arising from a patient-prescriber relationship as defined in Section 54-1733, Idaho Code. ( )

c. Patient Assessment. Obtain adequate information about the patient's health status to make appropriate decisions based on the applicable standard of care and the best available evidence. ( )

d. Collaboration with Other Health Care Professionals. Recognize the limits of the pharmacist's own knowledge and experience and consult with and refer to other health care professionals as appropriate. ( )

e. Documentation. Maintain documentation adequate to justify the care provided including, but not limited to, the information collected as part of the patient assessment, the prescription record, provider notification, and the follow-up care plan. ( )

f. Prescribing Exemption. The general requirements set forth in this section do not apply to the prescribing of devices and nonprescription drugs, prescribing under a collaborative pharmacy practice agreement, direct administration of a medication, or prescribing emergency drugs pursuant to Section 54-1735, Idaho Code. ( )

08. Prescription Drug Order: Validity. Prior to filling or dispensing a prescription drug order, a pharmacist must verify its validity. ( )

a. Invalid Prescription Drug Orders. A prescription drug order is invalid if not issued by a licensed prescriber for a legitimate medical purpose, and within the course and scope of the prescriber's professional practice and prescriptive authority. ( )

b. Antedating or Postdating. A prescription drug order is invalid if antedated or postdated. ( )

c. Tampering. A prescription drug order is invalid if, at the time of presentation, it shows evidence of alteration by any person other than the person who wrote it. ( )

d. Prescriber Self-Use. A prescription drug order written for a controlled substance is invalid if written for the prescriber's own use. ( )

e. Digital Image Prescriptions. A digital image of a prescription drug order is invalid if it is for a controlled substance or if the patient intends to pay cash for the drug in whole. ( )

09. Prescription Drug Order: Minimum Requirements. A prescription drug order must comply with applicable requirements of federal law and, except as differentiation is permitted for an institutional drug order,

include at least the following: ( )

a. Patient's Name. The patient's or authorized entity's name and: ( )

i. If for a controlled substance, the patient's full name and address; and ( )

ii. If for an animal, the species. ( )

b. Date. The date issued. ( )

c. Drug Information. The drug name, strength, and quantity. ( )

d. Directions. The directions for use. ( )

e. Prescriber Information. The name and, if for a controlled substance, the address and DEA registration number of the prescriber. ( )

f. Signature. A signature sufficient to evidence a valid prescription of either the prescriber or, if a renewal of a previous prescription, the prescriber's agent, when authorized by the prescriber. ( )

g. General Exemption. A prescriber may omit drug information and directions and make an indication for the pharmacist to finalize the patient's drug therapy plan. ( )

10. Filling Prescription Drug Orders: Practice Limitations. ( )

a. Drug Product Selection. Drug product selection is allowed only between therapeutic equivalent drugs as published in the FDA's Orange Book or Green Book. If a prescriber orders by any means that a brand name drug must be dispensed, then no drug product selection is permitted. ( )

b. Partial Filling. A prescription drug order may be partially filled within the limits of federal law. The total quantity dispensed in partial fillings must not exceed the total quantity prescribed. ( )

c. Refill Authorization. A prescription drug order may be refilled when permitted by state and federal law and as specifically authorized by the prescriber. A pharmacist may also refill a prescription to ensure continuity of care. ( )

11. Filling Prescription Drug Orders: Adaptation. A pharmacist may adapt drugs as specified in this rule. ( )

a. Change Quantity. A pharmacist may change the quantity of medication prescribed if: ( )

i. The prescribed quantity or package size is not commercially available; ( )

ii. The change in quantity is related to a change in dosage form, strength, or therapeutic interchange; ( )

iii. The change is intended to dispense up to the total amount authorized by the prescriber including refills; or ( )

iv. The change extends a maintenance drug for the limited quantity necessary to coordinate a patient's refills in a medication synchronization program. ( )

b. Change Dosage Form. A pharmacist may change the dosage form of the prescription if it is in the best interest of patient care, so long as the prescriber's directions are also modified to equate to an equivalent amount of drug dispensed as prescribed. ( )

c. Complete Missing Information. A pharmacist may complete missing information on a prescription

if there is evidence to support the change. ( )

d. Documentation. The adaption must be documented in the patient's record. ( )

12. Filling Prescription Drug Orders: Drug Product Substitution. Drug product substitutions in which a pharmacist dispenses a drug product other than that prescribed are allowed only as follows: ( )

a. Hospital. Pursuant to a formulary or drug list prepared by the pharmacy and therapeutics committee of a hospital; ( )

b. Institutional Facility. At the direction of the quality assessment and assurance committee of an institutional facility; ( )

c. Biosimilars. A pharmacist may substitute an interchangeable biosimilar product for a prescribed biological product if: ( )

i. The biosimilar has been determined by the FDA to be interchangeable as published in the FDA's Purple Book; ( )

ii. The name of the drug and the manufacturer or the NDC number is documented in the patient medical record. ( )

d. Therapeutic Interchange. A pharmacist may substitute a drug with another drug in the same therapeutic class, provided the substitution lowers the cost to the patient or occurs during a drug shortage. ( )

13. Filling Prescription Drug Orders: Transfers. A prescription drug order may be transferred within the limits of federal law. Drug outlets using a common electronic file are exempt from transfer limits. ( )

14. Labeling Standards. All prescription drugs must be in an appropriate container and bear information that identifies the drug product, any additional components as appropriate, and the individual responsible for its final preparation. ( )

a. Standard Prescription Drug. A prescription drug for outpatient dispensing must be labeled in accordance with federal law. ( )

b. Parenteral Admixture. If one (1) or more drugs are added to a preparation of sterile products intended for administration by injection, the admixture's container must include the date and time of the addition or the beyond use date. ( )

c. Prepackaged Product. The containers of prepackaged drugs must include an expiration date that is the lesser of the manufacturer's original expiration date, one (1) year from the date the drug is prepackaged, or a shorter period if warranted. ( )

d. Repackaged Drug. If a previously dispensed drug is repackaged, it must contain the prescription number and contact information for the original dispensing pharmacy, as well as a statement that indicates that the drug has been repackaged, and the contact information of the repackaging pharmacy. ( )

e. Distributed Compounded Drug Product. Compounded and sterile prepackaged drug product distributed in the absence of a patient specific prescription must be labeled as follows: ( )

i. If from a pharmacy, the statement: "not for further dispensing or distribution." ( )

ii. If from an outsourcing facility, the statements: "office use only" and "not for resale." ( )

15. Prescription Delivery: Restrictions. ( )

a. Acceptable Delivery. A drug outlet that dispenses drugs to patients in Idaho may deliver filled

prescriptions in accordance with federal law, as long as appropriate measures are taken to ensure product integrity and safety. ( )

b. Pick-up or Return by Authorized Personnel. Filled prescriptions may be picked up for or returned from delivery by authorized personnel from a secured delivery area. ( )

16. Destruction or Return of Drugs or Devices: Restrictions. A drug outlet registered with the DEA as a collector may collect controlled and non-controlled drugs for destruction in accordance with applicable federal law. Otherwise a dispensed drug or prescription device may only be accepted for return as follows: ( )

a. Potential Harm. When the pharmacist determines that harm could result if the drug is not returned. ( )

b. Did Not Reach Patient. Non-controlled drugs that have been maintained in the custody and control of the institutional facility, dispensing pharmacy, or their related clinical facilities may be returned if product integrity can be assured. Controlled substances may only be returned from a hospital daily delivery system under which a pharmacy dispenses no more than a seventy-two (72) hour supply for a drug order. ( )

c. Donation. Those that qualify for return under the provisions of the Idaho Legend Drug Donation Act as specified in Section 54-1762, Idaho Code. ( )

17. Recordkeeping: Maintenance and Inventory Requirements. ( )

a. Records Maintenance and Retention Requirement. Unless an alternative standard is stated for a specified record type, form, or format, records required to evidence compliance with statutes or rules enforced by the Board must be maintained and retained in a readily retrievable form and location for at least three (3) years from the date of the transaction. ( )

b. Prescription Retention. A prescription drug order must be retained in a readily retrievable manner by each drug outlet and maintained in accordance with federal law. ( )

c. Inventory Records. Each drug outlet must maintain a current, complete and accurate record of each controlled substance manufactured, imported, received, ordered, sold, delivered, exported, dispensed or otherwise disposed of by the registrant. Drug outlets must maintain inventories and records in accordance with federal law. A biennial inventory must be conducted at each registered location no later than seven (7) days after the date of the most recent inventory in a form and manner that satisfies the inventory requirements of federal law. Drugs stored outside a drug outlet in accordance with these rules must be regularly inventoried and inspected to ensure that they are properly stored, secured, and accounted for. Additional inventories are necessary when required by federal law. ( )

d. Rebuttal Presumption of Violation. Evidence of an amount of a controlled substance that differs from the amount reflected on a record or inventory required by state or federal law creates a rebuttable presumption that the registrant has failed to keep records or maintain inventories in conformance with the recordkeeping and inventory requirements of state and federal law. ( )

e. Drug Distributor Records. Wholesalers and other entities engaged in wholesale drug distribution must maintain inventories and records or transactions pertaining to the receipt and distribution or other disposition of drugs in accordance with federal law that include at least: ( )

i. The source of the drugs, including the name and principal address of the seller or transferor, and the address of the location from which the drugs were shipped; ( )

ii. The identity and quantity of the drugs received and distributed or disposed of; ( )

iii. The dates of receipt and distribution or other disposition of the drugs; and ( )

iv. Controlled substance distribution invoices, in the form required by federal law. ( )

f. Central Records Storage. Records may be retained at a central location in compliance with federal law. ( )

g. Electronic Records Storage. Records may be electronically stored and maintained if they remain legible and are in a readily retrievable format, and if federal law does not require them to be kept in a hard copy format. ( )

18. Reporting Requirements. ( )

a. Theft or Loss of Controlled Substances. A registrant must report to the Board on the same day reported to the DEA a theft or loss of a controlled substance that includes the information required by federal law. ( )

b. Criminal Convictions and Disciplinary Decisions. Licensees must report to the Board all felony convictions and any other criminal convictions involving any legend drug(s) within thirty (30) days of judgment. Licensees must also report to the Board all disciplinary decisions of any other licensing authority, or the surrender of a license in lieu of discipline, within thirty (30) days of the disciplinary order or the surrender. ( )

c. Adverse Event Reports. Outsourcing facilities must submit to the Board a copy of all adverse event reports submitted to the secretary of Health and Human Services in accordance with 21 CFR § 310.305. ( )

d. Individual and Outlet Information Changes. Changes in employment or changes to information provided on or with the initial or renewal application must be reported to the Board within ten (10) days of the change. ( )

e. Drug Distributor Monthly Reports. An authorized distributor must report to the Board specified data on controlled substances distributed in a form and manner prescribed by the Board. ( )

201. -- 299. (RESERVED)

300. DISCIPLINE.

01. Unprofessional Conduct. The following acts or practices by any licensee or registrant are declared to be specifically, but not by way of limitation, unprofessional conduct and conduct contrary to the public interest. ( )

a. Unethical Conduct. Conduct in the practice of pharmacy or in the operation of a pharmacy that may reduce the public confidence in the ability and integrity of the profession of pharmacy or endangers the public health, safety, and welfare. A violation of this section includes committing fraud, misrepresentation, negligence, concealment, or being involved in dishonest dealings, price fixing, or breaching the public trust with respect to the practice of pharmacy. ( )

b. Lack of Fitness. A lack of fitness for professional practice due to incompetency, personal habits, drug or alcohol dependence, physical or mental illness, or for any other cause that endangers public health, safety, or welfare. ( )

c. On-Duty Intoxication or Impairment. Intoxication, impairment, or consumption of alcohol or drugs while on duty, including break periods after which the individual is expected to return to work, or prior to reporting to work. ( )

d. Diversion of Drug Products and Devices. Supplying or diverting drugs, biologicals, and other medicines, substances, or devices legally sold in pharmacies that allows the circumvention of laws pertaining to the legal sale of these articles. ( )

e. Unlawful Possession or Use of Drugs. Possessing or using a controlled substance without a lawful prescription drug order. A failed drug test creates a rebuttable presumption of a violation of this rule. ( )

f. Self-prescribing of Controlled Substances. Prescribing any drug legally classified as a controlled substance to himself or herself, or to a spouse, child, or stepchild. ( )

g. Prescription Drug Order Noncompliance. Failing to follow the instructions of the person writing, making, or ordering a prescription as to its refills, contents, or labeling except as provided in these rules. ( )

h. Failure to Confer. Failure to confer with the prescriber when necessary or appropriate. ( )

i. Excessive Provision of Controlled Substances. Providing an excessive amount of controlled substances. Evidentiary factors of a clearly excessive amount include, but are not limited to, the amount of controlled substances furnished and previous ordering patterns (including size and frequency of orders). ( )

j. Failure to Counsel or Offer Counseling. Failing to counsel or offer counseling, unless specifically exempted or refused. ( )

k. Substandard, Misbranded, Adulterated, or Expired Products. Manufacturing, compounding, delivering, distributing, dispensing, or permitting to be manufactured, compounded, delivered, distributed or dispensed substandard, misbranded, or adulterated drugs or preparations or those made using secret formulas. Failing to remove expired drugs from stock. ( )

l. Prescriber Incentives. Allowing a commission or rebate to be paid, or personally paying a commission or rebate, to a person writing, making, or otherwise ordering a prescription. ( )

m. Exclusive Arrangements. Participation in a plan or agreement that compromises the quality or extent of professional services or limits access to provider facilities at the expense of public health or welfare. ( )

n. Failure to Report. Failing to report to the Board any violation of statutes or rules pertaining to the practice of pharmacy or any act that endangers the health, safety, or welfare of patients or the public. ( )

o. Failure to Follow Board Order. Failure to follow an order of the Board. ( )

p. Use of False Information. Knowingly using false information in connection with the prescribing, delivering, administering, or dispensing of a controlled substance or other drug product. ( )

q. Standard of Care. Acts or omissions within the practice of pharmacy which fail to meet the standard provided by other qualified licensees or registrants in the same or similar setting. ( )

r. Unnecessary Services or Products. Directly promoting or inducing for the provisions of health care services or products that are unnecessary or not medically indicated. ( )

s. Controlled Substance Non-Compliance. Violating provisions of the federal Controlled Substances Act or Title 37, Chapter 27, Idaho Code. ( )

02. Board Inspections and Investigations. ( )

a. Records Subject to Board Inspection. Records created, maintained, or retained by Board licensees or registrants in compliance with statutes or rules enforced by the Board must be made available for inspection upon request by Board inspectors or authorized agents. It is unlawful to refuse to permit or to obstruct a Board inspection. ( )

b. Inspections. Prior to the commencement of business, as applicable, and thereafter at regular intervals, registrants and licensees must permit the Board or its compliance officers to enter and inspect the premises and to audit the records of each drug outlet for compliance with laws enforced by or under the Board's jurisdiction. ( )

c. Inspection Deficiencies. Deficiencies noted must be promptly remedied, and if requested, the

Board office notified of corrective measures. One (1) follow-up inspection may be performed by the Board at no cost. For additional follow-up inspections, the drug outlet will be charged actual travel and personnel costs incurred in the inspection to be paid within ninety (90) days of inspection. ( )

d. Inspection Reports. Inspection reports must be reviewed with the Board inspector and signed by an agent of the drug outlet upon completion of the exit interview. ( )

e. Investigations. Licensees or registrants must fully cooperate with Board investigations conducted to confirm compliance with laws enforced by the Board, including audits of continuing education, to gather information pertinent to a complaint received by the Board or to enforce disciplinary actions. ( )

301. -- 399. (RESERVED)

400. FEES.
Nonrefundable fees are as follows: ( )

01. Licenses and Registrations – Professionals.

License/Registration	Initial Fee	Annual Renewal Fee
Pharmacist License	*Not more than* $140	*Not more than* $130
Nonresident PIC Registration	*Not more than* $290	*Not more than* $290
Pharmacist Intern	*Not more than* $50	*Not more than* $50
Technician	*Not more than* $35	*Not more than* $35
Practitioner Controlled Substance Registration	*Not more than* $60	*Not more than* $60

( )

02. Certificates of Registration and Licensure – Facilities.

License/Registration	Initial Fee	Annual Renewal Fee
Drug Outlet (unless otherwise listed)	*Not more than* $100	*Not more than* $100
Wholesale License	*Not more than* $180	*Not more than* $180
Wholesale Registration	*Not more than* $150	*Not more than* $150
Central Drug Outlet (Nonresident)	*Not more than* $500	*Not more than* $250
Mail Service Pharmacy	*Not more than* $500	*Not more than* $250
Durable Medical Equipment Outlet	*Not more than* $50	*Not more than* $50
Outsourcing Facility (Nonresident)	*Not more than* $500	*Not more than* $250
Manufacturer	*Not more than* $150	*Not more than* $150
Veterinary Drug Outlet	*Not more than* $35	*Not more than* $35

( )

03. Administrative Services.

Category	Fee

Experiential hours certification	*Not more than* $25

( )

04. Fee Exemption for Controlled Substance Registrations. Persons exempt pursuant to federal law from fee requirements applicable to DEA registrations are also exempt from fees applicable to Idaho practitioner controlled substance registrations. ( )

401. -- 699. (RESERVED)

700. SAFE COMPOUNDING.

01. Compounding Drug Preparations: General Provisions. Any compounding that is not permitted herein is considered manufacturing. ( )

a. Application. This rule applies to any person, including any business entity, authorized to engage in the practice of non-sterile compounding, sterile compounding, and sterile prepackaging of drug products in or into Idaho, except these rules do not apply to: ( )

i. The reconstitution of a non-sterile drug or a sterile drug for immediate administration; ( )

ii. The addition of a flavoring agent and/or a coloring agent to a drug product, so long as the agent is therapeutically inert and in the minimum quantity necessary; and ( )

iii. Product preparation of a non-sterile, non-hazardous drug according to the manufacturer's FDA approved labeling. ( )

b. General Compounding Standards. ( )

i. Active Pharmaceutical Ingredients. All active pharmaceutical ingredients must be obtained from an FDA registered manufacturer. FDA registration as a foreign manufacturer satisfies this requirement. ( )

ii. Certificate of Analysis (COA). Unless the active pharmaceutical ingredient complies with the standards of an applicable USP-NF monograph, a COA must be obtained for all active pharmaceutical ingredients procured for compounding and retained for a period of not less than three (3) years from the date the container is emptied, expired, returned, or disposed of. The following minimum information is necessary on the COA: product name, lot number, expiration date, and assay. ( )

iii. Equipment. Equipment and utensils must be of suitable design and composition and cleaned, sanitized, or sterilized as appropriate prior to use. ( )

iv. Disposal of Compromised Drugs. When the correct identity, purity, strength, and sterility of ingredients and components cannot be confirmed (in cases of, for example, unlabeled syringes, opened ampoules, punctured stoppers of vials and bags, and containers of ingredients with incomplete labeling) or when the ingredients and components do not possess the expected appearance, aroma, and texture, they must be removed from stock and isolated for return, reclamation, or destruction. ( )

c. Prohibited Compounding. Compounding any drug product for human use that the FDA has identified as presenting demonstrable difficulties in compounding or has withdrawn or removed from the market for safety or efficacy reasons is prohibited. ( )

d. Limited Compounding. ( )

i. Triad Relationship. A pharmacist may compound a drug product in the usual course of professional practice for an individual patient pursuant to an established prescriber/patient/pharmacist relationship and a valid prescription drug order. ( )

ii. Commercially Available Products. A drug product that is commercially available may only be compounded if not compounded regularly or in inordinate amounts and if: ( )

(1) It is medically warranted to provide an alternate ingredient, dosage form, or strength of significance; or ( )

(2) The commercial product is not reasonably available in the market in time to meet the patient's needs. ( )

iii. Anticipatory Compounding. Limited quantities of a drug product may be compounded or sterile prepackaged prior to receiving a valid prescription drug order based on a history of receiving valid prescription drug orders for the compounded or sterile prepackaged drug product. ( )

e. Drug Compounding Controls. Policies and procedures for the compounding or sterile prepackaging of drug products must ensure the safety, identity, strength, quality, and purity of the finished product. To meet this standard, licensees and registrants will take into consideration the applicable provisions of USP Chapter 795 concerning pharmacy compounding of non-sterile preparations, USP Chapter 797 concerning sterile preparations, Chapter 1075 of the USP-NF concerning good compounding practices, and Chapter 1160 of the USP-NF concerning pharmaceutical calculations. ( )

02. Sterile Preparation. ( )

a. Application. In addition to all other applicable rules in this chapter, including the rules governing Compounding Drug Preparations, these rules apply to all persons, including any business entity, engaged in the practice of sterile compounding and sterile prepackaging in or into Idaho. ( )

b. Dosage Forms Requiring Sterility. The sterility of compounded diagnostics, drugs, nutrients, and radiopharmaceuticals must be maintained or the compounded drug preparation must be sterilized when prepared in the following dosage forms: ( )

i. Aqueous bronchial and nasal inhalations, except nasal dosage forms intended for local application; ( )

ii. Baths and soaks for live organs and tissues; ( )

iii. Injections (for example, colloidal dispersions, emulsions, solutions, suspensions); ( )

iv. Irrigations for internal body cavities; ( )

v. Ophthalmic drops and ointments; and ( )

vi. Tissue implants. ( )

c. Compounder Responsibilities. Compounders and sterile prepackagers are responsible for ensuring that sterile products are accurately identified, measured, diluted, and mixed and are correctly purified, sterilized, packaged, sealed, labeled, stored, dispensed, and distributed, as well as prepared in a manner that maintains sterility and minimizes the introduction of particulate matter. ( )

i. Environmental Control Requirements. Except when prepared for immediate administration, the environment for the preparation of sterile preparations in a drug outlet must be in an isolated area, designed to avoid unnecessary traffic and airflow disturbances, and equipped to accommodate aseptic techniques and conditions. ( )

ii. Documentation Requirements. The following documentation must also be maintained by a drug outlet in which sterile preparations are prepared: ( )

(1) Justification of beyond use dates assigned, pursuant to direct testing or extrapolation from reliable

literature sources; ( )

(2) Training records, evidencing that personnel are trained on a routine basis and are adequately skilled, educated, and instructed; ( )

(3) Audits appropriate for the risk of contamination for the particular sterile preparation including: ( )

iii. Visual inspection to ensure the absence of particulate matter in solutions, the absence of leakage from bags and vials, and the accuracy of labeling with each dispensing; ( )

iv. Periodic hand hygiene and garbing competency; ( )

v. Media-fill test procedures (or equivalent), aseptic technique, and practice related competency evaluation at least annually by each compounder or sterile pre-packager; ( )

vi. Environmental sampling testing at least upon registration of a new drug outlet, following the servicing or re-certification of facilities and equipment, or in response to identified problems with end products, staff techniques or patient-related infections, or every six (6) months; ( )

vii. Gloved fingertip sampling testing; ( )

viii. Sterility testing; ( )

d. Temperature, logged daily; ( )

e. Beyond use date and accuracy testing, when appropriate; and ( )

f. Measuring, mixing, sterilizing, and purification equipment inspection, monitoring, cleaning, and maintenance to ensure accuracy and effectiveness for their intended use. ( )

03. Hazardous Drugs Preparation. In addition to all other applicable rules in this chapter, including the rules governing Compounding Drug Preparations and Sterile Preparation, these rules apply to all persons, including any business entity, engaged in the practice of compounding or sterile prepackaging with hazardous drugs. Such persons must: ( )

a. Ventilation. Ensure the storage and compounding areas have sufficient general exhaust ventilation to dilute and remove any airborne contaminants. ( )

b. Ventilated Cabinet. Utilize a ventilated cabinet designed to reduce worker exposures while preparing hazardous drugs. ( )

i. Sterile hazardous drugs must be prepared in a dedicated Class II biological safety cabinet or a barrier isolator of appropriate design to meet the personnel exposure limits described in product material safety data sheets; ( )

ii. When asepsis is not required, a Class I BSC, powder containment hood or an isolator intended for containment applications may be sufficient. ( )

iii. A ventilated cabinet that re-circulates air inside the cabinet or exhausts air back into the room environment is prohibited, unless: ( )

(1) The hazardous drugs in use will not volatilize while they are being handled; or ( )

(2) Written documentation from the manufacturer attesting to the safety of such ventilation. ( )

c. Clear Identification. Clearly identify storage areas, compounding areas, containers, and prepared

doses of hazardous drugs. ( )

d. Labeling. Label hazardous drugs with proper precautions, and dispense them in a manner to minimize risk of hazardous spills. ( )

e. Protective Equipment and Supplies. Provide and maintain appropriate personal protective equipment and supplies necessary for handling hazardous drugs, spills and disposal. ( )

f. Contamination Prevention. Unpack, store, prepackage, and compound hazardous drugs separately from other inventory in a restricted area in a manner to prevent contamination and personnel exposure until hazardous drugs exist in their final unit-of-use packaging. ( )

g. Training. Ensure that personnel working with hazardous drugs are trained in hygiene, garbing, receipt, storage, handling, transporting, compounding, spill control, clean up, disposal, dispensing, medical surveillance, and environmental quality and control. ( )

701. -- 799. (RESERVED)

800. PRESCRIPTION DRUG MONITORING PROGRAM.

01. Required Reporting. Specified data on controlled substances must be reported by the end of the business day by all drug outlets that dispense controlled substances in or into Idaho and prescribers that dispense controlled substances to humans. ( )

02. Online Access to PDMP. To obtain online access, a prescriber or pharmacist, or their delegate must complete and submit a registration application and agree to adhere to the access restrictions and limitations established by law. ( )

03. Profile Requests. Authorized persons without online access may obtain a profile by completing a Board form and submitting it to the Board office with proof of identification and other credentials necessary to confirm the requestor's authorized status pursuant to Section 37-2726, Idaho Code. ( )

801. -- 999. (RESERVED)