

IDAHO ADMINISTRATIVE BULLETIN

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April 7, 1999

Volume 99-4

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Preface

The Idaho Administrative Bulletin is published once each month by the Department of Administration, Office of the Administrative Rules Coordinator, pursuant to Section 67-5203, Idaho Code. The Bulletin is a compilation of all administrative rulemaking documents in Idaho. The Bulletin publishes the official text notice and full text of such actions.

State agencies are required to provide public notice of rulemaking activity and invite public input. The public receives notice of a rulemaking activity through the Idaho Administrative Bulletin and the Legal Notice published monthly in local newspapers. The Legal Notice provides reasonable opportunity for public input, either oral or written, which may be presented to the agency within the time and manner specified in the Legal Notice. After the comment period closes, the agency considers fully all information submitted in regard to the rule. Comment periods are not provided in temporary or final rulemaking activities.

CITATION TO THE IDAHO ADMINISTRATIVE BULLETIN

The Bulletin is cited by year and issue number. For example, Bulletin 98-1 refers to the first Bulletin issued in calendar year 1998, Bulletin 99-1 refers to the first Bulletin issued in calendar year 1999, etc. Volume numbers, which proceed from 1 to 12 in a given year, correspond to the months of publication, i.e.; Volume No. 1 refers to January; Volume No. 2 refers to February; and so forth. Example: The Bulletin published in January of 1999 is cited as Volume 99-1. The December 1998 Bulletin is cited as Volume 98-12.

RELATIONSHIP TO THE IDAHO ADMINISTRATIVE CODE

*The Idaho Administrative Code is published once a year and is a compilation or supplemental compilation of all final and enforceable administrative rules in effect in Idaho. In an effort to provide the reader with current, enforceable rules, temporary rules are also published in the Administrative Code. Temporary rules and final rules that have been approved by the legislature during the legislative session, and published in the monthly Idaho Administrative Bulletin, supplement the Administrative Code. Negotiated, proposed, and pending rules are **not** printed in the Administrative Code and are published only in the Bulletin.*

*To determine if a particular rule remains in effect, or to determine if a change has occurred, the reader should refer to the **Cumulative Index of Administrative Rulemaking**, printed in each Bulletin.*

TYPES OF RULES PUBLISHED IN THE ADMINISTRATIVE BULLETIN

The state of Idaho administrative rulemaking process comprises five distinct activities; Proposed, Negotiated, Temporary, Pending, and Final rulemaking. In the majority of cases, the process begins with proposed rulemaking and ends with final rulemaking. The following is a brief explanation of each type of administrative rule.

NEGOTIATED RULE

Negotiated rulemaking is a process in which all interested parties and the agency seek a consensus on the content of the rule. Agencies are encouraged to proceed through this informal rulemaking whenever it is feasible to do so. Publication of the text in the Administrative Bulletin by the agency is optional. This process should lead the rulemaking to the temporary and/or proposed rule stage.

PROPOSED RULE

A proposed rulemaking is an action by an agency in which the agency is proposing to amend or repeal an existing rule or to adopt a new rule. Prior to the adoption, amendment, or repeal of a rule, the agency must publish a notice of proposed rulemaking in the Bulletin. The notice of proposed rulemaking must include:

- a) the specific statutory authority for the rulemaking including a citation to a specific federal statute or regulation if that is the basis of authority or requirement for the rulemaking;*
- b) a statement in nontechnical language of the substance of the proposed rule, including a specific description of any fee or charge imposed or increased;*
- c) the text of the proposed rule prepared in legislative format;*
- d) the location, date, and time of any public hearings the agency intends to hold on the proposed rule;*
- e) the manner in which persons may make written comments on the proposed rule, including the name and address of a person in the agency to whom comments on the proposal may be sent;*
- f) the manner in which persons may request an opportunity for an oral presentation; and*
- g) the deadline for public (written) comments on the proposed rule.*

As stated, the text of the proposed rule must be published in the Bulletin. After meeting the statutory rulemaking criteria for a proposed rule, the agency may proceed to the pending rule stage. A proposed rule does not have an assigned effective date unless published in conjunction with a temporary rule docket. An agency may vacate a proposed rulemaking if it decides not to proceed further with the promulgation process.

TEMPORARY RULE

Temporary rules may be adopted only when the governor finds that it is necessary for:

- a) the protection of the public health, safety, or welfare; or*
- b) compliance with deadlines in amendments to governing law or federal programs; or*
- c) conferring a benefit.*

If a rulemaking meets any one or all of the above requirements, a rule may become effective before it has been submitted to the legislature for review and the agency may proceed and adopt a temporary rule.

A temporary rule expires at the conclusion of the next succeeding regular session of the legislature unless the rule is approved, amended, or modified by concurrent resolution or when the rule has been replaced by a final rule.

In cases where the text of the temporary rule is the same as that of the proposed rule, the rulemaking can be done concurrently as a temporary/proposed rule. State law requires that the text of a proposed or temporary rule be published in the Administrative Bulletin. Combining the rulemaking allows for a single publication of the text.

An agency may rescind a temporary rule that has been adopted and is in effect if the rule is being replaced by a new temporary rule or has been published concurrently with a proposed rulemaking that is being vacated.

PENDING RULE

A pending rule is a rule that has been adopted by an agency under the regular rulemaking process and

remains subject to legislative review before it becomes a final, enforceable rule.

When a pending rule is published in the Bulletin, the agency is required to include certain information in the Notice of Pending Rule. This includes:

- a) the reasons for adopting the rule;
- b) a statement of any change between the text of the proposed rule and the pending rule with an explanation of the reasons for any changes;
- c) the date the pending rule will become final and effective; and
- d) an identification of any portion of the rule imposing or increasing a fee or charge.

Agencies are required to republish the text of the rule when substantive changes have been made to the proposed rule. An agency may adopt a pending rule that varies in content from that which was originally proposed if the subject matter of the rule remains the same, the pending rule is a logical outgrowth of the proposed rule, and the original notice was written so as to assure that members of the public were reasonably notified of the subject. It is not always necessary to republish all the text of the pending rule. With the permission of the Rules Coordinator, only the Section(s) that have changed from the proposed text are republished. If no changes have been made to the previously published text, it is not required to republish the text again and only the Notice of Pending Rule is published.

FINAL RULE

A final rule is a rule that has been adopted by an agency under the regular rulemaking process and is in effect.

No pending rule adopted by an agency will become final and effective until it has been submitted to the legislature for review. Where the legislature finds that the agency has violated the legislative intent of the statute under which the rule was made, a concurrent resolution will be adopted rejecting, amending, or modifying the rule or any part thereof. A Notice of Final Rule must be published in the Idaho Administrative Bulletin for any rule that is rejected, amended, or modified by the legislature showing the changes made. A rule that has been reviewed by the legislature and has not been rejected, amended, or modified will become final with no further legislative action. No rule shall become final and effective before the conclusion of the regular or special legislative session at which the rule was submitted for review. However, a rule which is final and effective may be applied retroactively, as provided in the rule.

AVAILABILITY OF THE ADMINISTRATIVE CODE AND BULLETIN

The Idaho Administrative Code and all monthly Bulletins are available for viewing and use by the public in all 44 county law libraries, state university and college and community college libraries, the state law library, the state library, the Public Libraries in Boise, Pocatello, Idaho Falls and Twin Falls, the Lewiston City Library, East Bonner County Library, Eastern Idaho Technical College Library, Ricks College Library, and Northwest Nazarene College Library.

SUBSCRIPTIONS AND DISTRIBUTION

For subscription information and costs of publications, please contact the Department of Administration, Office of the Administrative Rules Coordinator, 650 W. State Street, Room 100, Boise, Idaho 83720-0306, telephone

(208) 332-1820.

The Administrative Bulletin is an official monthly publication of the State of Idaho. Yearly subscriptions or individual copies are available for purchase.

The Administrative Code, is an annual compilation or supplemental compilation of all final and enforceable temporary administrative rules and includes tables of contents, reference guides, and a subject index.

Individual Rule Chapters and *Individual Rulemaking Dockets*, are specific portions of the Bulletin and Administrative Code produced on demand.

Internet Access - The Administrative Code and Administrative Bulletin are available on the Internet at the following address:

<http://www.state.id.us/> - from Idaho Home Page select the Administrative Rules link.

EDITOR'S NOTE: All rules are subject to frequent change. Users should reference all current issues of the Administrative Bulletin for negotiated, temporary, proposed, pending, and final changes to all rules, or call the Office of the Administrative Rules at (208) 332-1820.

HOW TO USE THE IDAHO ADMINISTRATIVE BULLETIN

Rulemaking documents produced by state agencies and published in the *Idaho Administrative Bulletin* are organized by a numbering system. Each state agency has a two-digit identification code number known as the "IDAPA" number. (The "IDAPA" Codes are listed in the alphabetical/numerical index at the end of this Preface.) Within each agency there are divisions or departments to which a two-digit "TITLE" number is assigned. There are "CHAPTER" numbers assigned within the Title and the rule text is divided among major sections with a number of subsections. An example IDAPA number is as follows:

IDAPA 38.05.01.060.02.c.ii.

"IDAPA" refers to Administrative Rules in general that are subject to the Administrative Procedures Act and are required by this act to be published in the Idaho Administrative Code and the Idaho Administrative Bulletin.

"IDAPA 38." refers to the Idaho Department of Administration.

"05." refers to Title 05 which is the Department of Administration's Division of Purchasing.

"01." refers to Chapter 01 of Title 05, "Rules of the Division of Purchasing".

"060." refers to Major Section 060, "Content of the Invitation to Bid".

"02." refers to Subsection 060.02.

"c." refers to Subsection 060.02.c.

"ii." refers to Subsection 060.02.c.ii.

DOCKET NUMBERING SYSTEM

Internally, the Bulletin is organized sequentially using a rule docketing system. All rulemaking actions (documents) are assigned a "DOCKET NUMBER". The "Docket Number" is a series of numbers separated by a hyphen "-", (38-0501-9901). The docket numbers are published sequentially by IDAPA designation (e.g. the two-digit agency code). The following example is a breakdown of a typical rule docket:

"DOCKET NO. 38-0501-9901"

"38-" denotes the agency's IDAPA number; in this case the Department of Administration.

"0501-" refers to the TITLE AND CHAPTER numbers of the agency rule being promulgated; in this case the Division of Purchasing (TITLE 05), "Rules of the Division of Purchasing" (Chapter 01).

"9901" denotes the year and sequential order of the docket submitted and published during the year; in this case the first rulemaking action of the chapter published in calendar year 1999.

Within each Docket, only the affected sections of chapters are printed. (See **Sections Affected Index** in each Bulletin for a listing of these.) The individual sections affected are printed in the Bulletin sequentially (e.g. Section "200" appears before Section "345" and so on). Whenever the sequence of the numbering is broken the following statement will appear:

"(BREAK IN CONTINUITY OF SECTIONS)"

INTERNAL AND EXTERNAL CITATIONS TO ADMINISTRATIVE RULES IN THE CODE AND BULLETIN

When making a citation to another Section or Subsection that is part of the same rule, a typical internal citation may appear as follows:

"...as found in Section 201 of this rule." OR "...in accordance with Subsection 201.06.c. of this rule."

It may also be cited to include the IDAPA, Title, and Chapter number also, as follows:

"...in accordance with IDAPA 38.05.01.201."

"38" denotes the IDAPA number of the agency.

"05" denotes the TITLE number of the agency rule.

"01" denotes the Chapter number of the agency rule.

"201" references the main Section number of the rule that is being cited.

Citations made within a rule to a different rule chapter (external citation) should also include the name of the Department and the name of the rule chapter being referenced, as well as the IDAPA, Title, and Chapter numbers. The following is a typical example of an external citation to another rule chapter:

"...as outlined in the Rules of the Department of Administration, IDAPA 38.04.04, 'Rules Governing Capitol Mall Parking.'"

BULLETIN PUBLICATION SCHEDULE FOR 1999

Volume No.	Monthly Issue of Bulletin	Closing Date for Agency Filing	Publication Date
99-1	January, 1999	November 18, 1998	January 6, 1999
99-2	February, 1999	December 23, 1998	February 3, 1999
99-3	March, 1999	January 20, 1999	March 3, 1999
99-4	April, 1999	February 24, 1999	April 7, 1999
99-5	May, 1999	March 24, 1999	May 5, 1999
99-6	June, 1999	April 21, 1999	June 2, 1999
99-7	July, 1999	May 26, 1999	July 7, 1999
99-8	August, 1999	June 23, 1999	August 4, 1999
99-9	September, 1999	July 21, 1999	September 1, 1999
99-10	October, 1999	August 25, 1999	October 6, 1999
99-11	November, 1999	September 22, 1999	November 3, 1999
99-12	December, 1999	October 20, 1999	December 1, 1999

BULLETIN PUBLICATION SCHEDULE FOR 2000

Volume No.	Monthly Issue of Bulletin	Closing Date for Agency Filing	Publication Date
00-1	January, 2000	November 17, 1999	January 5, 2000
00-2	February, 2000	December 22, 1999	February 2, 2000
00-3	March, 2000	January 19, 2000	March 1, 2000
00-4	April, 2000	February 23, 2000	April 5, 2000
00-5	May, 2000	March 22, 2000	May 3, 2000
00-6	June, 2000	April 19, 2000	June 7, 2000
00-7	July, 2000	May 24, 2000	July 5, 2000
00-8	August, 2000	June 21, 2000	August 2, 2000
00-9	September, 2000	July 19, 2000	September 6, 2000
00-10	October, 2000	August 22, 2000	October 4, 2000
00-11	November, 2000	September 20, 2000	November 1, 2000
00-12	December, 2000	October 25, 2000	December 6, 2000

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THE OFFICE OF THE GOVERNOR

EXECUTIVE DEPARTMENT
STATE OF IDAHO
BOISE

EXECUTIVE ORDER NO. 99-01

**AUTHORIZING THE ESTABLISHMENT OF A 2002 WINTER GAMES
EXECUTIVE COMMITTEE REPLACING EXECUTIVE ORDER NO. 98-03**

WHEREAS, the Winter Olympic Games to be held in Salt Lake City, Utah in the year 2002 presents and opportunity to be a good neighbor to the host state, while strengthening the economic vitality of Idaho through increased development activity and visitations to the state; and

WHEREAS, it is important to enhance the quality of life of all Idahoans by promoting increased economic opportunity consistent with Idaho's heritage and values; and

WHEREAS, Idaho could gain world recognition and prestige by attracting favorable attention, leading to increased interest in and visitations to the state; and

WHEREAS, it is important for the citizens of Idaho to continue to develop social and cultural values with others; and

WHEREAS, the 2002 Winter Games Strategy, a plan to accomplish the foregoing has been developed; and

WHEREAS, it is important that Idaho have an official committee to coordinate activities relating to the 2002 Winter Olympic Games in Salt Lake City with entities and individuals both inside and outside Idaho;

NOW, THEREFORE, I, DIRK KEMPTHORNE, Governor of the State of Idaho, by the authority vested in me by law, do hereby establish the 2002 Winter Games Executive Committee. The Committee shall:

- 1. Oversee Idaho's implementation of the 2002 Winter Games Strategy.*
- 2. Serve as the official liaison for the State of Idaho with the International Olympic Committee, the Salt Lake City Olympic Organizing Committee, United States Olympic Committee, and other national Olympic committees, and sport federations.*
- 3. Interact with federal agencies according to the implementation of the Idaho 2002 Winter Games Strategy.*
- 4. Determine and develop economic, social, and cultural positive consequences.*
- 5. Serve as the official liaison for the State of Idaho for the encouragement of private businesses, state agencies, tribes, and committees that wish to be involved with Idaho's strategy for the 2002 Winter Games.*
- 6. Provide a work plan and budget to include possible revenue sources for implementation of the 2002 Winter Games Strategy.*
- 7. Amend, modify or alter Idaho's 2002 Winter Games Strategy, as necessary to meet changing circumstances, challenges and opportunities.*

The Committee shall have regular meetings as determined by the majority of the Committee and shall meet on special occasions upon the call of the chairpersons. Members of the Committee shall serve without compensation, but may be reimbursed for actual travel expenses not to exceed state guidelines.



IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Idaho at the Capitol in Boise on this sixteenth day of February in the year of our Lord nineteen hundred ninety-nine and of the Independence of the United States of America the two hundred twenty-second and of the Statehood of Idaho the one hundred eighth.

DIRK KEMPTHORNE
GOVERNOR

PETE T. CENARRUSA
SECRETARY OF STATE

THE OFFICE OF THE GOVERNOR

EXECUTIVE DEPARTMENT
STATE OF IDAHO
BOISE

EXECUTIVE ORDER NO. 99-02

**CONTINUATION OF THE IDAHO LEWIS AND CLARK TRAIL COMMITTEE
REPEALING AND REPLACING EXECUTIVE ORDER NO. 97-05**

WHEREAS, the Lewis and Clark Trail has great historical significance to the State of Idaho; and

WHEREAS, it is important that Idaho have an official organization to coordinate activities relating to the Lewis and Clark Trail with entities and individuals in Idaho and with other Lewis and Clark Trail states and organizations;

NOW, THEREFORE, I, DIRK KEMPTHORNE, Governor of the State of Idaho, do hereby continue the Idaho Lewis and Clark Trail Committee as an advisory body to state, local and federal governments on development and management of the Lewis and Clark Trail and commemoration activities relating to the Lewis and Clark Expedition...

The Committee shall:

- 1. Act as the coordinating organization in planning activities to foster state recognition of the historic significance of the Lewis and Clark Expedition;*
- 2. Promote public awareness of the historic significance of the Lewis and Clark Expedition and encourage the development and protection of historical sites and outdoor recreation resources along the Lewis and Clark Trail;*
- 3. Act in an advisory capacity to other Idaho commissions, bureaus, agencies and committees by making recommendations regarding their activities and policies that relate to the history and trail of the Lewis and Clark Expedition; and*
- 4. Serve as the official liaison with other Lewis and Clark Trail states, the national Lewis and Clark Trail Heritage Foundation, Inc., and federal departments, bureaus, and committees concerned with the Lewis and Clark Trail, including promotion of the aims and recommendations of the federal Lewis and Clark Trail Commission, which existed from 1964-1969.*

The Committee shall consist of no more than 15 persons who are appointed by the Governor and serve at his pleasure. The membership of the committee shall include the President of the Idaho chapter of the Lewis and Clark Trail Heritage Foundation, Inc., a representative of the Idaho Historical Society, a representative of the Idaho Department of Parks and Recreation, and the Governor or his designee.

The Committee shall have regular meetings as determined by the majority of the Committee and shall meet on special occasions upon the call of the Chairperson.

This Executive Order repeals and replaces Executive Order No. 95-16.



IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Idaho at the Capitol in Boise on this sixteenth day of February in the year of our Lord nineteen hundred ninety-nine and of the Independence of the United States of America the two hundred twenty-second and of the Statehood of Idaho the one hundred eighth.

DIRK KEMPTHORNE
GOVERNOR

PETE T. CENARRUSA
SECRETARY OF STATE

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.01.08 - IDAHO RULES FOR PUBLIC DRINKING WATER SYSTEMS
DOCKET NO. 16-0108-9801

NOTICE OF PENDING RULE AND TEMPORARY RULE

EFFECTIVE DATE: The temporary rule is effective June 1, 1999. This rule has been adopted by the Board of Health and Welfare (Board) and is now pending review by the 2000 Idaho State Legislature for final approval. The pending rule will become final and effective immediately upon the adjournment sine die of the Second Regular Session of the Fifty-fifth Idaho Legislature unless prior to that date the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and a temporary rule. The action is authorized by Chapter 1, Title 39, Idaho Code, and Chapter 21, Title 37, Idaho Code. Section 39-105(3)(e), Idaho Code, contains explicit authorization for capacity development. In addition, this rulemaking is required by Section 1420(a) of the federal Safe Drinking Water Act (42 U.S.C. Section 300g-9(a)). Failure to comply with this provision will result in losing 20% of the state's annual Drinking Water Revolving Loan Fund capitalization grant from the federal government for the years 1999 to 2003 and possibly beyond, if Congress continues the appropriations. This amounts to 1.5 to 2.0 million dollars per year over that period.

DESCRIPTIVE SUMMARY: A detailed summary of the reasons for adopting the rule is set forth in the initial proposal published in the Idaho Administrative Bulletin, Volume 98-11, November 4, 1998, pages 60 through 66. The agency received no public comments on the proposal, and the rule has been adopted as initially proposed. The rulemaking record is maintained at the Division of Environmental Quality, 1410 N. Hilton, Boise, Idaho, 83706.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this rule, contact Tom John at (208) 373-0502.

DATED this 25th day of February, 1999.

Paula Junae Saul
Environmental Quality Section
Attorney General's Office
1410 N. Hilton
Boise, Idaho 83706-1255

IDAPA 16
TITLE 01
Chapter 08

IDAHO RULES FOR PUBLIC DRINKING WATER SYSTEMS

The temporary rule is being adopted as originally proposed.
There are no substantive changes from the proposed rule text.

The original text was published in the Idaho Administrative Bulletin,
Volume 98-11, November 4, 1998, pages 60 through 66.

This rule has been adopted as Final by the Agency and is now pending
review by the 2000 Idaho State Legislature for final adoption.

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.09 - RULES GOVERNING MEDICAL ASSISTANCE
DOCKET NO. 16-0309-9805

NOTICE OF PENDING RULE AND AMENDMENT TO TEMPORARY RULE

EFFECTIVE DATE: The amendments to the temporary rule are effective March 1, 1999. These rules have been adopted by the agency and are now pending review by the 2000 Idaho State Legislature for final adoption. The pending rule becomes final and effective upon conclusion of the 2000 Idaho Legislative Session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Section(s) 56-202(b) and 56-203(b), Idaho Code.

DESCRIPTIVE SUMMARY: In Subsection 816.04 it was changed to read "Non-Payment Of Prescriptions". Subsection 812.01.d., "pregnant or lactating women" was added to this subsection. The proposed rules have been amended in response to public comment and to make typographical, transcriptional, and clerical corrections to the rules, and are being amended pursuant to Section 67-5227, Idaho Code.

Only the sections that have changes are printed in this bulletin. The original text of the proposed rules was published in the December 2, 1998 Administrative Bulletin, Volume 98-12, pages 46 through 55.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Gary Duerr at (208) 364-1829.

DATED this 24th day of March, 1999.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Legal Services Division
450 West State Street - 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone
(208) 334-5548 fax

IDAPA 16
TITLE 03
Chapter 09

RULES GOVERNING MEDICAL ASSISTANCE

There are substantive changes from the proposed rule text.

Only those sections that have changed from the original proposed text are printed in this Bulletin following this notice.

The complete original text was published in the Idaho Administrative Bulletin,
Volume 98-12, December 2, 1998, pages 46 through 55.

This rule has been adopted as Final by the Agency and is now pending
review by the 2000 Idaho State Legislature for final adoption.

THE FOLLOWING IS TEXT OF DOCKET NO. 16-0309-9805

806. PAYMENT FOR COVERED DRUGS.

Payment will be made, as provided in Section 817, only to pharmacies licensed by the Idaho Board of Pharmacy and registered with the Department as a provider for 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. (1-1-99)T(3-1-99)T

807. PRESCRIPTION REIMBURSEMENT DISPENSING FEE.

Reimbursement as defined in Subsection 817.04 shall consist of the Estimated Acquisition Cost (EAC), defined as an approximation of the net cost of the drug and a reasonable operating margin, plus a Dispensing Fee, is defined as the cost of filling a prescription including direct pharmacy overhead. The dispensing fee and shall be one (1) of two (2) types: (1-1-99)T(3-1-99)T

01. Regular Dose Fee. For services pertaining to the usual practice of pharmacy, including but not limited to:
 - a. Interpretation, evaluation, compounding, and dispensing of prescription drug orders; (1-1-99)T
 - b. Participation in drug selection; (1-1-99)T
 - c. Drug administration; (1-1-99)T
 - d. Drug regimen and research reviews; (1-1-99)T
 - e. Proper storage of drugs; (1-1-99)T
 - f. Maintenance of proper records; (1-1-99)T
 - g. Prescriber interaction; and (1-1-99)T
 - h. Patient counseling. (1-1-99)T
02. Unit Dose Fee. Unit-dose dispensing is defined as a system of providing individually sealed and appropriately labeled unit dose medication that ensures no more than a twenty-four (24) hour supply in any client's drug tray at any given time. These drug trays, which contain a twenty-four (24) hour supply of medication, shall be delivered to the facility at a minimum of five (5) days per week. (1-1-99)T

(BREAK IN CONTINUITY OF SECTIONS)

811. EXCLUDED DRUG PRODUCTS.

The following categories and specific products are excluded: (1-1-99)T

01. Non-Legend Medications. Non-legend medications unless included in Subsection 812.02. This includes federal legend medications that change to non-legend status as well as their therapeutic equivalents regardless of prescription status. (1-1-99)T
02. Legend Drugs. Any legend drugs for which federal financial participation is not available. (1-1-99)T
03. Diet Supplements. (1-1-99)T
04. Amphetamines And Related Products. Amphetamines and related products, except as outlined in Subsection 812.03, including, but not limited to: (1-1-99)T
- a. Benzphetamine; (1-1-99)T
 - b. Chlorphentermine; (1-1-99)T
 - c. Chlorlertamine; (1-1-99)T
 - d. Diethylpropion; (1-1-99)T
 - e. Fenfluramine; (1-1-99)T
 - f. Mazindol; (1-1-99)T
 - g. Phendimetrazine; (1-1-99)T
 - h. Phenmetrazine; (1-1-99)T
 - i. Phentermine; (1-1-99)T
 - j. Salts and optical isomers of the above; and (1-1-99)T
 - k. Combination products containing any of the above drugs. (1-1-99)T
05. Ovulation/Fertility Drugs. Ovulation stimulants, fertility drugs, and similar products including but not limited to: (1-1-99)T
- a. Clomiphene Citrate; (1-1-99)T
 - b. Menotropins; and (1-1-99)T
 - c. Urofollitropin. (1-1-99)T
06. Impotency Aids. Impotency aids, either as medication or prosthesis. (1-1-99)T
07. Nicotine Products. Nicotine chewing gum, sprays, inhalers, transdermal patches and related products. (1-1-99)T
08. Medications Utilized For Cosmetic Purposes. ~~Topical or oral~~ Medications utilized for cosmetic purposes or hair growth. Prior authorization may be granted for these medications if the Department finds other medically necessary indications. ~~(1-1-99)T~~ (3-1-99)T
09. Vitamins. Vitamins unless included in Subsection 812.01. (1-1-99)T
10. Medications Not Medically Necessary. Medications not deemed medically necessary by the Department. (1-1-99)T

812. ADDITIONAL COVERED DRUG PRODUCTS.

Additional drug products will be allowed as follows: (1-1-99)T

- 01. Therapeutic Vitamins. Therapeutic vitamins may include: (1-1-99)T
 - a. Injectable vitamin B12 (cyanocobalamin and analogues); (1-1-99)T
 - b. Vitamin K and analogues; (1-1-99)T
 - c. Pediatric legend vitamin-fluoride preparations; (1-1-99)T
 - d. Legend prenatal vitamins for pregnant or lactating women ~~of child bearing age;~~ ~~(1-1-99)T~~ (3-1-99)T
 - e. Legend folic acid; (1-1-99)T
 - f. Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients; and (1-1-99)T
 - g. Legend vitamin D and analogues. (1-1-99)T
- 02. Prescriptions For Nonlegend Products. Prescriptions for nonlegend products may include: (1-1-99)T
 - a. Insulin; (1-1-99)T
 - b. Disposable insulin syringes and needles; (1-1-99)T
 - c. Oral iron salts; and (1-1-99)T
 - d. Permethrin. (1-1-99)T
- 03. Prior Authorization Drugs. Prior authorization for drugs is as follows: (1-1-99)T
 - a. Medications requiring prior authorization include: (1-1-99)T
 - i. Amphetamines and related CNS stimulants; (1-1-99)T
 - ii. Growth hormones; (1-1-99)T
 - iii. Retinoids; ~~and~~ ~~(1-1-99)T~~ (3-1-99)T
 - iv. ~~Other pharmaceuticals as deemed necessary by the Department.~~ ~~(1-1-99)T~~
 - b. Some medications excluded in Section 811 may be accepted for other medically approved indications, provided that prior authorization is obtained. (1-1-99)T
 - c. The prior authorization procedure is initiated by the prescriber who shall submit the signed request to the Department. This request shall include: (1-1-99)T
 - i. Recipient name; (1-1-99)T
 - ii. Medicaid identification number; (1-1-99)T
 - iii. Date of birth; (1-1-99)T

- iv. Diagnosis; (1-1-99)T
 - v. Specific drug; (1-1-99)T
 - vi. Strength and dosage; (1-1-99)T
 - vii. Statement of medical necessity as to why this drug is needed versus other therapies; and (1-1-99)T
 - viii. Duration of therapy desired, not to exceed twelve (12) months. (1-1-99)T
- d. The Department will determine coverage based on this request, and will notify the client, prescriber, and pharmacy, if known. Specific details on the prior authorization procedure can be found in the pharmacy guidelines issued by the Department. (1-1-99)T

(BREAK IN CONTINUITY OF SECTIONS)

816. DISPENSING PROCEDURES.

The following protocol shall be followed for proper prescription filling. (1-1-99)T

01. Obtaining A Prescription Drug. To obtain a prescription drug, a MA recipient or authorized agent shall present the recipient's Medicaid identification card to a participating pharmacy together with a prescription from a licensed prescriber. (1-1-99)T

02. 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 shall be recorded on the prescription or logbook, or computer print-out, or on the recipient's medication profile. (1-1-99)T

03. Dispensing Prescription Drugs. Prescriptions must be dispensed according to: (1-1-99)T

- a. 21 CFR Section 1300 et seq.; (1-1-99)T
- b. Title 54, Chapter 17, and Title 37, Chapter 1, 27, and 32, Idaho Code; (1-1-99)T
- c. IDAPA 27.01.01, "Idaho State Board of Pharmacy"; (1-1-99)T
- d. IDAPA 16.03.09, "Rules Governing Medical Assistance," Sections 805 through 825. (1-1-99)T

04. Nonpayment Of Prescriptions. Prescriptions not filled in accordance with the provisions of Subsection 816.053 will be subject to nonpayment or recoupment. ~~(1-1-99)T~~(3-1-99)T

05. Prescriptions On File. Prescriptions shall be maintained on file in pharmacies in such a manner that they are available for immediate review by the Department upon written request. (1-1-99)T

817. PAYMENT PROCEDURES.

The following protocol shall be followed for proper reimbursement. (1-1-99)T

01. Filing Claims. Pharmacists shall 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 shall include information described in the pharmacy guidelines issued by the Department. (1-1-99)T

02. Claim Form Review. Each claim form is subject to review by a contract claim examiner, a pharmaceutical consultant, or a medical consultant. (1-1-99)T

03. 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. (1-1-99)T
04. Reimbursement. Reimbursement to pharmacies shall be limited to the lowest of the following: (1-1-99)T
- a. Federal Upper Limit (FUL), as established by the Health Care Financing Administration (HCFA), of the U.S. Department of Health and Human Services, plus the dispensing fee assigned by the Department; (1-1-99)T
- b. State Maximum Allowable Cost (SMAC), as established by the Department, plus the assigned dispensing fee; (1-1-99)T
- c. Estimated Acquisition Cost (EAC), as established by the Department following negotiations with representatives of the Idaho pharmacy profession ~~and defined in Section 807 as an approximation of the net cost of the drug and a reasonable operating margin,~~ plus the assigned dispensing fee; or ~~(1-1-99)T~~(3-1-99)T
- d. The pharmacy's usual and customary charge to the general public as defined in Subsection 817.03. (1-1-99)T
05. Dispensing Fees. Only one (1) dispensing fee per month will be allowed for the dispensing of each maintenance drug to any recipient as an outpatient or a resident in a care facility except: (1-1-99)T
- a. 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; (1-1-99)T
- b. Multiple dispensing of oral liquid maintenance medication if a reasonable quantity, as determined by the Department, is dispensed at each filling; (1-1-99)T
- c. 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 (1-1-99)T
- d. When the dose is being titrated for maximum therapeutic response with a minimum of adverse effects. (1-1-99)T
06. Remittance Advice. Claims are processed by computer, and payments are made directly to the pharmacy or its designated bank through electronic claims transfer. A remittance advice with detailed information of each claim transaction will accompany each payment made by the Department. (1-1-99)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.09 - RULES GOVERNING MEDICAL ASSISTANCE

DOCKET NO. 16-0309-9902

NOTICE OF TEMPORARY RULE

EFFECTIVE DATE: These temporary rules are effective March 1, 1999.

AUTHORITY: In compliance with Sections 67-5226, Idaho Code, notice is hereby given this agency has adopted temporary rules. The action is authorized pursuant to Section(s) 56-202(f), Idaho Code.

DESCRIPTIVE SUMMARY: Rule Sections 664 through 704 are added to implement an expansion of the Department's Home and Community-Based Services Waiver for the Aged and Disabled. Fifteen additional services are added, provider qualifications are specified, responsibilities of the Regional Medicaid Units are identified, and other necessary program activities are indicated.

In addition, Sections 146, and 148 for the current Personal Care Services program are modified as necessary to accommodate the expanded waiver program.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code and are necessary in order to confer a benefit.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary rules, contact Lloyd Forbes at (208) 364-1831.

DATED this 24th Day of March, 1999.

Sherri Kovach
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THE FOLLOWING IS TEXT OF DOCKET NO. 16-0309-9902

146. PERSONAL CARE SERVICES.

Pursuant to Sections 39-5601 through 39-5607, Idaho Code, it is the intention of the Department to provide personal care services to eligible recipients in their personal residence in order to prevent unnecessary institutional placement, to provide for the greatest degree of independence possible, to enhance the quality of life, to encourage individual choice, and to maintain community integration. For a recipient to be eligible for personal care services, the Department must find that the recipient requires personal care services due to a medical condition which impairs their physical or mental function or independence and must find the recipient capable of being maintained safely and effectively in their own home or residence with personal care services. (1-1-91)

01. Care And Services Provided. (1-1-91)

a. Medically oriented tasks having to do with a patient's physical or functional requirements, as opposed to housekeeping or skilled nursing care, provided in the patient's home. Such services may include, but are not limited to: (1-1-91)

- i. Basic personal care and grooming to include bathing, care of the hair, assistance with clothing, and basic skin care, but excluding the irrigation or suctioning of any body cavities which require sterile procedures and the application of dressings, involving prescription, medication, and aseptic techniques; and (1-1-91)
- ii. Assistance with bladder or bowel requirements which may include helping the patient to and from the bathroom or assisting the patient with bedpan routines, but excluding insertion or sterile irrigation of catheters; and (5-1-87)
- iii. Assisting the patient with medications which are ordinarily self-administered, when ordered by a physician, but excluding the giving of injections or fluids into the veins, muscles, or skin, or administering of medicine; and (7-15-83)
- iv. Assistance with food, nutrition, and diet activities to include the preparation of meals if incidental to medical need, as determined by a physician; and (7-15-83)
- v. The continuation of active treatment training programs in the home setting to increase or maintain client independence for the developmentally disabled client. (5-1-87)
- vi. Non-nasogastric gastrostomy tube feedings may be performed if authorized prior to implementation by the Department's Regional Medicaid Unit and if the following requirements are met: (2-19-92)
 - (1) The task is non-complex and can be safely performed in the given patient care situation; and (2-19-92)
 - (2) A registered nurse has assessed the patient's nursing care needs and has developed a written standardized procedure for gastrostomy tube feedings, which is individualized for the patient's characteristics and needs; and (2-19-92)
 - (3) Persons to whom the procedure can be delegated are identified by name. The registered nurse must provide proper instruction in the performance of the procedure, supervise a return demonstration of safe performance of the procedure, state in writing strengths and weaknesses of the person performing the procedure, and evaluate the performance of the procedure at least monthly; and (2-19-92)
 - (4) Any change in the patient's status or problem relative to the procedure must be reported immediately to the registered nurse; and (2-19-92)
 - (5) The individualized procedure, the supervised performance of the procedure, and follow-up evaluation of the performance of the procedure must be documented in writing by the supervising RN, and must be readily available for review, preferably with the patient's record. (2-19-92)
 - (6) Medication previously received could be given by the personal care provider through the non-nasogastric tube unless contraindicated. (2-19-92)
- vii. In addition to performing at least one (1) of the services listed in Subsections 146.01.a.i. through 146.01.a.vi., the provider may also perform the following services: (2-19-92)
 - (1) Such incidental housekeeping services essential to a patient's comfort and health, to include the changing of bed linens, rearranging furniture to enable the patient to move about more easily, laundry and room cleaning when incidental to the patient's treatment. Excluded are cleaning and laundry for any other occupant of the patient's residence; and (2-19-92)
 - (2) Accompanying the patient to clinics, physician office visits, or other trips which are reasonable for the purpose of obtaining medical diagnosis or treatment; and (7-15-83)
 - (3) Shopping for groceries or other household items required specifically for the health and maintenance of the patient. (2-19-92)

b. Service Limitations. The maximum amount of personal care services available to an eligible recipient is dependent on whether services are obtained under the Home and Community-based Services waiver (HCBS waiver) or under the State Medicaid Plan Service option. (1-1-91)

i. For adults receiving services under the State Medicaid Plan option, service delivery is limited to a maximum of sixteen (16) hours per week per recipient. (10-1-94)

ii. For individuals under the age of twenty-one (21) who meet medical necessity criteria under EPSDT, the eligible recipient may receive up to twenty-four (24) hours per day of service delivery under the State Plan option. (10-1-94)

iii. For individuals receiving services under the HCBS waiver, the eligible recipient may receive up to twenty-four (24) hours per day of service delivery, based on the medical need for such service as documented in the plan of care and the cost effectiveness criteria under the waiver program. (1-30-94)

02. Place Of Service Delivery. Personal Care Services (PCS) may be provided only in a recipient's personal residence. The following living situations are specifically excluded as a personal residence for the purpose of these rules: (1-1-91)

a. Certified nursing facilities (NF) or hospitals; and (1-1-91)

b. Licensed Intermediate Care Facility for the Mentally Retarded; and (7-15-83)

c. ~~Licensed Residential Care Intensive Treatment Facility For Children as described in IDAPA 16.06.01, "Rules Governing Family and Children's Services," Section 620.~~ (1-1-91)(3-1-99)T

d. ~~Licensed child foster care Level III professional child's foster homes and adult foster homes. A home receiving payment for specialized foster care, professional foster care, or group foster care.~~ (1-1-91)(3-1-99)T

03. Services Delivered Following A Written Plan. (7-15-83)

a. All PCS are provided based on a written plan of care which is the responsibility of the supervisory nurse to prepare and is based on: (7-15-83)

i. The physician's information including the physician's orders; and (7-15-83)

ii. The nurse's assessment and observations of the patient; and (7-15-83)

iii. Information elicited from the recipient. (7-15-83)

b. The plan of care must include all aspects of personal care necessary to be performed by the PCS provider, including the amount, type, and frequency of such services. (7-15-83)

c. The plan of care will be signed and approved by the physician prior to the initiation of the services by the PCS provider. (7-15-83)

d. The plan must be revised and updated based upon treatment results or a patient's changing profile of needs as necessary, but at least annually. (7-15-83)

04. Physician Supervision Of The Service. All Personal Care Services are provided under the order of a licensed physician. The physician must: (1-1-91)

a. Provide such medical information to the Department's Regional Medicaid Unit (RMU) as is necessary to establish that the recipient is medically eligible for NF or ICF/MR placement for those recipients receiving PCS under the Department's Home and Community Based Services waivers. For recipients eligible for PCS under the Idaho State Plan, the physician will certify, in writing, that the services are medically necessary.

~~(7-1-94)~~(3-1-99)T

b. Order all services delivered by the PCS provider. Such orders are signed and dated by the physician and include, at a minimum, his signature and date of approval on the recipient's plan of care. (7-15-83)

c. Update the plan of care, including his signature and date of approval, as necessary, but at least annually. (1-1-91)

d. Recommend institutional placement of the recipient if he identifies that PCS, in combination with other community resources, are no longer sufficient to ensure the health or safety of the recipient. (1-1-91)

05. Service Supervision. (1-1-91)

a. A registered nurse who is not functioning as the personal care provider will oversee the delivery of PCS. Such oversight will include: (1-1-91)

i. In conjunction with the attending physician the development of a plan of care for the recipient; and (1-1-91)

ii. Review of the treatment given by the personal care provider through a review of the recipient's PCS record as maintained by the provider and on-site interviews with the patient at least every ninety (90) days; and (1-1-91)

iii. Reevaluate the plan of care as necessary and obtaining physician approval on all changes. The entire plan is reviewed at least annually; and (1-1-91)

iv. Immediately notifies the physician of any significant changes in the recipient's physical condition or response to the service delivery; and (1-1-91)

v. Provides an on-site visit to the recipient to evaluate changes of condition when requested by the PCS provider, QMRP supervisor, provider agency, case manager, or recipient. (1-1-91)

b. In addition to the supervisory visit by the registered nurse, all clients who are developmentally disabled, other than those with only a physical disability, as determined by the Regional Medicaid Unit will receive oversight of service delivery by a Qualified Mental Retardation Professional (QMRP) as defined in 42 CFR 483.430. Such oversight will include: (8-5-91)

i. In conjunction with the attending physician and supervisory RN, the QMRP will assist in the development of the plan of care for the recipient for those aspects of active treatment which are provided in the home by the PCS attendant. (1-1-91)

ii. Review of the care and/or training given by the personal care provider through a review of the recipient's PCS record as maintained by the provider, and on-site interviews with the client at least every ninety (90) days. (1-1-91)

iii. Reevaluation of the plan of care as necessary, but at least annually. (1-1-91)

iv. An on-site visit to the recipient to evaluate any change of condition when requested by the PCS provider, provider agency, nurse supervisor, case manager, or recipient. (1-1-91)

06. PCS Provider Qualifications. (1-1-91)

a. Persons providing PCS: Individuals may provide PCS either as PCS agency employees, employees of record of a fiscal intermediary (FI), or as independent providers if they have at least one (1) of the following qualifications: ~~(1-1-91)~~(3-1-99)T

i. Registered Nurse, RN: A person currently licensed by the Idaho State Board of Nursing as a

registered nurse; or (7-15-83)

ii. Licensed Practical Nurse, L.P.N.: A person currently licensed by the Idaho State Board of Nursing as a licensed practical nurse; or (7-15-83)

iii. Nursing Assistant: All nursing assistants who provide PCS to eligible individuals must appear on the Idaho State Board of Nursing's registry of certificated nurse aides (CNA). An individual who has completed a certified nurse aide training program may be granted provisional provider status for up to ninety (90) days by the Department to allow for the completion of competency testing and registry. (1-30-94)

b. All persons who care for developmentally disabled clients other than those with only physical disabilities as identified by the Department's RMU will, in addition to the completion of the requirements of Subsection 146.06.a.iii., have completed one (1) of the Department approved developmental disabilities training courses. Providers who are qualified as QMRPs will be exempted from the Department approved developmental disabilities training course. Each region may grant temporary approval to an individual who meets all qualifications except for the required developmental disabilities training course to become a PCS provider to a developmentally disabled recipient if all of the following conditions are met: (7-1-94)

i. The RMU has verified that there are no qualified providers reasonably available to provide services to client requesting services; and (7-1-94)

ii. The provider must be enrolled in the next available training course with a graduation date no later than six (6) months from the date of the request for temporary status; and (7-1-94)

iii. The supervising QMRP makes monthly visits until the provider graduates from the training program. (7-1-94)

c. Agency providers must submit to the Department documentation of their worker's compensation and professional liability insurance coverage. In the case of worker's compensation, agencies will direct their sureties to provide a certificate of insurance to the Department. Independent providers must submit to the Department documentation of their professional liability insurance coverage. Termination of either type of insurance by the provider will be cause for termination of PCS Provider status by the Department. Agency providers and FIs will keep copies of employee health screens in their files for review by the Department as necessary. Independent providers will submit the completed health screen to the Department. Agency and independent providers will complete a criminal history check conducted by the Department. If no criminal history is indicated on the Self-Declaration form, individuals may be authorized by the Region to provide services on a provisional basis while awaiting the results of the fingerprinting process. Such authorization may be provided after the client's safety is assured by the responsible Region. ~~(1-30-94)~~(3-1-99)T

d. Individuals providing supervision to PCS attendants. (1-1-91)

i. RN supervisors will have a current Idaho professional nursing license (RN). (1-1-91)

ii. Qualified Mental Retardation Professional (QMRP) supervisors will be qualified by education and training as required in 42 CFR 483.430. (1-1-91)

iii. Supervising RNs and QMRPs who are independent providers will be independent contractors and obtain any desired benefits such as life, disability and/or unemployment insurance that he may desire, maintain professional liability insurance, and report all income to the appropriate authorities, pay social security and all other state and federal taxes. (1-1-91)

e. Provider agency. An entity which has a signed provider agreement with the Department and is capable of and responsible for all of the following: (1-1-91)

i. Recruitment, hiring, firing, training, supervision, scheduling and payroll for personal care attendants and the assurance of quality service provided by the personal care attendants; and (1-1-91)

- ii. Participation in the provision of worker's compensation, unemployment compensation and all other state and federal tax withholdings; and (8-5-91)
- iii. Maintenance of liability insurance coverage; and (1-1-91)
- iv. Provision of a licensed professional nurse (RN) and, where applicable, a QMRP supervisor to develop and complete plans of care and provide ongoing supervision of a recipient's care; and (1-1-91)
- v. Assignment of a qualified personal care attendant(s) to eligible recipients after consultation with and approval of such recipients; and (1-1-91)
- vi. Assure that all PCS attendants meet the qualifications in Subsection 146.06.a.; and (12-31-91)
- vii. Billing Medicaid for services approved and authorized by the RMU; and (1-1-91)
- viii. Make referrals for PCS eligible recipients for case management services when a need for such services is identified; and (1-1-91)
- ix. Conduct such criminal background checks and health screens on new and existing employees as required in Subsection 146.10 and 146.11. (12-31-91)
- f. Independent providers. Persons who meet the training requirements in Subsection 146.06.a. and will:
 - i. Obtain the required training, certifications, agreements, knowledge and information needed to function as an independent provider; and (1-1-91)
 - ii. Obtain any desired benefits such as life, disability and/or unemployment insurance that he may desire; and (1-1-91)
 - iii. Maintain professional liability insurance effective April 15, 1991, for certified nurse's aides, and upon completion of the certified nurse's aide course for all other providers; and (7-1-94)
 - iv. Report all income to the appropriate authorities, pay social security and all other state and federal taxes as an independent contractor; and (1-1-91)
 - v. Submit claims to the Medicaid Program for approved services; and (1-1-91)
 - vi. Provide for care by a fully trained and qualified replacement when unable to provide service; and (1-1-91)
 - vii. Provide unanticipated services that are not part of the plan of care in emergency situations; and (1-1-91)
 - viii. Participate in the background check and obtain the health screen required in Subsections 146.10 and 146.11; and (12-31-91)
- g. Fiscal intermediaries. An entity which has a signed provider agreement with the Department and meets the requirements of Subsection 669.03. (3-1-99)T
- ~~ixh.~~ When care is provided in the provider's home, acquire the appropriate level of child foster care licensure or certification. The provider must be licensed as a Level I or Level II children's foster home as defined in Section 39-1209~~13~~, Idaho Code, for care of individuals under eighteen (18) years of age. ~~For care of individuals eighteen (18) years of age or older, the provider must meet the environmental sanitation standards, fire and life safety standards, and building, construction and physical home standards for certification as an Adult Foster Home.~~ Noncompliance with the above standards will be cause for termination of the provider's provider agreement. (10-1-94)(3-1-99)T

g.i. Utilization of independent providers. Independent providers will be utilized in the following circumstances: (8-5-91)

i. When a provider agency is unavailable; or (8-5-91)

ii. When, based on an assessment involving the recipient, the recipient's family and the Department's regional Medicaid staff, it is determined that an independent provider will best meet the needs of the recipient. The assessment shall include consideration of the recipient's and/or family member's ability to select a provider and manage and evaluate the care he receives. (8-5-91)

iii. Recipients receiving PCS from an independent provider should be evaluated for the need for targeted case management from a provider agency or administrative case management from the Department. (1-1-91)

iv. The independent provider will not be considered an employee of the state, recipient, or RN supervisor, but will be considered an independent contractor. (1-1-91)

h.j. A PCS provider cannot be a relative of any recipient to whom the provider is supplying services. (5-1-87)

i. For the purposes of this subsection, a relative is defined as a spouse or a parent of a minor child. (1-1-91)

ii. Nothing in this subsection shall be construed to prohibit a relative from providing PCS where Medicaid is not the payment source for such services. (1-1-91)

07. Recipient Eligibility Determination. An eligible recipient may qualify for PCS coverage either under the Idaho State Medicaid Plan or the Department's Home and Community Based Services waiver. For both programs, the recipient must be financially eligible for MA as described in Idaho Department of Health and Welfare Rules, IDAPA 16.03.05, "Eligibility for the Aged, Blind and Disabled (AABD)". The cited chapter implements and is in accordance with the Financial Eligibility Section of the Idaho State Plan. In addition, waiver recipients must meet the following requirements: (12-31-91)

a. The Department's Regional Medicaid Unit must determine that: (1-1-91)

i. The recipient would qualify for nursing facility level of care as set forth in Subsections 180.03 and 180.08 if PCS were not made available; and (7-1-95)

ii. In the assessment of the RMU the patient could be maintained in their own home or residence and receive safe and effective services through the Personal Care Service Program; and (1-1-91)

iii. In the assessment of the RMU, the average monthly Medicaid cost of providing Personal Care Services and other community services to the patient would not exceed the average Medicaid cost of nursing facility care as described below: (7-1-94)

(1) The average monthly Medicaid cost of personal care and other medical services paid by Medicaid will be calculated utilizing the number of visits or hours or days of PCS and medical services prescribed by the attending physician for the patient. (1-1-91)

(2) The average monthly Medicaid patient cost of nursing facility care will be calculated by the Bureau of Medicaid Policy and Reimbursement utilizing projected Medicaid Program expenditures for institutional care, based on the average interim rate for that type of care. (7-1-95)

(3) If the amount identified in Subsection 146.07.a.iii.(1) is less than the amount identified in Subsection 146.07.a.iii.(2) then the individual is eligible for PCS. (1-30-94)

(4) If the amount identified in Subsection 146.07.a.iii.(1) is greater than or equal to the amount

identified in Subsection 146.07.a.iii.(2) then the individual is not eligible for PCS. (12-31-91)

(5) Eligible recipients receiving PCS under the Idaho State Plan must have medical justification, physician's orders, and plan of care for such services. All services will be authorized by the RMU prior to payment for the amount and duration of services. (1-1-91)

iv. Following the approval by the RMU for services under the waiver, the recipient must receive and continue to receive a waiver service. For the purposes of these rules, a waiver service is defined as personal care services in excess of sixteen (16) hours per week. A recipient who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program. (1-1-91)

b. A recipient who is determined by the Department to be eligible for the Personal Care Services Program under the Home and Community Based Services waiver may elect not to utilize PCS, but may choose admission to a nursing facility. (7-1-94)

c. The recipient's eligibility examiner will process the application in accordance with Idaho Department of Health and Welfare Rules, IDAPA 16.03.05, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)," as if the application was for admission to a nursing facility, except that the eligibility examiner will forward potentially eligible applications immediately to the RMU for review together with the physician's prescription for Personal Care Services. The Medicaid application process cited above conforms to all statutory and regulatory requirements relating to the Medicaid application process. (12-31-91)

d. The decisions of the RMU regarding the acceptance of the recipients into the PCS program will be transmitted to the eligibility examiner. The eligibility examiner will notify the applicant of the Department's determination in accordance with Idaho Department of Health and Welfare Rules, IDAPA 16.03.05, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)," except: (10-1-94)

i. The referring physician will be notified, in addition to the applicant, of the determination; and (7-15-83)

ii. If the application is approved, the RMU will provide a list of personal care providers to the client, or their representatives, to select the provider of their choice. (1-30-94)

08. Case Redetermination. (12-31-91)

a. Financial redetermination will be conducted pursuant to Idaho Department of Health and Welfare Rules, IDAPA 16.03.01, "Rules Governing Medicaid for Families and Children," and IDAPA 16.03.05, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)". Medical redetermination will be made at least annually by the RMU, or sooner at the request of the patient, the eligibility examiner, PCS provider agency, independent personal care provider, the supervising registered nurse, or the physician. The sections cited implement and are in accordance with Idaho's approved state plan with the exception of deeming of income provisions. (1-30-94)

b. The redetermination process will assess the following factors: (7-15-83)

i. The recipient's continued need for the Personal Care Services Program; and (7-15-83)

ii. Discharge from the Personal Care Services Program; and (7-15-83)

iii. Referral of the patient from the Personal Care Services Program to a nursing facility or licensed residential care facility. (7-1-94)

09. Criminal History Check. All personal care providers (case managers, RN supervisors, QMRP supervisors and personal care attendants) shall participate in a criminal history check as required by Section 39-5604, Idaho Code. The criminal history check will be conducted in accordance with IDAPA 16, Title 05, Chapter 06, "Rules Governing Mandatory Criminal History Checks". (10-1-94)

10. Health Screen. The Department will require that a health questionnaire be completed by each independent provider and provider agency employee who serves as a personal care attendant. Provider agencies and fiscal intermediaries will retain this in their personnel file. Independent providers will complete the questionnaires as part of the application. If the applicant indicates on the questionnaire that he has a medical problem, the individual will be required to submit a statement from a physician that his medical condition would not prevent him from performing all the duties required of a personal care provider. Misrepresentation of information submitted on the health screen is cause for termination of provider status for independent PCS providers or termination of employment for agency employees. (1-1-91)(3-1-99)T

11. PCS Record. Three (3) types of record information will be maintained on all recipients receiving PCS and are considered to be the PCS record. (1-1-91)

a. Personal Care Provider Information. Each provider will maintain a written documentation of each visit made to a patient, and will record at a minimum the following information: (1-1-91)

i. Date and time of visit; and (1-1-91)

ii. Services provided during the visit; and (1-1-91)

iii. A statement of the recipient's response to the service, including any changes noted in the recipient's condition; and (1-1-91)

iv. Length of visit and unless it is determined by the RMU that the recipient is unable to do so, the record of service delivery should be verified by the recipient as evidenced by their signature on the service record; and (1-1-91)

v. Any changes in the treatment plan authorized by the referring physician or supervising registered nurse as the result of changes in the recipient's condition. (1-1-91)

vi. A copy of the information contained in Subsections 146.13.a.i. through 146.13.a.v., will be maintained in the recipient's home unless authorized to be kept elsewhere by the RMU. Failure to maintain such documentation may result in the recoupment of funds paid for undocumented services. (1-1-91)

b. Plan of Care. The plan of care which is initiated by the attending physician, developed by the supervising RN and, when appropriate, QMRP must specify diagnosis, general treatment and the Personal Care Services which are required by the recipient. The plan will contain all elements required by Subsection 146.03 and a copy of the most current plan of care will be maintained in the recipient's home and will be available to the PCS Attendant, Supervising RN, QMRP and, if applicable, the case manager. (12-31-91)

c. Oversight Information. In addition to the plan of care, at least every ninety (90) days the Supervising RN and, where required, the QMRP will verify, in writing, that the services provided were consistent with the treatment plan. Any changes in the treatment plan will be documented and include the signature of the Supervising RN or QMRP. (10-1-94)

12. Provider Responsibility for Notification. It is the responsibility of the PCS provider to notify either the supervising RN or physician when any significant changes in the recipient's condition are noted during service delivery. Such notification will be documented in the PCS record. (7-15-83)

13. Records Maintenance. In order to provide continuity of services, when a patient is transferred among independent providers, or when the independent provider changes Supervising RNs, all of the foregoing patient's records will be delivered to and held by the field office of the Department until a replacement provider or Supervising RN assumes the case. When a patient utilizing independent PCS providers leaves the Personal Care Services Program, the records will be retained by the Department as part of the patient's closed case record. Provider agencies will be responsible to retain their clients' records for three (3) years following the date of service. (10-1-94)

14. Provider Coverage Limitations. ~~Each individual person who is an independent PCS provider may not receive compensation from Medicaid funds for service to more than three (3) PCS recipients on any given day~~

except:

(1-1-91)(3-1-99)T

a. ~~Where three (3) or more recipients live within the same building, in which case the maximum number of recipients for which a PCS provider may be compensated shall be five (5); or In congregate living situations, payment is limited to one (1) claim per provider act. In no case may more time be billed than was actually spent by the provider in service delivery.~~ (7-15-83)(3-1-99)T

b. ~~If the recipient's residence is the home of the PCS provider, nNo provider may serve more than two (2) ICF/MR level clients who are authorized for eight (8) or more hours of care per day. No provider may be served more than one (1) NF level client authorized for more than eight (8) hours of care per day, unless approved by the Department under Section 39-1301(a), Idaho Code.~~ (1-1-91)(3-1-99)T

e. ~~As approved by the Director or his designee.~~

(7-15-83)

15. ~~Home and Community-Based Waiver Recipient Limitations. The number of unduplicated count Medicaid recipients to receive personal care services under the home and community based waiver will be limited to the projected number of users contained in the Department's approved waiver. Individuals who apply for personal care services after the waiver maximum has been reached will be placed on a waiting list and will have their applications processed after September 30 of each new waiver year. The earliest effective date of personal care services service delivery for these clients will be October 1 of each new waiver year.~~ (10-1-94)

165. ~~Community Awareness Program. The Department will establish a community awareness program that will educate Idaho citizens regarding the purpose and function of all long-term care alternatives including, but not limited to, personal care services and individual recipient rights. This program will be developed in cooperation with other state agencies including, but not limited to, the Office On Aging and the Division of Vocational Rehabilitation.~~ (1-1-91)

(BREAK IN CONTINUITY OF SECTIONS)

148. PROVIDER REIMBURSEMENT FOR PERSONAL CARE SERVICES.

01. ~~Reimbursement Rate. Personal care providers will be paid a uniform reimbursement rate for service as established by the Department pursuant to Section 39-5606, Idaho Code, on an annual basis. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department.~~ (1-1-91)

02. ~~Calculated Fee. The fee calculated for personal care provider reimbursement includes a basic rate for services and mileage. No separate charges for mileage will be paid by the Department for nonmedical client transportation or provider transportation to and from the recipient's home. Fees will be calculated as follows:(1-1-91)~~

a. ~~Annually the Bureau of Medicaid Policy and Reimbursement will conduct a poll of all Idaho nursing facilities and establish the weighted average hourly rates (WAHR) for nursing facility industry employees in comparable positions (i.e. RN, QMRP, and Nurse's aide) in Idaho to be used for the reimbursement rate to be effective on July 1 of that year.~~ (1-30-94)(3-1-99)T

b. ~~The Bureau of Medicaid Policy and Reimbursement will then establish three (3) payment levels for both provider agencies and independent providers for PCS attendant services as follows:~~ (1-30-94)(3-1-99)T

i. ~~Weekly service needs of zero to sixteen (0-16) hours or waiver recipients zero to eight (0-8) hours/ day:~~

Provider Agencies	WAHR x 1.55	=	\$ amount/hour
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Independent Providers	WAHR x 1.22 (which is a supplemental component to cover training, social security and liability insurance)	=	\$ amount/hour
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(1-30-94)

ii. Extended visit, one (1) recipient (eight and one-quarter hour (8.25) up to twenty-four (24) hours):

Provider Agencies and Fiscal Intermediary	(WAHR x actual hours of care up to 5 hours x 1.55) plus (\$.65 x 1.55 hours on site on-call)	=	\$ amount (Maximum \$532,3351)
Independent Providers	(WAHR x actual hours of care up to 5 hours x 1.22) plus (\$.65 x 1.22 x actual hours on site on-call)	=	\$ amount (Maximum \$506,5743)

~~(7-1-97)~~(3-1-99)T

iii. Extended visit, two (2) recipients (~~six~~ eight and one-quarter (~~6~~8.25) up to twenty-four (24) hours):

Provider Agencies and Fiscal Intermediary	(WAHR x actual hours of care up to 4 hours) x (1.55 plus \$.65 x 1.55 x hours on site on-call)	=	\$ amount (Maximum \$450,4673)
Independent Providers	(WAHR x hours actual care up to 4 hours x 1.22) plus (\$.65 x 1.22 x hours on site on-call)	=	\$ amount (Maximum \$3741,144)

~~(7-1-97)~~(3-1-99)T

c. The attending physician will be reimbursed for services provided using current payment levels and methodologies for other physician services provided to eligible recipients. (1-1-91)

d. The supervisory RN and QMRP will be reimbursed at a per visit amount established by the Department for supervisory visits. Client evaluations and Care Plan Development will be reimbursed at a rate established by the Department, following authorization by the RMU. (1-1-91)

i. The number of supervisory visits by the RN and QMRP to be conducted per calendar quarter will be approved as part of the PCS care plan by the RMU. (1-1-91)

ii. Additional evaluations or emergency visits in excess of those contained in the approved care plan will be authorized when needed by the RMU. (1-1-91)

(BREAK IN CONTINUITY OF SECTIONS)

664. --764. (RESERVED) WAIVER SERVICES FOR AGED OR DISABLED ADULTS.

The Department provides waiver services to eligible participants: to prevent unnecessary institutional placement; to provide for the greatest degree of independence possible; to enhance the quality of life; to encourage individual choice; and to achieve and maintain community integration. For a participant to be eligible, the Department must find that the participant: (3-1-99)T

01. Has A Disabling Condition. Requires services due to a disabling condition which impairs their mental or physical function or independence; and (3-1-99)T

02. Safe In A Non-Institutional Setting. Be capable of being maintained safely and effectively in a non-institutional setting; and (3-1-99)T

03. Requires Such Services. Would, in the absence of such services, require the level of care provided in a Nursing Facility (NF) as set forth in Subsection 180.03. (3-1-99)T

665. PURPOSE.

Idaho's elderly and physically disabled citizens should be able to maintain self-sufficiency, individuality, independence, dignity, choice, and privacy in a cost-effective home-like setting. When possible, services should be available in the consumer's own home and/or community regardless of their age, income, or ability and should encourage the involvement of natural supports, such as family, friends, neighbors, volunteers, church, and others. (3-1-99)T

666. (RESERVED).

667. WAIVER PHASE IN.

The HCBS Waiver services will be provided statewide upon full implementation. New services will be phased in by geographic regions, beginning with Region VI beginning in March, 1999, followed by Regions V and VII in October, 1999, then Regions I and II in December, 1999, and Regions III and IV in February, 2000. (3-1-99)T

668. TARGET GROUP.

Persons who would be medicaid eligible if residing in a NF, require the level of care provided in a NF, are over the age of eighteen (18), demonstrate significant disability on the Uniform Assessment Instrument (UAI), and have deficits which affect their ability to function independently. (3-1-99)T

669. DEFINITIONS.

The following definitions apply to Sections 664 through 704 of the rules: (3-1-99)T

01. Plan For Services (PFS). A written plan, initially developed by the RMU or its contractor for services provided under the Home and Community-Based Services Waiver. This plan must be approved by the RMU and Medicaid reimbursable services must be contained in the plan. (3-1-99)T

02. Uniform Assessment Instrument (UAI). A set of standardized criteria adopted by the Department to assess functional and cognitive abilities. (3-1-99)T

03. Fiscal Intermediary (FI). An entity that acts as an intermediary between the Medicaid program and eligible waiver participants for the purposes of assisting consumers in performing tasks associated with the employment of waiver service providers. The core tasks of the FI are to: (3-1-99)T

a. To directly assure compliance with legal requirements related to employment of waiver providers;
and (3-1-99)T

b. To offer supportive services to enable consumers to perform the required employer tasks themselves. (3-1-99)T

04. Provider Agency Or Agency. An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for the care given, and provides payroll and benefits for care providers working for them. (3-1-99)T

05. Employer Of Record. An entity which bills for services, withholds required taxes, and conducts other administrative activities for a waiver program participant. Such an entity is also called a fiscal intermediary. (3-1-99)T

06. Employer Of Fact. A participant or representative of a participant who hires, fires, and directs the services delivered by a waiver program provider. This individual may be a family member. (3-1-99)T

07. Participant. An aged or disabled individual who requires and receives services under the Home and Community-based Waiver program. (3-1-99)T

670. SERVICES PROVIDED.

01. Services Provided Under Waiver. Services that may be provided under the waiver are: (3-1-99)T
- a. Adult day health; (3-1-99)T
 - b. Assistive technology; (3-1-99)T
 - c. Assisted transportation; (3-1-99)T
 - d. Attendant care; (3-1-99)T
 - e. Chore services; (3-1-99)T
 - f. Adult companion; (3-1-99)T
 - g. Adult residential care; (3-1-99)T
 - h. Consultation; (3-1-99)T
 - i. Home delivered meals; (3-1-99)T
 - j. Homemaker; (3-1-99)T
 - k. Home modifications; (3-1-99)T
 - l. Personal care services in excess of the State Medicaid Plan; (3-1-99)T
 - m. Personal emergency response system; (3-1-99)T
 - n. Psychiatric consultation; (3-1-99)T
 - o. Respite care; and (3-1-99)T
 - p. Skilled nursing. (3-1-99)T
02. Administrative Case Management. The Department will also provide administrative case management. (3-1-99)T

671. PRE-AUTHORIZATION REQUIREMENTS.

01. Pre-Authorization Requirements. All waiver services must be preauthorized by the Regional Medicaid Unit (RMU). Authorization will be based on the information from: (3-1-99)T
- a. The UAI; (3-1-99)T
 - b. The plan for service developed by the RMU or its contractor; and (3-1-99)T
 - c. Any other medical information which verifies the need for NF services in the absence of the waiver services. (3-1-99)T
02. UAI Administration. The UAI will be administered, and the initial plan for service developed, by the RMU or its contractor. (3-1-99)T

672. PROVIDER QUALIFICATIONS.

Each provider must have a signed provider agreement with the Department for each of the services it provides. (3-1-99)T

01. Employment Status. Unless otherwise specified by the Department, each individual service provider must be an employee of an agency, or an employee of record for a FI. The Department may enter into provider agreements with individuals in situations where no agency exists, or no FI is willing to provide services. Such agreements will be reviewed annually to verify whether coverage by an agency or FI is still not available.

(3-1-99)T

02. Provider Qualifications. All providers of homemaker, respite care, adult day health, transportation, chore companion, attendant adult residential care, home delivered meals, and behavior consultants must meet, either by formal training or demonstrated competency, the training requirements contained in the provider training matrix and the standards for direct care staff and allowable tasks/activities in the Department's approved waiver request.

(3-1-99)T

03. Personal Care Providers Qualifications. Personal Care Providers must meet the requirements of Section 146 of these rules.

(3-1-99)T

04. Specialized Medical Equipment Provider Qualifications. Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers.

(3-1-99)T

05. Nursing Service Provider Qualifications. Nursing Service Providers must be licensed as an R.N. or L.P.N. in Idaho or be practicing on a federal reservation and be licensed in another state.

(3-1-99)T

06. Psychiatric Consultation Provider Qualifications. Psychiatric Consultation Providers must have:

(3-1-99)T

a. A master's degree in a behavioral science;

(3-1-99)T

b. Be licensed in accordance with state law and regulations; or

(3-1-99)T

c. Have a bachelor's degree and work for an agency with direct supervision from a licensed or Ph.D. psychologist and have one (1) year's experience in treating severe behavior problems.

(3-1-99)T

07. Consultation Services. Services must be provided through an agency or FI by a person who has demonstrated skills in training participants/family members in hiring, firing, training, and supervising their own care providers.

(3-1-99)T

08. Adult Residential Care Providers. The facility will meet all applicable state laws and regulations. In addition, the provider must ensure that adequate staff are provided to meet the needs of the participants accepted for admission.

(3-1-99)T

09. Home Delivered Meals. Providers must be a public agency or private business and must be capable of:

(3-1-99)T

a. Supervising the direct service;

(3-1-99)T

b. Providing assurance that each meal meets one-third (1/3) of the recommended daily allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences;

(3-1-99)T

c. Delivering the meals in accordance with the plan for care, in a sanitary manner and at the correct temperature for the specific type of food;

(3-1-99)T

d. Maintaining documentation that the meals served are made from the highest USDA grade for each specific food served; and

(3-1-99)T

e. Being inspected and licensed as a food establishment by the district health department.

(3-1-99)T

673. ADULT DAY CARE.

Adult Day Care is a supervised, structured day program, outside the home of the participant, that may offer one (1) or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. (3-1-99)T

01. Facilities. Facilities which provide adult day care must be maintained in safe and sanitary manner. Facilities will provide the necessary space and staff to meet the needs of the participants accepted by the provider. Supervision must be provided by the facility as necessary, to assure the safety and comfort of participants served. (3-1-99)T

02. Providers' Homes. Providers accepting participants into their homes for services must maintain the homes in a safe and sanitary manner. Supervision must be provided by the provider as necessary to assure the safety and comfort of participants served. (3-1-99)T

674. -- 675. (RESERVED).

676. ASSISTIVE TECHNOLOGY.

Assistive technology is any item, piece of equipment, or product system beyond the scope of the Medicaid state plan, whether acquired off the shelf or customized, that is used to increase, maintain, or improve the functional capability of the participant. Assistive technology also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment. All items shall meet applicable standards of manufacture, design and installation. The equipment must be the most cost effective to meet the participant's need. (3-1-99)T

677. ASSISTED TRANSPORTATION SERVICES.

Individual assistance with non-medical transportation services, including escort to a person who has difficulties (physical or cognitive) using regular vehicular transportation. Such services are specified in the plan for services in order to enable waiver participants to gain access to waiver and other community services and resources. (3-1-99)T

01. Assisted Transportation Service. Assisted transportation service is offered in addition to medical transportation required in Section 150, and shall not replace it. (3-1-99)T

02. Service Without Charge. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge or public transit providers will be utilized. (3-1-99)T

678. -- 679. (RESERVED).

680. ATTENDANT CARE.

Services that involve personal and medically oriented tasks dealing with the functional needs of the participant. These services may include, but are not limited to personal care and medical tasks that can be done by unlicensed persons, or delegated to an unlicensed person by a licensed health care professional. Additionally, it may include administration of medications, ventilator care, and tube feeding. Services may occur in the participant's home, community, work, school or recreational settings. (3-1-99)T

01. Responsibility For Care. The participant or family must be able and willing to assume responsibility for the direction of the participant's care and for personnel activities such as provider selection and supervision. (3-1-99)T

02. Supervision. The Department may require supervision by a health care professional if the required care is so complex that such supervision is necessary for health and safety. (3-1-99)T

681. PSYCHIATRIC CONSULTATION.

Direct consultation and clinical evaluation of participants, who are currently experiencing or may be expected to experience a psychological, behavioral, or emotional crisis. This service may provide training to the direct service provider or participant's family related to the needs of a participant. These services also provide emergency intervention involving the direct support of the participant in crisis. (3-1-99)T

682. CHORE SERVICES.

01. Intermittent Assistance. Intermittent assistance including, but not limited to: (3-1-99)T
- a. Yard maintenance; (3-1-99)T
 - b. Minor home repair; (3-1-99)T
 - c. Heavy housework; (3-1-99)T
 - d. Sidewalk maintenance; and (3-1-99)T
 - e. Trash removal to assist the participant to remain in their home. (3-1-99)T
02. Chore Activities. Chore activities include: (3-1-99)T
- a. Washing windows; (3-1-99)T
 - b. Moving heavy furniture; (3-1-99)T
 - c. Shoveling snow to provide safe access inside and outside the home; (3-1-99)T
 - d. Chopping wood when wood is the participant's primary source of heat; and (3-1-99)T
 - e. Tacking down loose rugs and flooring. (3-1-99)T
03. Availability Of Services. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer, agency, or third party payor is willing to or is responsible for their provision. (3-1-99)T
04. Rental Property. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (3-1-99)T

683. ADULT COMPANION SERVICES.

01. Services. In-home services to insure the safety and well-being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergency situations, or other conditions that would require a person on-site. (3-1-99)T
02. Service Activities. The service provider may provide voice cuing and occasional assistance with toileting, personal hygiene, dressing, and other activities of daily living. However, the major responsibility is to provide companionship and be there in case they are needed. (3-1-99)T

684. CONSULTATION.

01. Services To Participant Or Family Member. Services provided by an agency or through an FI to a participant or family member to increase their skills as an employer or manager of their own care. Such services are directed at achieving the highest level of independence and self reliance possible for the participant/family. (3-1-99)T
02. Services To The Provider. Services to the provider are for the purpose of understanding the special needs of the participant and the role of the care giver. (3-1-99)T

685. HOMEMAKER SERVICES.

01. Homemaker Services. Assistance to the participant with light housekeeping, laundry, assistance with essential errands, meal preparation, and other light housekeeping duties if there is no one else in the household capable of performing these tasks. (3-1-99)T

02. Homemaker. The homemaker must be an employee of an agency or an employee of record of a fiscal intermediary. (3-1-99)T

686. -- 688. (RESERVED).

689. HOME DELIVERED MEALS.

01. Home Delivered Meals. Meals which are designed to promote adequate participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. (3-1-99)T

02. Meals Delivered. Home delivered meals are limited to participants who: (3-1-99)T

a. Rent or own their own home; (3-1-99)T

b. Are alone for significant parts of the day; (3-1-99)T

c. Have no regular caretaker for extended periods of time; and (3-1-99)T

d. Are unable to prepare a balanced meal. (3-1-99)T

690. HOME MODIFICATIONS.

01. Minor Housing Adaptations. Minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization. Such adaptations may include: (3-1-99)T

a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but shall exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. (3-1-99)T

b. All services shall be provided in accordance with applicable state or local building codes. (3-1-99)T

02. Permanent Environmental Modifications. Permanent environmental modifications are limited to modifications to a home owned by the participant or the participant's family and the home is the participant's principal residence. (3-1-99)T

03. Portable Or Non-Stationary Modifications. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (3-1-99)T

04. Services Meet All Applicable Codes. All services must meet applicable state and/or local building, plumbing, electrical and/or requirements for certification. (3-1-99)T

691. NURSING SERVICES.

01. Services. Intermittent or continuous oversight, training, or skilled care which is within the scope of the Nurse Practice Act and as such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. These services are not appropriate if they are less cost effective than a Home Health visit. (3-1-99)T

02. Nursing Services. Nursing services may include but are not limited to: (3-1-99)T
- a. The insertion and maintenance of nasogastric tubes and the monitoring or installation of feeding material: (3-1-99)T
- b. The maintenance of volume ventilators including associated tracheotomy care, tracheotomy, and oral pharyngeal suctioning. (3-1-99)T
- c. Maintenance and monitoring of IV fluids and/or nutritional supplements which are to be administered on a continuous or daily basis: (3-1-99)T
- d. Injections: (3-1-99)T
- e. Blood glucose monitoring; and (3-1-99)T
- f. Blood pressure monitoring. (3-1-99)T

692. PERSONAL CARE SERVICES UNDER THE WAIVER.

Services which are described in Section 146 of these rules and are provided in excess of state plan limitations and the restrictions contained in Subsection 146.01.b.i. of these rules. (3-1-99)T

01. Hourly Services. Personal care services under the waiver include limited hourly services in the home of the client only. For services in the home of the provider, see Section 694, Adult Residential Care. (3-1-99)T

02. Requirements For An FI. Consumers of PCS will have one (1) year from the date which services begin in their geographic region, as described in Section 667 of these rules, to obtain the services of an FI and become an employee of fact or to use the services of an agency unless the provisions of Subsection 670.01 are met. (3-1-99)T

693. PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS).

01. Personal Emergency Response System. A system which may be provided to monitor waiver participant safety or provide access to emergency crisis intervention for emotional, medical, or environmental emergencies through the provision of communication connection systems. (3-1-99)T

02. Limitations. PERS are limited to participants who: (3-1-99)T
- a. Rent or own their home; (3-1-99)T
- b. Are alone for significant parts of the day; (3-1-99)T
- c. Have no regular caretaker for extended periods of time; and (3-1-99)T
- d. Would otherwise require extensive routine supervision. (3-1-99)T

694. ADULT RESIDENTIAL CARE.

01. Adult Residential Care Services. Services are those that consist of a range of services provided in a congregate setting licensed in accordance with IDAPA 16.03.22, "Rules for Residential Care Facilities in Idaho," that may include: (3-1-99)T

- a. Medication management; (3-1-99)T
- b. Assistance with activities of daily living; (3-1-99)T
- c. Meals, including special diets; (3-1-99)T
- d. Housekeeping; (3-1-99)T

- e. Laundry; (3-1-99)T
- f. Transportation; (3-1-99)T
- g. Opportunities for socialization; (3-1-99)T
- h. Recreation; and (3-1-99)T
- i. Assistance with personal finances. (3-1-99)T

02. Administration Oversight. Administrative oversight must be provided for all services provided or available in this setting.

03. Written Plan. A written plan for services will be negotiated between the participant or legal representative, and a facility representative. (3-1-99)T

695. RESPITE CARE SERVICES.

01. Respite Care Services. Occasional breaks from care giving responsibilities to non-paid care givers. The care giver or participant is responsible for selecting, training, and directing the provider. (3-1-99)T

02. Limitations. While receiving respite care services, the waiver participant cannot receive other waiver services which are duplicative in nature. Respite care services provided under this waiver will not include room and board payments. (3-1-99)T

696. PLACE OF SERVICE DELIVERY.

01. Place Of Service Delivery. Waiver services may be provided in the participant's: (3-1-99)T

- a. Personal residence; (3-1-99)T
- b. Employment program; or (3-1-99)T
- c. Community. (3-1-99)T

02. Excluded Living Situations. Living situations specifically excluded as a personal residence are: (3-1-99)T

- a. Skilled, or Intermediate Care Facilities; (3-1-99)T
- b. Nursing Facility (NF); (3-1-99)T
- c. Licensed Intermediate Care Facility for the Mentally Retarded (ICF/MR); and (3-1-99)T
- d. Hospitals. (3-1-99)T

697. ROLE OF THE REGIONAL MEDICAID UNIT.

The RMU will provide for the administration of the UAI, and the development of the initial PFS. This will be done either by RMU staff or a contractor. The RMU will review and approve all PFSs, and the will authorize Medicaid payment by type, scope, and amount. (3-1-99)T

01. Services Not In PFS. Services which are not in the PFS approved by the RMU are not eligible for Medicaid payment. (3-1-99)T

02. Excess Services. Services in excess of those in the approved PFS are not eligible for Medicaid payment. (3-1-99)T

03. Early Approval Date. The earliest date that services may be approved by the RMU for Medicaid payment is the date that the participant's PFS is signed by the RMU or its contractor and signed by the participant or his designee. (3-1-99)T

698. SERVICE DELIVERED FOLLOWING A WRITTEN PLAN FOR SERVICES.

All waiver services must be authorized by the RMU in the Region where the participant will be residing and provided based on a written PFS. (3-1-99)T

01. Development Of The PFS. The initial PFS is developed by the RMU or its contractor, based on the UAI, in conjunction with: (3-1-99)T

a. The waiver participant (efforts must be made to maximize the participant's involvement in the planning process by providing him with information and education regarding his rights); and (3-1-99)T

b. The guardian, when appropriate; and (3-1-99)T

c. The supervising nurse or case manager, when appropriate; and (3-1-99)T

d. Others identified by the waiver participant. (3-1-99)T

02. Contents Of The PFS. The PFS must include the following: (3-1-99)T

a. The specific type, amount, frequency, and duration of Medicaid reimbursed waiver services to be provided; and (3-1-99)T

b. Supports and service needs that are to be met by the participant's family, friends, neighbors, volunteers, church, and other community services; and (3-1-99)T

c. The providers of waiver services when known; and (3-1-99)T

d. Documentation that the participant has been given a choice between waiver services and institutional placement; and (3-1-99)T

e. The signature of the participant or his legal representative and the RMU or its contractor, agreeing to the plan. (3-1-99)T

03. PFS Revision. The plan must be revised and updated at least annually, based upon treatment results or a change in the participant's needs. (3-1-99)T

04. Authorization Of Services. All services reimbursed under the Home and Community Based Waiver must be authorized by the RMU prior to the payment of services. (3-1-99)T

05. Service Supervision. The Plan for Service, which includes all waiver services, is monitored by the participant, family, the RMU or its contractor. (3-1-99)T

699. PARTICIPANT ELIGIBILITY DETERMINATION.

Waiver eligibility will be determined by the RMU. The participant must be eligible for Medicaid as described in IDAPA 16.03.05, "Rules Governing Eligibility for the Aged, Blind, and Disabled (AABD)". In addition, waiver participants must meet the following requirements. (3-1-99)T

01. Requirements For Determining Participant Eligibility. The RMU must determine that: (3-1-99)T

a. The participant would qualify for NF level of care as set forth in Section 180 of these rules, if the waiver services listed in Section 664 of these rules were not made available; and (3-1-99)T

b. The participant could be safely and effectively maintained in the requested/chosen community

residence with appropriate waiver services. This determination must be made by the RMU. Prior to any denial of services on this basis, the case manager must verify that services to correct the concerns of the team are not available. (3-1-99)T

c. The average daily cost of waiver services and other medical services to the participant would not exceed the average daily cost to Medicaid of NF care. (3-1-99)T

d. Following the approval by the RMU for services under the waiver, the participant must receive and continue to receive a waiver service as described in these rules. A participant who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program. (3-1-99)T

02. Admission To A Nursing Facility. A participant who is determined by the RMU to be eligible for services under the waiver may elect to not utilize waiver services and may choose admission to an NF. (3-1-99)T

03. Redetermination Process. Case Redetermination will be conducted by the RMU or its contractor. The redetermination process will verify that the participant continues to meet NF level of care and the participant's continued need for waiver services. (3-1-99)T

700. PROVIDER REIMBURSEMENT.

The criteria used in reimbursing providers for waiver services are: (3-1-99)T

01. Fee For Services. Waiver service providers will be paid on a fee for service basis as established by the Department depending on the type of service provided. Adult residential care will be paid on a per diem basis, based on the number of hours of service required by the participant. (3-1-99)T

02. Provider Claims. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department's payment system contractor. (3-1-99)T

03. Calculation Of Fees. The fees calculated for waiver services include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location when the participant is not being provided waiver or state plan transportation. (3-1-99)T

701. PROVIDER RECORDS.

Records will be maintained on each waiver participant. (3-1-99)T

01. Service Provider Information. Each service provider shall document each visit made or service provided to the participant, and will record at a minimum the following information: (3-1-99)T

a. Date and time of visit; and (3-1-99)T

b. Services provided during the visit; and (3-1-99)T

c. Provider observation of the participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and (3-1-99)T

d. Length of visit, including time in and time out, if appropriate to the service provided. Unless the RMU or its contractor determines that the participant is unable to do so, the service delivery will be verified by the participant as evidenced by their signature on the service record. (3-1-99)T

02. Original Record. The provider is required to keep the original service delivery record. A copy of the service delivery record will be maintained in the participant's living arrangement unless authorized to be kept elsewhere by the RMU. Failure to maintain documentation according to these rules shall result in the recoupment of funds paid for undocumented services. (3-1-99)T

03. Plan For Service. The PFS initiated by the RMU or its contractor must specify which waiver

services are required by the participant. The plan will contain all elements required by Subsection 698.02 and a copy of the most current PFS will be maintained in the participant's home and will be available to all service providers and the Department. A copy of the current PFS and UAI will be available from the RMU to each individual service provider with a release of information signed by the participant or legal representative. (3-1-99)T

702. PROVIDER RESPONSIBILITY FOR NOTIFICATION.

The service provider is responsible to notify the physician, supervising RN, or case manager, and family if applicable, when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. (3-1-99)T

703. RECORDS RETENTION.

Provider agencies, FIs, and other providers are responsible to retain their records for five (5) years following the date of service. (3-1-99)T

704. HOME AND COMMUNITY BASED SERVICES WAIVER PARTICIPANT LIMITATIONS.

The number of Medicaid participants to receive waiver services under the home and community based services waiver for the aged and disabled will be limited to the projected number of users identified in the Department's approved waiver. If necessary, participants who apply for waiver services after the waiver maximum has been reached will be placed on a waiting list and will have their applications processed after September 30 of each new waiver year. The earliest effective date of waiver service delivery for these participants will be October 1 of each new waiver year. (3-1-99)T

705. -- 764. (RESERVED).

**IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.09 - RULES GOVERNING MEDICAL ASSISTANCE**

DOCKET NO. 16-0309-9903

NOTICE OF TEMPORARY RULE

EFFECTIVE DATE: These temporary rules are effective March 1, 1999.

AUTHORITY: In compliance with Section 67-5226, Idaho Code, notice is hereby given this agency has adopted temporary rules. The action is authorized pursuant to Section(s) 56-202(f), Idaho Code.

DESCRIPTIVE SUMMARY: Expands and clarifies specific criteria to be utilized to determine if an individual with mental retardation (or a related condition) meets ICF/MR level of care.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code and are necessary in order to protect public health, safety and welfare.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary rules, contact Jean Christensen at (208) 364-1828.

DATED this 7th day of April, 1999.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Division of Legal Services
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone
(208) 334-5548 fax

THE FOLLOWING IS TEXT OF DOCKET NO. 16-0309-9903

611. INDIVIDUALS WITH MENTAL RETARDATION OR RELATED CONDITIONS.

Individuals who have mental retardation or a related condition as defined in Section 66-402, Idaho Code, must be determined by an interdisciplinary team to need the consistent, intense, frequent services including active treatment provided in an ICF/MR as indicated in Sections 612 through 615. ~~(1-1-98)F(3-1-99)T~~

612. CRITERION 1 - FUNCTIONAL LIMITATIONS.

01. Persons Sixteen Years Of Age Or Older. Persons (sixteen (16) years of age or older) may qualify based on their functional skills. Persons with an age equivalency composite score of ~~seven-eight (78)~~ years and zero (0) months or less on a full scale functional assessment (Woodcock Johnson Scales of Independent Behavior, or SIB-R, or subsequent revisions) would qualify; or ~~(1-1-98)F(3-1-99)T~~

02. Persons Under Sixteen Years Of Age. Persons (under sixteen (16) years of age) qualify if their composite full scale functional age equivalency is less than ~~forty-four~~ fifty percent (~~44~~50%) of their chronological age; or ~~(1-1-98)F(3-1-99)T~~

613. CRITERION 2 - MALADAPTIVE BEHAVIOR.

01. A Minus Twenty-Two (-22) Or Below Score. Individuals may qualify for ICF/MR level of care based on maladaptive behavior. Persons will be eligible if their General Maladaptive Index on the Woodcock Johnson Scales of Independent Behavior or SIB-R or subsequent revision is minus twenty-two (-22) or less; or (11-1-98)T

02. Above A Minus Twenty-Two (-22) Score. Individuals who score above minus twenty-two (-22) may qualify for ICF/MR level of care if they endanger themselves by engaging in self-abusive behaviors that are life threatening or that lead to permanent disfigurement, or endanger others by engaging in aggressive acts that qualify as a felony if they have the capacity to stand trial aggressive or self injurious behaviors of such intensity that the behavior seriously endangers the safety of the individual or others, the behavior is directly related to developmental disability, and the person requires active treatment to control or decrease the behavior; or ~~(11-1-98)T~~(3-1-99)T

614. CRITERION 3 - COMBINATION FUNCTIONAL/MALADAPTIVE BEHAVIORS.

Persons may qualify for ICF/MR level of care if they display a combination of Criterion 1 and 2 at a level that is significant and it can be determined they are in need of the level of services provided in an ICF/MR, including active treatment services. Significance would be defined as: (11-1-98)T

01. Persons Sixteen Years Of Age Or Older. For persons sixteen (16) years of age or older, an overall age equivalency up to ~~seven eight~~ and one-half (7 $\frac{1}{2}$) years is significant in the area of functionality when combined with a General Maladaptive Index on the Woodcock Johnson SIB up to minus seventeen (-17), minus twenty-two (-22) inclusive; or ~~(11-1-98)T~~(3-1-99)T

02. Persons Under Sixteen Years Of Age. For persons under sixteen (16) years of age, an overall age equivalency between up to forty-four percent (44%) and forty-seven fifty-three percent (47.53%) of their chronological age is considered significant when combined with a General Maladaptive Index on the Woodcock Johnson SIB between minus seventeen (-17), and minus twenty-two (-22) inclusive; or ~~(11-1-98)T~~(3-1-99)T

(BREAK IN CONTINUITY OF SECTIONS)

630. CHANGE IN ELIGIBILITY - ICF/MR.

Annual and subsequent redeterminations. Persons not meeting ICF/MR level of care after redetermination. Individuals who were redetermined ineligible between November 1, 1998 and March 1, 1999 will be eligible to continue services until March 1, 2001. Individuals redetermined after March 1, 1999 will be eligible to continue services until March 1, 2001. Individuals who do not meet ICF/MR level of care after March 1, 2001, will lose Medicaid payment for services on the date specified by the RMU or Access unit. All new applicants after March 1, 1999 must meet this criteria to be eligible. ~~(11-1-98)T~~(3-1-99)T

01. Transitioning To A Less Restrictive Environment. Persons living in an ICF/MR shall be transitioned to a less restrictive environment as soon as possible after the determination that the recipient does not meet ICF/MR level of care. (11-1-98)T

02. Home Care For Certain Disabled Children (HCDC). Persons receiving HCDC Medicaid services through ICF/MR eligibility, will receive services until the end of the month in which the redetermination was made. These individuals must receive ten (10) days notification of termination of services. If the redetermination is made less than ten (10) days from the end of the month, payment continues until the end of the following month. (11-1-98)T

03. Developmentally Disabled Waiver. Individuals receiving Developmentally Disabled waiver services will have thirty (30) days from the time of the determination to transition to other community supports. (11-1-98)T

(BREAK IN CONTINUITY OF SECTIONS)

654. ~~RECERTIFICATION ANNUAL REDETERMINATION FOR ICF/MR LEVEL OF CARE.~~

~~A physician or physician's assistant or nurse practitioner~~ The RMU or Access Unit staff must ~~recertify~~ redetermine the ~~resident participant's~~ continuing need for ICF/MR placement by written, signed, and dated documentation in the ~~resident's medical record~~ level of care. Documentation will consist of the completion of a ~~recertification~~ redetermination statement on the "Recertification Level of Care" form HW020983 and/or the entry of all required information on the physician's order sheet. Such documentation shall be accomplished no later than every three hundred sixty-five (365) days from the most recent ~~such certification~~ determination. ~~(1-1-98)T(3-1-99)T~~

(BREAK IN CONTINUITY OF SECTIONS)

656. ~~--659-- (RESERVED) REQUEST FOR RECONSIDERATION OF ICF/MR LEVEL OF CARE.~~

~~Applicants who have been found to not be eligible for ICF/MR level of care may request a reconsideration by a team which includes administrative staff from the Division of Family and Community Services, the Division of Medicaid and Interdisciplinary Professionals who were not involved in the original eligibility decision. This action does not replace the participant's right to a fair hearing. If a person requests a reconsideration, they will have thirty (30) days from the decision of the Review Team to file for a fair hearing.~~ ~~(3-1-99)T~~

657. ~~-- 659. (RESERVED).~~

IDAPA 27 - IDAHO BOARD OF PHARMACY
27.01.01 - RULES OF THE IDAHO BOARD OF PHARMACY
DOCKET NO. 27-0101-9901
NOTICE OF TEMPORARY RULE

EFFECTIVE DATE: These temporary rules are effective March 3, 1999.

AUTHORITY: In compliance with Section 67-5226, Idaho Code notice is hereby given this agency has adopted a temporary rule. The action is authorized pursuant to Section 54-1717, Idaho Code.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of the supporting reasons for temporary rulemaking.

This rule of procedure lists the agency's mailing and street addresses, telephone number, facsimile number, office hours for filing documents, and the officer or officers with whom all documents in rule-makings or contested cases must be filed.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(b) and 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

This rule is necessary to be in compliance with the requirements of IDAPA 04.11.01, "Idaho Rules of Administrative Procedure of the Attorney General," which the Board of Pharmacy follows in rulemakings or contested cases.

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

This rule does not propose or increase a fee or charge.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary rule, contact Richard Markuson at (208) 334-2356.

DATED this 3rd day of March, 1999.

Richard K. Markuson, Director
Idaho Board of Pharmacy
280 N. 8th St., Ste. 204
Boise, ID 83702
Phone: (208) 334-2356

THE FOLLOWING IS TEXT OF DOCKET NO. 27-0101-9901

011. ~~099.~~ (RESERVED) FILING OF DOCUMENTS.

01. Place And Time For Filing. All documents in rulemakings or contested cases shall be filed with the executive director of the Board of Pharmacy at the office of the Board of Pharmacy in Boise, Idaho, between the hours of 8 a.m. and 5 p.m. each day except Saturdays, Sundays and holidays. For purposes of such filing, the mailing and street addresses, telephone number, and facsimile number of the Board are as follows:

Idaho State Board of Pharmacy
280 N. 8th Street, Suite 204
P.O. Box 83720
Boise, Idaho 83720-0067

Telephone: (208) 334-2356
Facsimile: (208) 334-3536

(3-3-99)T

02. Manner Of Filing. One (1) original of each document is sufficient for filing, provided, however, the person or officer presiding over a particular rulemaking or contested case proceeding may issue orders requiring the filing of additional copies for use in such proceeding. Any pleading or document, not over ten (10) pages in length, and not requiring a filing fee, may be transmitted to the Board for filing by a facsimile machine process (FAX), provided such FAX transmission must be received legibly, and in its entirety, during the office hours set forth in Subsection 011.01. It shall be the responsibility of the filing party to verify with Board staff that a FAX transmission was successfully, and legibly, completed in its entirety. (3-3-99)T

012. -- 099. (RESERVED).

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16.03.09 - RULES GOVERNING MEDICAL ASSISTANCE

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IDAPA 27 - IDAHO BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO BOARD OF PHARMACY

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Bulletin Summary of Proposed Rule-Making

PUBLIC NOTICE OF INTENT TO PROPOSE OR PROMULGATE NEW OR CHANGED AGENCY RULES

The following agencies of the state of Idaho have published the complete text and all related, pertinent information concerning their intent to change or make the following rules in the new issue of the state Administrative Bulletin.

All rules published in this issue of the Bulletin are temporary and/or pending rules. There are no proposed rules being promulgated or published in this Bulletin.

Please refer to the Idaho Administrative Bulletin, **April 7, 1999, Volume 99-4** for notices and text of all rule-makings, public hearing schedules, governor's executives orders, and agency contact names.

Citizens of your county can view all issues of the Idaho Administrative Bulletin at the county law libraries.

Copies of the Administrative Bulletin and other rules publications are available for purchase. For subscription information and ordering call (208) 332-1820 or write the Office of the Administrative Rules Coordinator, Department of Administration, 650 W. State St., Room 100, Boise, Idaho 83720. Visa and Mastercard accepted.

The Idaho Administrative Bulletin and Administrative Code are available on the Internet at the following address: **<http://www.state.id.us/>** - from the State of Idaho Home Page select Administration Rules.

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